

The Coroners Service for Northern Ireland

Business Review

April 2006 to March 2007

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the community
through the
administration
of justice



www.coronersni.gov.uk

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Presiding Judge's Foreword

It is a great pleasure for me to be able to say something by way of introduction to the first published report of the new Coroners Service for Northern Ireland ("CSNI") which covers its first twelve months of operation.

Prior to April 2006 the Coroners' districts in Northern Ireland were under the control of individual coroners responsible for one or more of them. Each had its own systems and methods of working, many Coroners were part-time and there was no centrally- available information concerning their performance nor any published performance targets or outcomes.

As a result of a commendable and far-sighted initiative on the part of the Northern Ireland Court Service, those districts have all been drawn together into a single district covering the whole of

Northern Ireland housed in one central location staffed by full-time Coroners and dedicated support staff with clear performance targets.

The first task of the new CSNI was to gather in all the files from the former districts, catalogue and file them according to a common system and then examine each open file to ascertain the stage it had reached and the remaining work required in order to close the case. Only then could the work described in this Business Review begin to happen.

The success of the service in its first year has been remarkable. Almost all the performance targets have been met or exceeded by our willing team despite the rise in the number of deaths reported to the service, a trend that seems to be continuing year on year. The work of the Coroners' Liaison Officers,

another pioneering innovation unique to Northern Ireland, whose task is to ensure that bereaved families are kept informed at every stage as the investigation proceeds, has been universally and deservedly praised.

The entire CSNI team can feel justifiably proud of their hard work and significant early achievements and confident that, now having “found their feet”, they will go from strength to strength in further developing and providing the innovative and effective service that is already an example to other coroners throughout these islands.

A handwritten signature in black ink, reading "Reg. Weir". The signature is written in a cursive style with a large initial 'R' and 'W'.

Reg Weir
Presiding Judge for the CSNI

Introduction

1. The Coroners Service for Northern Ireland (CSNI) was established on the 3rd April 2006 as the single Coroners District for Northern Ireland. Mr Justice Weir is the Presiding Judge, Mr John Leckey the Senior Coroner and two new fulltime Coroners, Mr Brian Sherrard and Ms Suzanne Anderson have been appointed. CSNI is based at May's Chambers, 73 May Street, Belfast, BT1 3JL.
2. This document provides statistical information on the first year of operation for CSNI including the operational targets set out in its Charter along with information on the development of partnerships and interagency agreements.
3. Coroners investigate the circumstances of sudden, unnatural or violent deaths in accordance with The Coroners Act (NI) 1959. The Coroner seeks to establish the cause of death by ordering medical examinations, obtaining witness statements and medical records and may hold an inquest.
4. **April 2006 to March 2007**
From April 2006 to March 2007 4253 deaths were reported to the CSNI by medical practitioners, PSNI officers and others. Of these 820 deaths did not require a Coroner's investigation and a medical practitioner provided the death certificate. A further 1746 deaths were reported to the CSNI as the deceased had not seen their general practitioner within the previous 28 days. The Coroner was able to have these deaths registered without the need for a post mortem examination following inquiries with the general practitioner concerned. The remaining 1687 deaths were the subject of more lengthy investigations and the majority of these cases required a post mortem examination. In a very small percentage the deaths were reported after burial and a post mortem had not been carried out.

TABLE 1 – DEATHS REPORTED APRIL 2006 TO MARCH 2007

	Number of deaths reported	Enquiries to Coroner requiring no action	Deaths requiring Investigation without post mortem	Deaths Requiring investigation with specialist and/or post mortem
Northern Ireland	4253	820	1746	1687

5. The following table provides a broad study categorisation of the 4253 deaths reported in the first year of the CSNI. Such details were not readily available prior to the centralisation of Coroner's districts.

TABLE 2 – STUDY CATEGORIES OF DEATHS REPORTED APRIL 2006 TO MARCH 2007

Reported deaths April 2006 to 2007	
Natural	3244
Alcohol related	100
Drugs related	29
Road Traffic Collisions (RTCs)	149
Hospital deaths	224
Possible suicides	214
Murders	31
Accidental	99
Industrial related	56
Other	107
	4253

Some deaths may suit more than one category however the most relevant for study purposes have been chosen, e.g. a death in hospital following a road traffic collision will be included in the RTC and not the hospital death category.

