Review of the

CORONERS SERVICE
FOR NORTHERN IRELAND

Report of the Review Team

June 2015
Acknowledgments

This review addresses concerns from the Coroners Service for Northern Ireland (CSNI) judicial and administrative personnel regarding current and potential future resourcing pressures. It also supports implementation of a key priority included in The Stormont House Agreement of December 2014 to ensure “Processes dealing with the past should be victim-centred. Legacy inquests will continue as a separate process to the Historical Inquiry Unit. Recent domestic and European judgments have demonstrated that the legacy inquest process is not providing access to a sufficiently effective investigation within an acceptable timeframe. In light of this, the Executive will take appropriate steps to improve the way the legacy inquest function is conducted to comply with ECHR Article 2 requirements”.

The Review Team presented emerging findings at the beginning of June 2015. This is its final report. We are very grateful to all those who met us and provided evidence to the Review. We are also grateful to the staff of the CSNI for providing us with information and answering our queries.
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EXECUTIVE SUMMARY

In 2014/15, 4,000 deaths were reported to the Coroner (which is around 29% of all deaths in Northern Ireland); approximately 65% of these reported deaths were closed following cause of death being provided by medical practitioners. A total of 115 inquests were heard during this period.

While good progress has been made in improving the coronial system since the centralisation of the Coroners Service for Northern Ireland in 2006, there are still opportunities to enhance the current service to ensure it is clear, timely and efficient and supports both families and improved public safety.

The proposals outlined in this report provide a range of measures designed to address the key issues raised by participants in the coronial system and from comparator analysis with the systems in England and Wales, Ireland and Scotland.

In Northern Ireland, nationally and internationally, independent, transparent and accessible coronial death investigation systems recognise the significant contributions to public safety and the administration of justice that can occur from investigating and learning from deaths. It is therefore very important that our system delivers as high a standard as possible to families and the general public.

The most significant areas of reform relate to legislation, structure and service delivery. The report includes recommendations to better define how deaths should be investigated and improve the timeliness and consistency of how cases proceed through the coronial system. It also proposes ways to address areas of duplication and confusion between Coroners and other investigating authorities and ensure effective information provision by strengthening the use of memoranda of understanding and ensuring the Presiding Judge has a clear oversight role.

While some of the recommended changes only affect a small number of cases and will not have a big impact on volumes of cases or overall timeliness they can have a significant impact for the families and professionals who are involved with those cases.
This has been a targeted review and as such has centred on submissions from key stakeholders on areas where the operation of CSNI could be enhanced, rather than a public consultation process. However all those consulted have been comfortable with the thrust of the recommendations in this report.

The report emphasises with all Coroners the importance of them and the many participants in the system embracing the theme of improving services to families and making operational changes alongside legislative change.

In tandem with the review, the Department of Justice is working to improve the quality and consistency of coronial pathology services and work is progressing as part of the Stormont House Agreement to improve the delivery of the legacy inquest function.

While this began as a small targeted review, on-going discussions with key stakeholders have surfaced a growing number of ideas for change which will assist with the communications and education that needs to go in tandem with the change process to be led by the CSNI in implementing the recommendations in this report.
SUMMARY OF RECOMMENDATIONS

Below is a summary of the recommendations contained within the report.

Recommendation 1: CSNI to review on-call arrangements for Coroners.

Recommendation 2: CSNI should increase awareness of the on-line death reporting facility and instigate a pilot of its use within a number of Health Trusts.

Recommendation 3: Each Coroner should record their direction on deaths reported on the CSNI IT System to ensure their decision-making is accurately recorded and provide an audit trail of their decisions.

Recommendation 4: CSNI to review listing processes to ensure inquests are held at the earliest possible date, agreeing timeframes with interested parties for submission of statements and reducing the number of adjournments/cancellations.

Recommendation 5: CSNI to investigate whether Coroner’s can avail of training provided by the Judicial College for new and existing Coroners.

Recommendation 6: CSNI should agree arrangements with the Office of the Lord Chief Justice (OLCJ) for deploying coronial resource during periods of sick absence.

Recommendation 7: CSNI to consider producing an annual report to the President of the Coroners Service with the focus of driving up standards, challenging delay and improving consistency of approach.

Recommendation 8: CSNI to ask the NI Judicial Appointments Commission and the Minister to adjust Coroner complement to two full-time Coroners and a number of Deputy Coroners to create more flexibility and better align and integrate with additional resource at a higher judicial tier to deal with the most complex inquests.

Recommendation 9: CSNI to revise current case allocation and management arrangements so that the workload is evenly spread amongst Coroners and a consistent service is delivered to bereaved families.

Recommendation 10: CSNI to review performance targets with a view to including targets in relation to completing investigations and holding inquests; to implement a monitoring mechanism of charter standards to ensure compliance and make improvements where necessary.

Recommendation 11: CSNI to review existing Service Level /Working Practice Agreements and introduce these for all key stakeholders to improve working relationships.

Recommendation 12: CSNI to re-introduce a Coroners User Group with defined Terms of Reference, to improve communication.
Recommendation 13: CSNI to review legislation with a view to identifying areas for modernisation. Areas for consideration include the introduction of partial post-mortems and other forms of examination; delivery of summonses and investigative powers for Coroners Officers.
CHAPTER 1: BACKGROUND AND HISTORY

1.1 BACKGROUND

1.1.1 This review addresses concerns from CSNI judicial and administrative personnel regarding current and potential future resourcing pressures and on the basis of broad consultation with interested parties, makes recommendations to ensure greater resilience across CSNI to ensure that the Coroner service meets the needs of modern society. The review also supports implementation of a key priority included in The Stormont House Agreement (SHA) of December 2014 to ensure “Processes dealing with the past should be victim-centred. Legacy inquests will continue as a separate process to the HIU. Recent domestic and European judgments have demonstrated that the legacy inquest process is not providing access to a sufficiently effective investigation within an acceptable timeframe. In light of this, the Executive will take appropriate steps to improve the way the legacy inquest function is conducted to comply with ECHR Article 2 requirements”. Actions to further that policy are included in the review recommendations.

1.2 REVIEW TEAM

1.2.1 This review was set up in May 2015 by the Chief Executive, Northern Ireland Courts and Tribunals Service (NICTS) and work began immediately. The review team was led by Mandy Morrison, Acting Head of Tribunals and Enforcement Division, supported by Julie McBride, Colette Simmons and Richard Kernaghan, NICTS. The Terms of Reference for the review is attached (Annex A).

