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The Coroners Service of Northern Ireland
Proposals for Administrative Redesign

A consultation paper issued by
the Northern Ireland Court Service

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Foreword

Lord Filkin CBE
Parliamentary Secretary at the
Department for Constitutional
Affairs and Minister for the
Northern Ireland Court Service

The existing coroners service in Northern Ireland has been essentially unchanged since the enactment of the Coroners Act (Northern Ireland) 1959. I am grateful for the dedication and hard work of those who have worked within the system.

However, limitations in the inquest systems across England, Wales and Northern Ireland have been recognized for some time. The Government is aware, in particular, of the concerns held by many stakeholders in Northern Ireland about the number of cases which remain outstanding due, in part, to unresolved legal proceedings. As a result, the Government is committed to modernising the service to ensure that it meets the needs of bereaved families and the wide range of agencies with which the coroners service interfaces.

The agencies in England, Wales and Northern Ireland are working in partnership to ensure that the coroners service is developed in a way which will ensure that it is independent, professional, modern and transparent. This will include legislative change when appropriate. It is expected that the Home Office will put forward proposals outlining plans for reforming the death certification and investigation process later this year.

As an interim measure, the Northern Ireland Court Service has, following consultation with key stakeholders, produced proposals for improving the inquest system in Northern Ireland through administrative redesign, in advance of the introduction of new legislation.

I am pleased to introduce this consultation document, which seeks your views on our proposals.

Lord Filkin

Introduction

1. The coroners service in Northern Ireland is managed by the Northern Ireland Court Service, which is the Lord Chancellor's department in Northern Ireland.

2. The existing coroners service has a long history and parts of its practice have not been reviewed or updated for many years.

3. The Government is aware of the limitations of the current service and is keen to improve the service provided to families of people who have died and also to ensure that public confidence in the system is high.

4. For that reason the Government commissioned an independent review of the coronial and death certification systems in England, Wales and Northern Ireland chaired by Mr Tom Luce CB. The Review appointed a Northern Ireland Reference Group. The report, "Death Certification and Investigation in England, Wales and Northern Ireland" was published in June 2003. The report's principal recommendations are detailed at Annex A.

5. The Court Service issued the Luce Report to relevant interest groups in Northern Ireland, including the political Parties, the Northern Ireland Human Rights Commission and others. The report was also made available on the Court Service and Home Office websites.

6. In addition, the Court Service undertook a series of consultation meetings with political Parties and other stakeholders.

7. As well as the Luce Review, the Government asked Dame Janet Smith to hold an inquiry into the deaths caused by Harold Shipman. Dame Janet's third report "Death Certification and the Investigation of Deaths by Coroners", published in July 2003, did not cover Northern Ireland specifically. A summary of the report's conclusions is at Annex B.

8. Although the two reports contain a broadly common analysis of the defects of the present system, there are some important points of divergence, mainly concerning the scope of the death certification process.

9. Proposals outlining the Government's plans for reform of the coroners service are expected to be published by the Home Office later this year.

Interim Administrative Redesign Proposals

10. In the interim, the Court Service intends to proceed with improvements to a number of areas of the coroners service in Northern Ireland through administrative redesign, including:

    (i) Creating a single Northern Ireland coroners jurisdiction (page 8)

    (ii) Revising the judicial structure (page 10)

    (iii) Providing an improved service to the public (page 12)

    (iv) Establishing protocols with other agencies (page 14)

    (v) Death investigation (page 16)

    (vi) Improving the availability and relevance of management information (page 18)

    (vii) Introducing a Coroners Service Inspectorate (page 19)

    (viii) Planning future policy on the reform of the coroners service (page 20).

    This consultation document seeks your views on each of the proposals.

11. The consultation period is open until **30 April 2004.**

12. A form for submitting your views is at Annex F. It is also available electronically on the Court Service website www.courtsni.gov.uk.

    Please send the completed form to:

The Consultation Co-ordinator
The Northern Ireland Court Service
Windsor House
9-15 Bedford Street
Belfast BT2 7LT
Fax No: (028) 9041 2390
E-mail: informationcentre@courtsni.gov.uk

The Role of the Coroner

1. Coroners in Northern Ireland are independent judicial officers appointed by the Lord Chancellor. To be eligible for appointment they must have practised for not less than five years either as a member of the Bar of Northern Ireland or as a solicitor.