6. A comparison of coroners' caseload by calendar year from 2002 to 2006 reveals that the number of reported deaths has risen from 3563 in 2002 to 4244 in 2006 a rise of 19%. Current figures suggest that this rise will continue to approximately 4300 in 2007.

Table 3 - DEATHS REPORTED FFOM 2002 TO 2007 (predicted figure)

Year	Total Number of deaths reported in period	Enquiries to Coroner requiring no action	Deaths requiring investigation without post mortem	Deaths requiring investigation with post mortem
2002	3563	619	1355	1589
2003	3603	621	1335	1647
2004	3906	719	1446	1741
2005	4006	720	1549	1590
2006	4244	868	1732	1644
2007 (predicted)	4308	741	1853	1714

Business Performance

7. Deaths reported to Coroners fall into four distinct categories
 - Requirement for an inquest – a full investigation will lead to an inquest being held to establish the cause of death and the circumstances in which the death occurred. The Coroner will then issue a Form 21 to the registrar of deaths to enable the death to be registered.
 - Form 17 issued – an investigation requiring a post mortem examination has been carried out following which the Coroner has decided that an inquest is not necessary. A certificate to that effect is issued to the registrar of deaths to allow registration by the family of the deceased.
 - Form 14 issued – an investigation without a post mortem examination has been carried out and a certificate issued to the registrar of deaths to allow registration by the family of the deceased.
 - Other disposals – after discussions with any relevant medical practitioner the Coroner is content that an investigation is not required. The medical practitioner will issue a death certificate.

Table 4 demonstrates the business disposals for April 2006 to March 2007, the first year of the CSNI.

TABLE 4 – DISPOSAL OF BUSINESS APRIL 2006 TO MARCH 2007

	Outstanding at Start	Number of deaths reported	Number of inquests held	No inquests but post Mortem	No inquests and no post Mortem	Other disposals of registered entries	Outstanding at end
Northern Ireland	1347*	4253	226	1528	1746	820	1262

*1329 deaths reported with an additional 18 deaths that were previously reported to district Coroners but that came to light after the file transfer to CSNI.

8. The figures reveal the following –

Inquests

226 inquests were completed involving 475 hours and 50 minutes of court time. On average 250 inquests are held per year. Although the number of inquests held in 2006/2007 was below this average there was more time spent in court dealing with these cases. This reflects the increased complexity of the inquests. The average hearing time required per inquest was greater than those of the previous three years.

TABLE 5 – INQUEST FIGURES 03/04 TO 06/07

	Number of inquests	Duration of Sitting	
		Total time in hours	Average time
2003/2004	247	291:07	1:11
2004/2005	250	337:33	1:27
2005/2006	279*	441:44	1:35
2006/2007	226	475:50	2:06

*17 inquests had no time recorded. The average time for this period of 1 hour 30 minutes has been assumed for comparison purposes.

Our target is to dispose of 80% of inquests within 10 weeks of the Coroner's direction.

74% of inquests were listed within 10 weeks of the direction to proceed. A further 6% exceeded the target by less than one week giving 80% achieved within 11 weeks. The majority of cases exceeding the target were delayed due to the non-availability of the family or other expert witnesses,

the lack of available dates within the target period in the coroners' diaries or the longer period required to arrange juries.

Form 17s

1528 investigations were concluded by form 17 (post mortem carried out but no inquest deemed necessary). 843 of these deaths occurred from natural causes and did not require an inquest. In the other 785 cases the results of the post mortem examination were sufficient to conclude the investigation.

In these 'natural deaths – post mortem only' **our target is to issue the Form 17 to the Registrar of Deaths in 95% of cases within 5 working days of the Coroner's decision.**

Analysis of the 785 cases reveals that 95% were processed within the 5 day target, and 98% within 6 days.

Form 14s

1746 investigations were concluded by Form 14 (investigation without the need for post mortem or inquest). Such investigations are generally conducted by phone prior to a formal letter of fact being sent to the Coroner by the general practitioner concerned.

Our target is to issue the Form 14 to the Registrar of Deaths in 95% of cases within 3 working days of the Coroner's decision.

Analysis of the 1746 cases reveals that the target was met in 99.7% of cases.