1.3 METHODOLOGY

1.3.1 During May, we carried out a number of exploratory visits and invited views and information from individuals and organisations involved in the delivery of the Coroners Service and from other comparable jurisdictions in England, Wales, Scotland and Republic of Ireland (ROI) to inform a benchmarking
exercise. June was spent analysing and following up the evidence received – including meetings with a range of interested parties – and carrying out visits to gather evidence from and outside CSNI. Members of the team also attended inquests. A list of all those we met is attached (Annex B).

1.4 HISTORY OF THE CORONERS' SERVICE

Northern Ireland Legislation

1.4.1 The jurisdiction of the Coroner in Northern Ireland is defined principally by the Coroners Act (Northern Ireland) 1959, and the Coroners (Practice and Procedure) Rules (Northern Ireland) 1963 [SR1963 No 199].

1.4.2 The Legal Aid and Coroners Courts Act (Northern Ireland) 2014 when commenced will provide for the Lord Chief Justice to be President of the Coroners' courts and for the appointment of a Presiding Coroner. Other relevant legislation is the Births and Deaths Registration (Northern Ireland) Order 1976.

The Wright Committee

1.4.3 The impetus for the 1959 Act came as a result of the Wright Committee in England and Wales which recommended that:

- Coroners' jurisdiction be limited to the investigation of the facts;
- only solicitors and barristers could be appointed as Coroners;
- Coroner no longer to have power to commit any person for trial on a charge of murder, manslaughter or infanticide;
- verdicts of censure or exoneration to be prohibited;
- laws of evidence to be observed in cases involving criminality;
- Coroner to be obliged to adjourn an inquest for 14 days, if requested by a Chief Officer of Police;
- Coroner to have discretion to dispense with holding a[n] inquest in the case of deaths due to simple accidents; and
- Coroner should have discretion whether or not to view a body.
The Broderick Committee

1.4.4 In 1971, the Broderick Report in England and Wales established that the accurate certification of the cause of death had now become the most important function of the Coroner. In particular, the Broderick Committee recommended that the Coroner should:

- have a statutory duty “to determine the identity of the deceased and the fact and cause of death”;
- make enquiries in order to decide whether a post-mortem examination or an inquest or some other action is required;
- “properly interested persons” should be given an “absolute” right to participate in an inquest, and legal aid should be made available to enable them to be legally represented;
- Coroner should have discretion to hold a “short” inquest based exclusively on documentary evidence;
- abolition of the duty of a Coroner’s jury to name the person responsible for causing a death and the Coroner’s obligation to commit a named person for trial; and
- the term “verdict” should be abandoned and replaced by “findings”.

The Luce Report

1.4.5 The Luce Report was presented to Parliament in 2003 based on a review and report on death certification and the Coroner services in England, Wales and Northern Ireland, authored by a group chaired by Mr Tom Luce CB, former Head of Social Care Policy Department of Health, with members from the legal profession, the Royal College of Pathologists, and others.

1.4.6 The report suggested the following changes:

i. A consistent professional service, based on full-time leadership throughout England, Wales and Northern Ireland;

ii. Consistency of service to families to be underpinned by a Family Charter having legal effect;
iii. A service that deals effectively with legal and health issues, works effectively across the full range of public health and public safety, and supports and audits the death certification process;

iv. In death certification, a common process to replace the “three-tier” cremation process with a “two-tier” certification system for all deaths equally, whether the body is buried or cremated;

v. More innovative and accessible outcomes to Coroner’s death investigations; and

vi. A proper recognition of the work of Coroner’s officers.

1.4.7 In advance of the introduction of new legislation to give full effect to the Luce recommendations, the then Northern Ireland Court Service, following consultation with key stakeholders, produced proposals for improving the system, through administrative redesign, including:

- Creating a single Northern Ireland Coroners jurisdiction.
- Revising the judicial structure.
- Providing an improved service to the public in relation to improved family liaison, enhanced administration and information technology, better public relations, court hearings, training for Coroners and liaison between the Coroners Service and other Agencies.
- Establishing protocols with other Agencies.
- Death investigation.
- Improving the availability and relevance of management information.
- Introducing a Coroners Service inspectorate.
- Planning future policy on the reform of the Coroners’ service.

1.4.8 The legislation remains mainly unchanged since 1959. Although the administrative arrangements for the Coroner service have been examined many times over the past ten years, and most recently in 2014.
CHAPTER 2: STRUCTURES AND SERVICE DELIVERY MODEL

2.1 Service Delivery Overview

2.1.1 In response to the Luce Review, CSNI was established as a centralised service in April 2006; implemented a new staffing and judicial structure (Annex C); and introduced the role of Coroners Liaison Officer (CLO) to improve family liaison. Her Majesty’s Inspectorate of Court Administration (HMICA’s) undertook an inspection of the CSNI in 2007. HMICA concluded that, whilst CSNI had made progress, there were a number of areas of improvement identified including performance management, information provision and communication with bereaved families, resourcing and support of staff, as well as more effective stakeholder engagement. HMICA under the delegated statutory authority of the Criminal Justice Inspectorsate Northern Ireland (CJINI) conducted a follow-up review in May 2009 and found that considerable progress had been made in meeting the seven recommendations made in the original inspection report.

2.1.2 An internal review was undertaken by CSNI Senior management in August 2014 following concerns raised by staff about the lack of clarity around decision making and roles and responsibilities between the Coroners and administrators. Annex D provides an update on progress against the accepted recommendations and observations made by the Review Team.

Current Structures

2.1.3 The judicial structure remains unchanged since 2006 when CSNI was established and has been used as the working baseline in respect of complement. There is no statutory maximum number of Coroners. Under the Justice (Northern Ireland) Act 2002 it is for the Northern Ireland Judicial Appointments Commission (NIJAC), with the agreement of the Department of Justice (DOJ), to determine the maximum number of those who may hold any judicial office for which no statutory maximum is prescribed. In the case of Coroners any such determination is to be the subject of consultation with the
Lord Chief Justice. All Coroners must either be practising solicitors or barristers for five years.