2. Coroners derive the legislative authority to carry out their function from the Coroners Act (NI) 1959 and the Coroners (Practice and Procedure) Rules (NI) 1963.

3. The coroner's role is to seek to establish the cause of deaths in cases reported to the Coroner that appear to be:

   - unexpected or unexplained;
   - a result of violence;
   - a result of an accident;
   - a result of negligence; or
   - a result of any cause other than natural illness or disease.

4. In Northern Ireland there are approximately 3,500 deaths reported to coroners each year and approximately 230 inquests are held. Annual statistics for 2002 showing deaths reported and cases dealt with is at Annex C.

5. When a death is reported to a coroner, there are normally **four courses of action** open to him or her:

   (i) if the death was reported only because it had proved impossible to contact the deceased's general practitioner but subsequently the general practitioner is contacted and is content to issue a death certificate, the coroner, if satisfied, can release the body;

   (ii) a coroner may permit the death to be registered after initial enquiries but without conducting a post-mortem examination;

(iii) a coroner may permit the death to be registered after a post-mortem examination has been held and the coroner is satisfied with the cause of death detailed in the post-mortem report and concludes that it is not necessary to hold an inquest; and

(iv) a coroner may proceed to hold an inquest whether or not a post-mortem examination has been conducted.

6. Coroners' investigations are supported by information from the police or Police Ombudsman's investigation into the death and from families, the bereaved, witnesses and reports from pathologists and forensic scientists.

Creating a Single Northern Ireland Coroners Jurisdiction

Current Structure

1. Northern Ireland is currently divided into seven coroners' districts:

   - Londonderry;
   - North Antrim;
   - Greater Belfast;
   - East Tyrone and Magherafelt;
   - Fermanagh and Omagh;
   - Armagh; and
   - South Down.

2. There is a full-time coroner and two deputy coroners in the Greater Belfast district. Six part-time coroners and four deputy coroners provide a service to the other districts.

What we are proposing

3. It is proposed that the seven coroners' districts should be amalgamated into a single district covering the whole of Northern Ireland. Inquests will continue to be held throughout Northern Ireland as required. The coroners service will have its administrative headquarters in Belfast.

4. Creating a single coroners jurisdiction will entail revising the current resource arrangements, accommodation and IT provision. Further information on each of these aspects is given later in this consultation document.

Why we are proposing this change

5. The Luce Review recommended *"the introduction of a consistent professional service based on full-time leadership, reformed into a single Northern Ireland jurisdiction"*.

6. The current structure of seven coroners' districts under one full-time and six part-time coroners is based on historical arrangements, rather than an analysis of service requirements and the needs of users.

7. Creating a single jurisdiction supported by an administrative headquarters will help to achieve uniformity of practice and a more effective and consistent service to bereaved families and other users.

8. It will also enable more effective collation and analysis of management information, which will facilitate the detection of patterns or trends.

Revising the Judicial Structure

Current Structure

1. The coroners service currently comprises one full-time coroner, six part-time coroners and six deputy coroners.

What we are proposing

2. It is proposed that, when the single Northern Ireland coroners jurisdiction has been created, it should be headed by a senior presiding judge at High Court level. There should also be a full-time coroner and two full-time deputy coroners.

3. The senior presiding judge will be appointed as a coroner following consultation with the Lord Chief Justice of Northern Ireland.

4. The current full-time coroner will assume day-to-day responsibility for the new single jurisdiction. Two full-time deputy coroners will be appointed through open competition.

Why we are proposing this change

5. We are proposing the appointment of a senior presiding judge in response to the recommendation in the Luce Review, which recommended that *"Each of the new national coronial jurisdictions 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 levels".*

6. It is envisaged that the presiding judge would provide guidance and leadership for the coroners service and hear complex cases. It is also anticipated that the appointment of a presiding judge will help to alleviate the current backlog of cases. It will also provide a means of ensuring that the coroners service becomes more fully integrated into mainstream judicial services.

7. The Luce Review also recommended that *"the service should become a service of predominantly full-time, legally qualified professionals appointed, trained and supported to modern judicial and public service standards".*

8. A coroners service comprised of full-time coroners will aid the delivery of a more modern and effective service to the public by creating a team of appropriately trained and specialist coroners, focused on one area of expertise. It will also create more opportunities for the sharing of best practice and communication within the profession.