Outstanding Caseload

9. The investigation of deaths can be a lengthy process often involving investigation by other departments. Approximately 1500 post mortems per year are carried out by the State Pathology Department with a further number (approximately 100) carried out by hospital pathologists based in the Royal Victoria Hospital. At least 40% of these deaths will not be from natural causes and will require a full PSNI investigation on behalf of the Coroner and many will also require examination of the evidence by medical and/or other professional experts before an inquest or Form 17 can be listed. There are therefore a number of investigations pending at any period of time and these are referred to as the outstanding caseload.

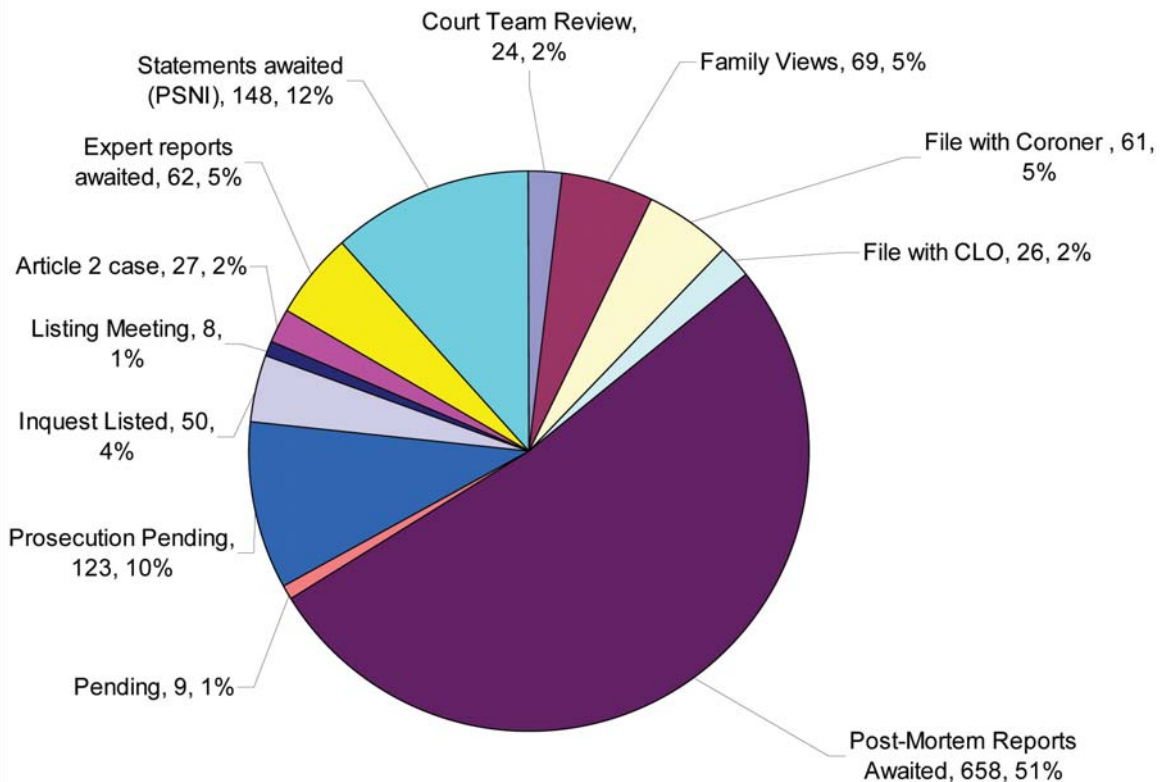
Inherited caseload

10. Prior to April 2006 Northern Ireland comprised seven Coroners' Districts. From 2003 to the end of 2004 the outstanding caseload for Coroners throughout Northern Ireland rose from 1633 to 1892 cases. Administrative work commenced in June 2005 to transfer all outstanding cases from outlying Districts to the then Greater Belfast District in readiness for the establishment of CSNI in April 2006. 1329 outstanding cases were transferred to CSNI.

Outstanding caseload at end of March 2007

11. The pie diagram on the following page has been drawn from a summary of cases outstanding at the end of the first year and indicates the percentage of cases in each area of work or status.