2.1.4 CSNI operates as a single jurisdiction covering the whole of Northern Ireland. Currently, there is a Senior Coroner and two Coroners and these are full-time positions. One of the County Court Judges is also a Coroner and has been assigned to deal with coronial business on a temporary basis when required. Their work is supported by a High Court Judge, who is the Presiding Judge of the Coroners Service. The Presiding Judge has responsibility for supporting the Senior Coroner in providing guidance and leadership; shaping the practice and procedure of Coroners in the functions of their office; guidance on the interpretation of case law in respect of Coroners practice and procedure; and hearing complex and or contentious inquests as and when deemed appropriate.

2.1.5 The Coroners (Practice and Procedure) Rules (Northern Ireland) 1963 provide that a Coroner shall at all times hold himself/herself ready to undertake any duties in connection with deaths reported to him/her, inquests and post-mortem examinations. To meet this requirement, the Coroners currently operate an on-call rota, each Coroner providing cover one week in three. Northern Ireland has a three day burial culture so decisions need to be made quickly so has not to delay the release of a body for funerals. The Coroner will normally only deal with emergencies and the rota works well when all three Coroners are available however as part of our discussions with the Coroners, they felt that it needed reviewed.

**Recommendation 1: CSNI to review on-call arrangements for Coroners.**

**Legacy**

2.1.6 Since the establishment of CSNI, the office has managed the legacy caseload alongside routine coronial business and only a small number of legacy cases (12) have been concluded. Legacy inquests require considerable amounts of pre-hearing preparation and review by the Coroners and legal teams. They
are often subject to legal challenges prior to, during and after inquest. Since 2010 there have been seven inquests disposed of relating to eight deaths. Some of these inquests are currently the subject of judicial review proceedings and related appeals.

2.1.7 The legacy caseload has steadily increased as there have been continuing referrals from the Attorney General for Northern Ireland (AGNI) under Section 14 of the Coroners Act (NI) 1959 which have outstripped disposals. It is highly unlikely that significant progress can be made with this caseload without adversely impacting on the routine business of the CSNI as legacy cases are extremely complex and time consuming. Since 2010 there have been 27 new legacy cases (relating to 44 deaths) referred to the Coroner by the AGNI. It is anticipated that the Police Service for Northern Ireland (PSNI) will increase evidence production in respect of those cases already with the Coroner, and this will put a strain on the resources within CSNI, both coronial and administrative, to meet the expectations and demands to deliver simultaneous legacy inquests while still maintaining the business as usual work of CSNI. The referral of legacy cases from the AGNI is expected to continue for the foreseeable future.

2.1.8 In March 2012, the Minister of Justice agreed to an increase in the complement of Coroners following the appointment of one of the Coroners to the office of County Court Judge. Due to the significant expertise and experience built up by this Coroner, it was agreed with the Lord Chief Justice that his continuing to hold office as a Coroner as well as being appointed a Judge would allow his expertise to be called upon, if required, to support business needs and provide greater flexibility in deploying judicial resources. A new full-time Coroner was also appointed to replace him.

2.1.9 At this time, it was also agreed with the Minister of Justice that further work on formally establishing maximum numbers for judicial offices was to be undertaken with a view to setting out the judicial complement at each tier but no work has been progressed. Therefore NIJAC and Management Support
Branch, NICTS hold the agreed complement at each tier agreed at devolution. There are no reviews planned but requests for a change to complement are considered if a specific request is received or business need identified (as was the case concerning the coronial tier).

**Delivery Model**

2.1.10 There are approximately 14,000 deaths annually in Northern Ireland of which approximately 4,000 are reported to Coroners. Case allocation is based on historical arrangements rather than on the level of work and families’ needs. All Coroners work full-time and operate an on-call rota system. However their case loads vary considerably due to the case allocation and management system they operate. Currently, Coroners take carriage of those deaths reported when covering as duty Coroner. The majority of cases are closed within a few days of deaths being reported while others are closed following receipt of the full post-mortem report. If progressed to inquest additional coronial input is required as files are prepared for inquest. The present allocation of cases has created backlogs, delays and an inconsistent standard of service for bereaved families particularly during periods of long term absence or busy periods.

2.1.11 Coroners are paid a salary in accordance with recommendations made by the Senior Salaries Review body. This is reviewed annually. The Coroners have dedicated premises in central Belfast and support staff. Courthouse facilities are used for the holding of inquests. The Department of Justice employs forensic consultant pathologists based at the State Pathologist’s Department to carry out post-mortem examinations on behalf of the Coroner. Neuropathology and paediatric services are also provided to the Coroner by the Department of Justice through a Service level Agreement with Belfast Health and Social Care Trust. Details of the CSNI caseload and disposal, including legacy case, over the past five years and analysis of the current caseload at the end of April 2015 is attached *(Annex E).*
2.1.12 Responsibility for the various services of Coroners is spread across a number of organisations: the Department of Justice, is responsible for the legislation and policy; the NIJAC for appointments, the Ministry of Justice determines the rates of salary via the Senior Salaries Review Body, while NICTS pay for salaries, fees and travel; the Department of Health Social Services and Public Safety for the pathology services and post-mortem facilities which are used by the Coroners.

2.2 THE CORONIAL INVESTIGATION

2.2.1 The principal circumstances in which deaths are reportable to the Coroner are provided in sections 7 and 8 of the 1959 Act which include:

- as a result of violence or misadventure or by unfair means;
- as a result of negligence or misconduct or malpractice on the part of others;
- from any cause other than natural illness or disease for which he had been seen; and treated by a registered medical practitioner within 28 days prior to his death;
- in circumstances which require investigation; and
- where a dead body is found or an unexpected or unexplained death occurs attended by suspicious circumstances.

2.2.2 The majority of deaths that are reported to the Coroner are closed quite quickly either by agreement with the Coroner that a medical practitioner can issue a death certificate or by lodgment of a proforma letter; or based on the result of a post-mortem. Only a relatively small number go forward for an inquest.

Post-mortem

2.2.3 The post-mortem examination is a key stage in the Coroner’s investigation as its findings identify the medical cause of death and often determine whether any further action on the part of the Corner is required. If the post-mortem examination shows that the death was from natural causes and there is no need for an inquest, then the Coroner will issue a certificate so that the death
can be registered. The Coroners Act (NI) 1959 states the “where on any inquest it appears to a Coroner that the cause of death has not been satisfactorily explained to him, he may ........ employ a registered medical practitioner on the list .... to perform a complete post-mortem examination.”

Inquest

2.2.4 Deciding to hold an inquest or not is a matter for the Coroner. The purpose of the inquest is to determine:
- Who the deceased was.
- When and where they died.
- How they came by their death.

It is usually the 'how' question that is the main focus of the inquest. It is a fact-finding process. The inquest cannot make findings in respect of criminal or civil liability. If any death that the Coroner investigates shows that a criminal offence may have been committed, the Coroner must give the Public Prosecution Service a written report. An inquest is mandatory if a prisoner dies in a prison and the Coroner must sit with a jury. In other cases a Coroner may sit alone to hear an inquest or with the assistance of a jury. To comply with Article 2 of the European Convention on Human Rights “how” is to be interpreted as in what circumstances (R (Middleton) v West Somerset Coroner [2004] UKHL0).

2.2.5 Section 14 of the Coroners Act, allows the Attorney General to order an inquest where he has reason to believe that a deceased person has died in circumstances which in his opinion make the holding of an inquest advisable, irrespective of whether one was held previously.

2.2.6 The process map (Annex F) details the processes of death reporting and investigations undertaken by the Coroners.
2.3 ROLES AND RESPONSIBILITIES

Presiding Judge

2.3.1 Tom Luce recommended that the coronial jurisdiction “… should be headed by a member of the permanent or senior judiciary and should include arrangements for enabling exceptionally complex inquests to be heard at higher judicial level.” Northern Ireland Court Service: “Proposals for Administrative Redesign” – February 2004 proposed a service “… headed by a senior presiding judge at High Court level.” [There should also be a full time Coroner and two full time deputy Coroners.] “The senior presiding judge will be appointed as a Coroner following consultation with the Lord Chief Justice.” [At the time JAC was not in place.] Northern Ireland Court Service: “Modernising the Coroners’ Service – The Way Ahead” – April 2005 concluded that the above proposal was “welcomed by everyone who responded.” It also stated that “the Lord Chief Justice of Northern Ireland will be invited to appoint a High Court judge as presiding judge for the Coroners’ Service. The presiding judge will have the same powers as a Coroner …”

2.3.2 The Presiding Judge was appointed by the Judicial Appointments Commission in March 2006 following consultation with the Lord Chief Justice. He supports the Senior Coroner in providing guidance and leadership in shaping the practice and procedure of Coroners in the functions of their office through monthly meetings with Coroners and administrative staff. He will hear complex and or contentious inquests as and when deemed appropriate.

Senior Coroner

2.3.3 The Senior Coroner is not a statutory office and has therefore no distinct statutory functions or powers. The job description for the Senior Coroner states that he has judicial, leadership and administrative responsibilities for the Coroners’ Service, including the supervision of casework allocation between the coroners; monitoring the effectiveness of casework procedures and a number of other responsibilities. He also represents the public face of the Coroner Service in its operational dealings with external organisations and agencies. The job description supplied to the Review Team by the Senior
Coroner is more detailed than Annex C but includes the same role and main responsibilities. A copy can be made available if required.

Coroner

2.3.4 The Coroners' primary role is to inquire into deaths reported to the CSNI where there is reason to believe that the deceased person died either directly or indirectly as detailed in paragraph 2.2.1. The Coroner will seek to establish the cause of death and will make whatever inquiries are necessary to do this e.g. ordering a post-mortem examination, obtaining witness statements and medical records, or holding an inquest.

2.3.5 The Coroner is an independent office holder who operates in the public interest in a judicial capacity co-ordinating the medico-legal investigations into certain deaths. If the Coroner's inquiries ultimately end up with the holding of an inquest, then it must be remembered that a Coroner's court is an inquisitorial court rather than an adversarial one. There is no “parties” in the Coroner's court. All depositions, post-mortem reports and verdict records are preserved by the Coroner and are only available on application to properly interested persons. The Coroner may summon a jury and may call witnesses but all these court-like aspects still focus on the establishment of the facts and not on apportioning guilt or blame. As Lord Lane pointed out: "........ an inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are not suitable for the other. In an inquest it should not be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish the facts. It is an inquisitorial process, a process of investigation quite unlike a trial....". (Lord Lane C.J in R v South London Coroner, ex parte Thompson (1982),126 S.J. 625).

Medical Officer

2.3.6 There is one full-time Medical Officer appointed to CSNI, currently provided through a Recruitment Agency. This role is important as the Medical Officer provides oral and written medical advice relating to reported deaths, post-
mortem reports, expert reports or inquest proceedings to Coroners and bereaved families. The Medical Officer has regular contact with key stakeholders including practitioners, hospital doctors, pathologists, PSNI and other stakeholder and related organisations. The Medical Officer has been effective in progressing cases to inquest or closure.

Administration Teams

2.3.7 As a result of the review in 2014, the administrative support within CSNI was re-organised into functional teams (Annex G). The new structure is currently working well however once it is embedded it would be prudent to review the complement to ensure it is sufficient within each team. The administration function is currently split into the following teams:

- Death Reporting;
- Case Management and Progression;
- Listing; and
- Coroners Liaison Officers.

Death Reporting Team

2.3.8 The Death Reporting Team receives on average of 4,000 reported deaths each year. Following a recent internal review a guidance document, “Referring deaths to the Coroner” was agreed and signed off by each of the Coroners. All reported deaths are now passed by a Coroner with the exception of those in which an automatic post-mortem is required. Complex or unusual hospital deaths are referred in the first instance to the Medical Officer who will instigate her own enquiries before agreeing a line of action with the Coroner.

2.3.9 The recording of deaths can be complex and it is paramount that the death reporting team accurately record and pass information onto the Coroner correctly. Cases are allocated to whichever Coroner is on duty when the death is reported. During office hours if the duty Coroner is unavailable due to
other commitments such as covering inquests etc., deaths can be referred to any other available Coroner.