Outstanding Coroners' Caseload end March 2007



12. **51%** of the outstanding caseload at end March 2007 could not be progressed until the post mortem report was received. Post mortem reports from State Pathology can currently take in excess of 5 months to reach CSNI and in some cases the reports can be more than 1 year outstanding. CSNI have been in discussions with the State Pathology Department and the Northern Ireland Office (who are responsible for providing forensic pathology services) to develop a service level agreement that will deliver a more acceptable timeframe and reduce the backlog. These discussions are ongoing.
13. **5%** of cases were referred to medical or forensic experts for a report to be prepared. Some cases are subject to long delays awaiting these reports but these are often very complex cases. Identifying an expert who is willing to assist the Coroner may be problematic in itself.
14. PSNI were dealing with **24%** of the remaining outstanding caseload. Investigations may be ongoing or there may be pending prosecutions relating to the circumstances of the death. CSNI has been working in co-operation with the PSNI to develop agreements on reducing delay and providing a uniform and improved quality service by PSNI to the CSNI.
15. The remaining **20%** were being actioned for inquest hearing or Form 17 disposal. 50 inquests had been listed for hearing and 69 cases were awaiting the views of the deceased families following discussion on the inquest process or investigation. 27 cases had been delayed pending the House of Lords decision in relation to troubles related deaths (*Jordan and others*). This decision was delivered on 28th March 2007 and these inquests are now being considered for scheduling in 2007/2008.

CSNI Charter Targets

16. CSNI published a Charter in April 2006 setting out its aims for the disposal of business and the standard of service provided to users. The main business disposal targets have already been commented on earlier in this document. In addition to these the Charter gives commitment to the following areas:

- **Our overall aim is to list inquests not later than one year following the death provided all enquiries have been completed and witnesses are available.**

17. Given the backlog of cases inherited by the CSNI it has been impossible to meet this target as 1100 were already outstanding for more than 1 year in April 2006. In CSNI's first year 366 of these inherited cases have been concluded. The 734 remaining are delayed due to reasons outside the CSNI's control e.g. prosecutions pending,

outstanding post-mortem or expert reports, etc.

- **Our aim where possible is to give at least four weeks notice before the date of inquest.** If this must be changed, bereaved families will be informed within 24 hours of the new arrangements being made.

This target has been achieved in 100% of such instances.

- **To introduce the post of Coroners Liaison Officer and provide the following service to bereaved families:**

- Contact the next of kin within 24 hours of the post-mortem and provide preliminary information on the cause of death
- Inform the next of kin if any organs or tissue samples were retained at the post-mortem examination, explain why these may have been retained and the requests that may later be made on their release

Since the appointment of the CLOs all of the above procedures have been successfully implemented. Initial telephone contact is made in the majority of cases directly following the receipt of the preliminary post mortem results. This information is then confirmed in writing and issued within 24 hours. Measurement of this 24 hour target has been developed from June 2006 and shows that this has been met in 100% of CLO cases.

- Contact the next of kin within 10 working days of the Coroner's decision requiring further investigations, following receipt of the post-mortem report, to explain the position

No formal measurement of this target was available during this reporting period. Systems are being developed to allow CSNI to report on this target in the future.

Other Initiatives

18. CSNI has endeavoured throughout the first year to engage with users of the service to provide information on the Coroner's process, develop protocols for working practices and provide information to the bereaved.

Bereaved families

19. A range of leaflets has been developed to provide pertinent information and guidance on the Coronial process. These also contain contact details of some useful support groups that may be of further assistance to the bereaved. These leaflets have been made available to organisations that come in contact with bereaved families (PSNI, hospitals) for distribution. This service will be expanded in the next year to health centres and other groups whose work touches bereaved families e.g, Cruse Bereavement Care, Victim Support. Families who are contacted directly by Coroners Liaison Officers are also provided

with the leaflets. Both the leaflets and useful contacts are also available on the web site at **www.coronersni.gov.uk**.

20. NI Court Service and CSNI have been involved in the development of a bereavement strategy for Northern Ireland. This work is progressing and the strategy will be delivered in 2007.

Service Providers

21. Coroners' investigations involve working with medical staff and other agencies which include, amongst others, PSNI and the State Pathology Department. The Coroner's investigation is dependent on these groups providing reports and attending as witnesses at inquest hearings. Throughout the year, meetings have been arranged with many providers to establish a uniform and timely service to the CSNI.