2.3.10 Deaths can be reported on-line however there has been little up-take with this option from medical practitioners. We are unsure if the lack of use of the on-line service is due to limited awareness of the service; reluctance to use or if there is a training need. The majority of deaths are reported by a phone call and the Death Reporting Team record this information on the CSNI IT system. The staff relay this information to the Coroner, usually via phone and the Coroner directs how to proceed based on that information. This process works on the basis that the information is recorded and relayed correctly by both the death reporting staff and the Coroner. It is suggested that the Coroners should be given access to the CSNI computer system enabling them to record their direction onto the screen. This should quicken the process, ensure accurate recording of decisions by the Coroner and provide an audit trail of how decisions were reached, ensuring that the Coroner maintains responsibility and accountability for decisions. Coroners would seldom deal directly with individuals reporting deaths during normal working hours.

Administration Team On-call

2.3.11 The Coroner’s Office is open from 9.30am to 4.30pm each week day and 9.30am to 12.30pm at week-ends and all public holidays except Christmas Day. When the office is closed, deaths can be reported to an answer phone facility so CSNI can action these the following day. The administrative staff provide cover during the week-end and public holidays on a rota basis and at times it can be difficult to get cover as this is on a voluntary basis. Encouraging the use of on-line death reporting tool may enable this service to be provided in a different way.

**Recommendation 2:** CSNI should increase awareness of the on-line death reporting facility and instigate a pilot of its use within a number of Health Trusts.

**Recommendation 3:** Each Coroner should record their direction on deaths reported on the CSNI IT System to ensure their decision-making is accurately recorded and provide an audit trail of their decisions.
2.3.12 The Case Management Team has a workload of approximately 500 to 600 cases. Systems are in place to ensure that documentation for cases in which an inquest is likely, are requested at the earliest opportunity. Cases are referred to the Coroner for final direction once the post-mortem report and all relevant statements have been received. The Coroner will view the file and confirm a witness list and if any further information is required. Coroners may pass files onto the Medical Officer or Coroner’s Solicitor if further medical or legal advice is required.

2.3.13 Much time is spent by the Case Management Team in monitoring the progress of cases by way of a BF function available on the CSNI IT system. Lists are generated highlighting cases in which actions have not been adhered to. This results in the issue of further reminder letters or if necessary further referral to the Coroner. Letters requesting information from PSNI are issued to Occurrence Case Management Teams in line with the Working Practice Agreement (WPA) between PSNI and CSNI.

Listing Team

2.3.14 The listing of cases is a judicial function. This means it is for the Coroner to decide dates and times of inquests and any preliminary hearings. Once files are ready to proceed to inquest they are passed from the Case Progression Team to the Listing Team. This team is responsible for securing a suitable date and venue for the hearing of the inquest. They are responsible for summoning jurors and producing witness summonses which are served by the PSNI. The Team is also responsible for the listing of preliminary hearings directed by the Coroner, in order to address issues raised by parties as cases are progressed to listing. The Listing Team have advised that they do not list a case until all the paperwork is ready however the statistics for Jan – April 2015 (Annex E), show that on average 44% of preliminary hearings or inquests have been adjourned or cancelled for a number of reasons including at the direction of the Coroner, case not being ready, late application for funding, and witness unavailability. A lot of work goes into preparing a case
for listing and on the face of it there are a high percentage of adjournments/cancellations.

**Recommendation 4:** CSNI to review listing processes to ensure inquests are held at the earliest possible date, agreeing timeframes with interested parties for submission of statements and reducing the number of adjournments/cancellations.

2.3.15 A Court Clerk will be present at all inquests in order to provide administrative support to the Coroner. As all inquests are now recorded on “For the Record” (FTR), a system which records information discussed in coroner court proceedings, it is the Court Clerks responsibility to keep a log of key issues. They read the statements provided by each of the witnesses and result details of findings. They are also responsible for swearing in witnesses and Juries. CSNI staff carry out this function for Inquests listed in Belfast while business listed outside Belfast is covered by NICTS personnel based in the regional courthouses.

*Coroners Liaison Officer*

2.3.16 There are three Coroners Liaison Officers (CLO) within CSNI. A CLO is assigned to a family when a post-mortem has been ordered. They are responsible for liaising with the family regarding the preliminary cause of death following the post-mortem examination; advising if any organs or tissue samples were retained and why; and keeping the families informed throughout the Coroner’s investigation. The CLO’s work closely with the PSNI and its OCMT.

2.3.17 The PSNI in most cases are responsible for investigating the factual circumstances surrounding a death on behalf of the Coroner and will work closely with all administrative teams. A PSNI Investigating Officer will act as the Coroner’s Officer for the purpose of taking possession of a body, identification, transfers to the mortuary (if necessary), reporting information and gathering evidence. The WPA with the PSNI sets out the time limits for responding to queries and requests for information.
2.3.18 A CLO will be on-call from 5.00pm on Friday evenings to 8.00am on Monday and during public holidays to progress any automatic post-mortem cases, make contact with families to advise of preliminary findings and deal with any queries. The CLO will also receive requests for organ transplant approval which they forward to the Coroner for direction.

2.3.19 The CSNI has two solicitors employed in the Coroners Service who provide advice and support on legacy and non-legacy cases. The solicitors are responsible for advising the Coroners in respect of legal issues which arise in the preparation for and conduct of Inquests; and advising as to satellite litigation relating to Inquests, i.e. judicial review leave applications, substantive hearings and appeals. The solicitors also carry out a number of other functions in relation to disclosure, liaising and advising Counsel; communicating with the legal representatives; preparing and serving all necessary legal pleadings, affidavits and exhibits, court documents and bundles of authorities and liaising with administrative staff re listing of and preparation for preliminary hearings and inquests.

2.3.19 There is also a small administrative team that provide support on legacy work. However this arrangement is being reviewed as part of the new staffing structure for the planned Legacy Inquest Unit.

2.4 TRAINING

2.4.1 Coroners are required to keep abreast of legal developments and to attend any training organised by the Judicial Studies Board (JSB) and other training events and seminars as appropriate (for example in relation to medical and bereavement issues); induction training is provided by way of mentoring from existing Coroners and access to specific training in England and Wales. Coroners may also be required to sit in a representative capacity on committees/working groups connected with the legal system and from time to time to undertake a variety of other judicial and public duties. As part of our
discussions with the Coroners, they specified that training specific to providing Coroner services would be beneficial.

**Jurisdictional Comparison**

**England and Wales (E&W)**

2.4.2 The Chief Coroner has devised, developed and implemented training for all Coroners which for the first time is compulsory. Training is conducted under the auspices of the Judicial College or by the Chief Coroner and his office. Newly appointed Coroners in E&W undergo compulsory Coroner induction training. All new Coroners are required to attend a three-day induction training course which involves a mix of law, medicine and good practice. In conjunction with the induction training Assistant Coroners will have additional in-house training at the Coroner’s office and access to guidance and advice on the judicial intranet.

**Scotland**

2.4.3 Training is generally carried out in-house and provided by forensic pathologists, police officers and by senior staff within each Scottish Fatal Investigation Unit (SFIU). Electronic training packages are also available on the Crown Office Intranet. All staff undergoes training in delivering difficult messages to assist them in dealing with relatives of deceased persons.

**Republic of Ireland (ROI)**

2.4.4 The Coroners Society of Ireland holds in-house training days, meetings and seminars for all Coroners which they can avail of, although there is no formal training for Coroners.

**Recommendation 5**: CSNI to investigate whether Coroner’s can avail of training provided by the Judicial College for new and existing Coroners.
2.5 APPOINTMENTS AND DEPLOYMENT

2.5.1 Greater flexibility through the appointment of deputies would help to ease the problems of Coroners not being available for whatever reason and they should be able to be deployed as and when the need arises.

2.5.2 There is a power to appoint deputy Coroners under section 2(1) of the Coroners Act (NI) 1959. Section 6(2) of the 1959 Act also provides that where the Coroner for any district is unable owing to illness, absence or for any other cause to discharge his duties as such or neglects or fails to discharge those duties the LCJ may, after consultation with the [Department of Justice], in writing direct any Coroner or other person possessing the qualifications referred to in sub-section (3) of section (2) to act in that district.

Recommendation 6: CSNI should agree arrangements with the Office of the Lord Chief Justice (OLCJ) for deploying Coronial resource during periods of sick absence.
CHAPTER 3: FUTURE STRUCTURE FOR CSNI

3.1 INTRODUCTION

3.1.1 As stated in paragraph 2.1.10, the existing model in CSNI is not operating effectively due to Coroners being responsible for legacy and non-legacy cases and the way in which cases are currently allocated. A Senior Business Manager is to be appointed to CSNI who will have managerial responsibility for the Coronial and Legacy Administrative Teams and input into the allocation and management of cases. The Minister has already approved the appointment of an additional County Court Judge to support progression of legacy cases.

3.2 PRACTICE AND EXPERIENCE IN OTHER JURISDICTIONS

3.2.1 To assist with determining the most appropriate structure and service delivery model, the Review Team undertook a benchmarking exercise to provide a comparative analysis of coronial structures, processes, and key areas of reform together with support services and training in England and Wales, Republic of Ireland and Scotland. As Northern Ireland has a centralised Coroner Service it has been difficult to directly compare jurisdictions in terms of geographical mix (urban and rural) coupled with population numbers.

3.2.2 The Review Team gathered information from a number of areas (Hertfordshire, Birmingham, & Solihull, Northamptonshire, Kent, Cumbria, Dublin and Kildare) which have some of the similar characteristics and which were identified by the Coroners themselves; a synopsis of the findings is below. The benchmarking data (Annex H) provides more detail in relation to specific areas in terms of population, number of deaths, inquests and number of Coroners. Each of the areas examined publish details of inquests on their websites, including the name of the deceased, date of death, nature of death, inquest date and duration.

**England and Wales**

3.2.3 The Coroners and Justice Act 2009 (the 2009 Act), created the post of Chief Coroner for E&W. The Chief Coroner’s role is to set national standards in the
Coroner system, to develop a national framework in which Coroners will operate, and to implement and develop statutory and other Coroner reforms. The Chief Coroner produces an annual report to the Lord Chancellor and section 36 of the 2009 Act contains a number of statutory requirements for the contents of the report, including: matters that the Chief Coroner wishes to bring to the attention of the Lord Chancellor; an assessment for the year of the consistency of standards between Coroners areas; the number and length of investigations; and those that were not concluded as well as the reasons for the length of those investigation and measures taken.

**Recommendation 7:** CSNI to consider producing an annual report to the President of the Coroners Service with the focus of driving standards, challenging delay and improving consistency of approach.

3.2.4 There are currently 99 coronial areas in E&W, with 90 Senior Coroners; Coroners and support staff are appointed by the local authority. The Chief Coroner is hoping to reduce the number of areas to 75 or less. Some 220,000 deaths are reported to Coroners each year, circa 95,000 will involve a post-mortem examination. Each Coroner should deal with approximately 3,000 – 5,000 reported deaths each year; currently 60% of Coroner areas have fewer than 2,000. Most inquests will be held within six months, and if they are over 12 months they must be reported to the Chief Coroner under the 2009 Act.

3.2.5 The table below provides a snapshot of the number of deaths and inquests in the benchmarked areas in E&W.

<table>
<thead>
<tr>
<th>Area</th>
<th>Number of deaths reported</th>
<th>Number of inquests held</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hertfordshire</td>
<td>3200</td>
<td>10%</td>
</tr>
<tr>
<td>Birmingham &amp; Solihull</td>
<td>4205</td>
<td>25%</td>
</tr>
<tr>
<td>Northamptonshire</td>
<td>2578</td>
<td>10%</td>
</tr>
</tbody>
</table>
3.2.6 An initial analysis of the routine workload shows that the average caseload for the 99 Coroner areas in England and Wales is 2,261. Each Coroner area has one Senior Coroner and one or more Assistant Coroners. A Coroner area may also have an Area Coroner (who may function as a deputy to the Senior Coroner). In Hertfordshire, there is one Senior Coroner and four Assistant Coroners dealing with approximately 3,000 reported deaths per year. In Birmingham and Solihull there are two full-time Coroners and six Assistant Coroners dealing with approximately 4,300 reported deaths per year.

**Deputy/Assistant Coroners**

3.2.7 Senior Coroners are assisted by Deputy or Assistant Coroners who are paid a flat fee per day for office cover and an additional daily fee when sitting in Court (Annex I). In some areas Deputy/Assistant Coroners are given their own workload, with new cases provided to them when their cases have concluded. Assistant Coroners are given at least 15 days’ work a year and are part of a local team of Coroners, managed and supported by the local Senior Coroner in regular team meetings.