Coroners and staff have participated in work shops and seminars to provide information and support and have been actively involved in PSNI training events.

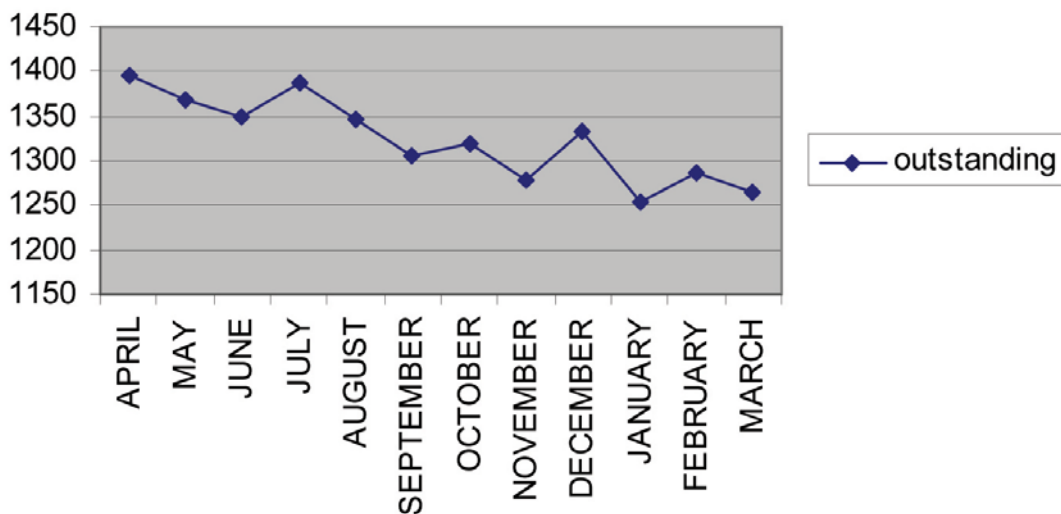
22. **Other interested organisations**

Prior to the establishment of the CSNI it proved impossible to provide the level of detailed statistical information requested by other organisations e.g PSNI, Health Trust. Throughout the first year, CSNI has developed reports and met with many organisations to assist with their work and is now better able to provide more specific information on request. This facility is steadily growing and will be developed further in 2007/08.

Summary

23. At the establishment of the CSNI there were 1329 outstanding cases that required investigations. In addition to this workload the number of new deaths reported rose to 4253. Despite the continuing increase in the number of reported deaths and the initial settling in period for the CSNI progress has been made in reducing the outstanding caseload. This caseload has fallen from 1329 at the beginning of April 2006 to 1265 outstanding at the end of March 2007 - an overall decrease for the first year of the amalgamated service of 9%.
24. 1143 of the cases outstanding at the beginning of April 2006 related to deaths that occurred prior to the end of 2005. These cases have been reduced to 364 at the end of the first year in operation of the CSNI.

Outstanding Caseload



25. In addition to reducing the backlog of cases the CSNI has dedicated resources to improving the interaction with bereaved families and other customers. The successful introduction of the role of the CLO and the participation in inter-agency forums has led to substantial improvements in the provision of information and services. These initiatives will be continued and enhanced in 2007/08.
26. The statistical analysis detailed in this report shows that considerable success has been achieved in the first year since the establishment of the Coroner's Service for Northern Ireland.

Our first year's achievements are summarised as follows:

Business Plan Targets

- 80% of inquests disposed of within 10 weeks of the Coroner's direction - **74% achieved (80% achieved within 11 weeks)**

- Form 17 issued to the Registrar of Deaths in 95% of cases within 5 working days of the Coroner's decision – **95% achieved**
- Form 14 issued to the Registrar of Deaths in 95% of cases within 3 working days of the Coroner's decision - **99.7% achieved.**

Coroners Service Charter Targets

- inquests are listed not later than one year following the death provided all enquiries have been completed and witnesses are available - **87% achieved**
- at least four weeks notice given before the date of inquest – **100% achieved**
- Coroners Liaison Officers introduced to provide the service detailed to bereaved families – **24 hour target 100% achieved, 10 day target monitoring to be developed**



INVESTOR IN PEOPLE

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