**Coroner Officers/Investigators**

3.2.8 Coroners are also supported in most areas by Senior Coroner Officers (Annex J) or Coroner Officers (Annex K), who are mainly appointed by local authorities. A Senior Coroner will manage and oversee the day to day running of the Coroner service and Coroner service staff to ensure that work is distributed effectively in order to deliver the relevant investigatory and administrative tasks and delivery of coronial business. Coroner Officers gather evidence such as written statements and medical reports to assist the Coroner in the execution of duties.
On-call

3.2.9 In E&W on-call arrangements vary greatly. The only requirement is that Coroners must be available to address matters relating to an investigation into a death which must be dealt with immediately and cannot wait until the next working day. It is generally felt that this means being available at all times to deal with homicides, mass fatalities and organ donation. As E&W is split into numerous districts, the arrangements vary greatly in each council district, to an informal agreement between the police and the Coroner that they can be rung up at night for a homicide or other emergency. Alternatively in some districts you would have a properly funded and organised on-call rota, with Coroner Officers acting as the first point of call and with the Senior Coroner available to deal with a wide range of matters including release of the body, post-mortem directions and scanning.

3.2.9 It is understood that as a general rule Coroners are exempt from the European Working Time Directive. E&W have informally addressed this issue and believe this position to be correct.

Republic of Ireland

3.2.10 ROI currently has 45 Coroner jurisdictions with 41 Coroners; only one of those Coroners is a full-time Coroner (Dublin) who has a dedicated office and support staff. The remaining 40 Coroners are part-time or known as Acting Coroners who work from busy practices as lawyers or doctors and have insufficient time and resources to allocate to supporting relatives throughout the full cycle of Coroner activity. They are paid a basic retainer which is intended to cover on-call duty and office services; and a fee per case which is paid in relation to the work carried out. A number of existing Coroners (16) were appointed under the Coroners Act 1962 which means they can only be a Coroner within their assigned area, while Coroners (25) appointed after the amendment to legislation can work in others areas, as long as it remains within the same local authority. It is hoped that as Coroners retire the number of jurisdictions and Coroners can be reduced.
3.2.11 Each Coroner is responsible for delivering and managing their own workload. In the ROI there were 15,833 deaths reported and 2053 inquests held in 2014. In County Kildare there were 534 deaths reported and 74 inquests held in 2014. One of the recommendations in the Report of the Coroner’s Review Group in 2000, was the introduction of Coroners Officers, however due to a lack of funding none have yet been appointed.

Scotland

3.2.12 Scotland operates a completely different system in that it does not have Coroners. Deaths are investigated by the Procurators Fiscal Service staffed with a number of Procurator Fiscal Deputies who are nearly all qualified lawyers (those who are not lawyers must be commissioned), employed by the Crown Office and Procurator Fiscal Service (COPFS) in specialist units and offices around Scotland. They are appointed in the same manner as any other civil servant. Procurator Fiscal Deputies also investigate and prosecute criminal cases.

3.2.13 The structure within the COPFS is that there is a National Unit (based in Glasgow) which is responsible for policy, administration etc. The Procurator Fiscal is head of the Scottish Fatal Investigation Unit (SFIU) and there are three SFIUs situated in the West (Glasgow), East (Edinburgh) and the North (Inverness, Aberdeen and Dundee) of Scotland who deal with all referred deaths arising in their geographical areas. There are 45 members of staff in SFIU including lawyers and members of support staff. Death reports received by the Procurator Fiscal Service are considered by members of the legal staff who will direct the nature and level of investigation required. There are four Principal Deputies in charge of each geographical area who manage and allocate the case work within that area. In 2014/2015 there were 9,549 reported deaths in Scotland; there were 61 mandatory Fatal Accident Inquiries (FAI) held following a death which gives rise to reasonable suspicion or, where the person is in custody; seven discretionary FAIs related to the
discretion of the Lord Advocate who petitions the Court for an inquiry where he considers that it is necessary in the public interest to do so. However the Review Team was unable to ascertain the average number of cases assigned to an individual Procurator Fiscal deputy.

### 3.3 NON-LEGACY FUTURE STRUCTURE

3.3.1 Accepting the services are not directly comparable with the areas analysed thus far, the analysis would suggest the judicial structure for CSNI could be two full-time Coroners for non-legacy cases with three Assistant/Deputy Coroners’ to provide flexibility in the delivery model and contingency as the need arises. Guidance would need to be developed clearly detailing the roles and responsibilities of deputy Coroners and in what circumstances they could be deployed i.e. to cover leave or unplanned absences and whether they would have their own cases to manage. Appropriate management arrangements will also need to be put in place to ensure that deputy Coroners are utilised only as and when required. If the complement within CSNI is to be reduced to two Coroners, it would be beneficial if any appointed deputies could be part of the on-call rota and paid a set fee. **Annex L** shows how CSNI might be structured.

**Recommendation 8:** CSNI to ask the NI Judicial Appointments Commission and the Minister to adjust Coroner complement to two full-time Coroners and a number of Deputy Coroners to create more flexibility and better align and integrate with additional resource at a higher judicial tier to deal with the most complex inquests.

### 3.4 FUTURE STRUCTURE FOR LEGACY INQUESTS

3.4.1 Under the Stormont House Agreement, the inquest process is to remain a central means by which the State discharges its Article 2 procedural obligation. The challenge is how to achieve this more efficiently and effectively than has been the experience to date. Inevitably, this will involve linkage with the investigative work of the Historical Investigations Unit once established. The Northern Ireland Executive is currently considering a number of options for improving the delivery of the legacy inquest function in Northern Ireland. The Minister has already approved the appointment of an additional County Court Judge to support progression of legacy cases.
3.4.2 A Legacy Inquest Unit, reporting to a CSNI Senior Business Manager, will be established to progress cases and will be supported by the appointment of Coroner’s Investigating Officers; legal support and administrative support.

3.5 CASE ALLOCATION AND MANAGEMENT

3.5.1 The link between the existing organisational structure and the most appropriate and effective way of delivering the service is not currently strong. The Coroners advised that during the last number of years, different methods have been used to allocate cases such as alphabetical split and the most recent being that whichever Coroner is on duty that week takes carriage of those cases. This method can lead to an unfair allocation of cases in terms of numbers, complexity and duration. It can also lead to families receiving a different level of service, for example if a Coroner is on long-term sick or unplanned leave then their workload is not progressing as quickly as others; in these instances cases are not routinely re-assigned to another Coroner. During discussions with The Honourable Mr Justice Weir, His Honour Judge Sherrard and each of the Coroners, we discussed the way in which cases are allocated and the consensus was that the current system was not working and needed to be changed to put the needs of bereaved families at the centre of the service.

3.5.2 One option proposed by the Review Team, which found favour, was to baseline the current caseload, in conjunction with the Coroners, in terms of number of cases, complexity and estimated duration. These cases would be shared amongst the Coroners. For new deaths reported to the Death Reporting Team, direction on how to proceed would still be given by the Coroner on-call or whichever Coroner is available in the office or by telephone. For those deaths which require a post-mortem or inquest these would be allocated to the Coroner, or Deputy Coroner as required, at the case progression stage by the Case Progression Team, in conjunction with the Senior Business Manager/Presiding Judge. Caseloads would be monitored to ensure as even as possible distribution between the Coroners. Also more
effective identification of those cases requiring investigation and targeted resources would be a key element of any new case management model. This would help to ensure that a consistent service was delivered to bereaved families.

**Recommendation 9:** CSNI to revise current case allocation and management arrangements so that the workload is evenly spread amongst Coroners and a consistent service is delivered to bereaved families.

### 3.6 PERFORMANCE STANDARDS

3.6.1 Current CSNI business standards only measure the administrative processes involved in the completion of Coroners’ investigations. The performance standards cover three key administrative functions which directly impact on the efficient disposal of CSNI business as follows:

- 97% of all deaths investigated that do not require a post-mortem examination will have the certificate of registration issued to the Registrar of Deaths within three working days of the death being reported to the Coroner.

- 92% of all deaths that require a post-mortem examination and that examination reveals a natural cause of death, will have the certificate of registration issued to the Registrar of Deaths within five working days of receipt of the post-mortem report.

- In 92% of inquests the administrative listing arrangements will be completed within 28 days of the Coroner’s direction to list.

3.6.2 All three CSNI standards have been continually exceeded since they were introduced in 2006. As highlighted in paragraph 2.3.11, a large percentage of inquests are adjourned or cancelled so it may be advisable to consider introducing targets in relation to completing investigations and holding inquests.
3.6.3 CSNI also has a Coroners Service Charter which sets out the standards of service that bereaved family members, witnesses and other properly interested persons can expect to receive from the CSNI. However performance against the standards is not routinely monitored.

**Recommendation 10:** CSNI to review performance targets with a view to including targets in relation to completing investigations and holding inquests; to implement a monitoring mechanism of charter standards to ensure compliance and make improvements where necessary.

3.7 STAKEHOLDER ARRANGEMENTS AND PROTOCOLS

3.7.1 CSNI has a number of stakeholders with whom they engage and interact to differing degrees. There is much that is good in the current Coroner system and many stakeholders viewed their working relationships with the Coroners as positive however a common theme throughout our meetings was the desire to have better communication, improved contact with and access to the Coroners and enhanced working relationships with CSNI overall.

3.7.2 A few stakeholders have in place a Service Level Agreement (SLA) or WPA; these have not been updated or reviewed recently. The agreements detail each party’s roles and responsibilities, timescales for production and receipt of documentation and standards of service. Each of the stakeholders we spoke with would welcome having an SLA or WPA with the CSNI so that timescales and standards of service can be jointly agreed. While they appreciate and understand they must comply with the Coroners instructions, they sometimes feel that there is a lack of appreciation of the work that goes into gathering statements, test results from post-mortems or reports. The Belfast Trust have a target of four weeks to get requested information to CSNI, the Trust advised us that they found this extremely challenging to meet.

As part of our discussions stakeholders advised that they are not always clear as to why an individual has been called as a witness to an inquest and that the facilities and structure of the Coroners Court could be improved to run...
more efficiently. Most of the stakeholders mentioned that there used to be a Coroners User Group which they found very useful to discuss issues, share experiences and information. They would like to see this reintroduced with defined terms of reference.

**Recommendation 11**: CSNI to review existing Service Level / Working Practice Agreements and introduce these for all key stakeholders to improve working relationships.

**Recommendation 12**: CSNI to re-introduce a Coroners User Group with defined Terms of Reference, to improve communication.

### 3.8 LEGISLATIVE REFORM

3.8.1 Coroner legislation has mostly remained unchanged for over fifty years. The Luce Review envisaged significant legislative reform but to date only the organisational and administrative arrangements for the Coroners Service have been reviewed and revised since the new service was established in April 2006. This contrasts with transformational societal changes throughout the second half of the twentieth century.

3.8.2 The Coroners legislation has been in effect since 1959 and does not necessarily meet current requirements. For example Section 27 (1) of the 1959 Act refers to “perform a complete post-mortem”; as part of our discussions with State Pathology Division it was suggested if partial more specific post-mortems could be directed by the Coroner thereby reducing the cost of post-mortems on the taxpayer and the length of time for a post-mortem report. Areas such as other forms of examination could also be explored such as cross-sectional imaging (CT scan or MRI scan).

3.8.3 Under section 14 (2) of the Coroners and Justice Act 2009, Coroners in England and Wales have discretion as to the type of post-mortem examination to be held. A hospital post-mortem, usually asked for by the patient’s doctor, can be limited to certain areas of the body, such as the head, chest or abdomen, and will be discussed with a family member for their
consent. A ‘medico-legal’ (involving both legal and medical aspects) post-mortem examination can be instructed by a Coroner in circumstances similar to NI. This is called a ‘Coroner’s post-mortem’ and they do not have to ask the next of kin’s consent.

**Recommendation 13:** CSNI to review legislation with a view to identifying areas for modernisation. Areas for consideration include the introduction of partial post-mortems and other forms of examination; delivery of summonses and investigative powers for Coroners Officers.
CHAPTER 4: IMPLEMENTATION

4.1 WAY FORWARD

4.1.1 As part of the review process, the Review Team shared emerging findings with the Chief Executive NICOTS, Lord Chief Justice and key members of the Coroners Service; broad agreement was reached on the issues and responses.

4.1.2 On agreement of this report, an implementation plan will be developed prioritising the recommendations that can be implemented with relative ease and agreeing a way forward for those that will require further engagement with stakeholders. It is the Review Teams intention that the findings from this report will be shared with key stakeholders.