Providing an Improved Service to the Public

Current Situation

1. The Government is committed to providing an efficient and responsive coroners service in which the public can have confidence. The review of the coroners service and our consultations with the Northern Ireland political Parties and other key stakeholders, identified a number of ways in which the service provided to bereaved families and others could be improved.

2. Significantly, there is a general lack of knowledge about the role of the coroners service and how it interfaces with other agencies engaged in death certification and investigation. Also, the information given to bereaved families about their individual cases could be provided more appropriately.

What we are proposing

3. It is proposed that the service to the public could be improved in the following ways:

(i) **Improved Family Liaison**

We shall ensure that appropriately trained administrative staff will be available to provide the family of the bereaved with information about the role of the coroner, the reason for a post-mortem examination, organ retention issues (if appropriate) the purpose of an inquest and the procedures that will be followed. They will also be able to provide better information on the progress of any particular case.

(ii) **Enhanced Administration and Information Technology**

There will be additional administrative staff to support coroners.

We shall also enhance the available IT facilities to improve the efficiency of office administration and case management and enable more effective and proactive review and follow-up of case papers.

(iii) **Better Public Relations**

The Court Service Information Service will provide an enhanced public relations service to the coroners service to support liaison with the media and members of the public.

Information on the coroners service will be available through the Northern Ireland Court Service website www.courtsni.gov.uk

(iv) **Court Hearings**

Appropriately trained administrative staff will carry out in-court duties during inquests. This will include swearing in a jury, if required, and any witnesses to be heard at the inquest. In appropriate cases lawyers will be engaged to assist coroners in the presentation of evidence at complex inquests.

(v) **Training for Coroners**

Improving the training available for coroners is an important part of these proposals. We shall continue to make use of the existing training programmes and provide new programmes in conjunction with Judicial Studies Board for Northern Ireland and other relevant bodies.

(vi) **Liaison between the Coroners Service and other Agencies**

The Court Service will ensure that coroners' views are represented on Committees and Working Groups in areas that affect the coroners jurisdiction. Coroners will work closely with the State Pathologist's Department, Hospital Pathologists and the Chief Medical Officer in Northern Ireland to ensure that post-mortems are conducted only when necessary and to national standards.

Coroners in Northern Ireland will maintain close contact with the coroners service in England and Wales to promote the exchange of information and good practice.

Why we are proposing this change

4. Providing a professional service to families who have been bereaved is an important responsibility of the coroners service. The changes we are proposing will help improve the service we give to the public and other users including witnesses.

Establishing Protocols with Other Agencies

Current Situation

1. The coroners service deals with a wide range of other agencies involved in death certification and investigation. Work has already progressed on developing inter-agency protocols including:

(i) Establishing Child Death Protocols

In certain cases when a child has died there may have been a number of agencies involved with the child prior to death, for example, the Department of Health, Social Services and Public Safety, the NI Guardian ad Litem Agency, the National Society for the Prevention of Cruelty to Children etc.

It is important that the coroner is fully aware of all relevant information during the investigation process. The establishment of appropriate protocols will ensure that information is available to the coroner and that any recommendations made by the coroner can be passed to the relevant agency following the inquest. Lessons learnt from deaths can then be used to prevent any further tragedies.

(ii) Establishing a Protocol with the Police Ombudsman

When it is apparent that the police may have been involved in a death, it will generally not be appropriate for them to carry out the investigation into that death. In these circumstances, the Police Ombudsman will investigate the death and the Ombudsman's investigating officer will assume the role and responsibility the police presently perform. The coroner will be provided with copies of witness statements and other relevant information concerning the death.

(iii) Other Protocols

Informal working arrangements currently exist between the coroners and agencies with which coroners come into contact in the course of their investigations.

What we are proposing

2. It is proposed that the coroners service should establish a working group with the relevant agencies to develop protocols in relation to child deaths.

3. A protocol with the Police Ombudsman will be formalised.

4. The current informal arrangements with other agencies should be formalised with the production of written protocols.

Why we are proposing the change

5. The Luce Report identified that "*In some coroner districts there are standing protocols between the coroner and the various children's services and the child protection agencies setting out how the children's agencies should be involved in death investigation and how the coroner and his staff should work with them".*

   The review recommended that, *"There should be such protocols in all areas, taking into account the characteristics of the areas and the configuration of the relevant children's health and social services and the child protection networks".*

6. Establishing protocols with other agencies will set the standard of investigation expected. It will enable the departments to agree on areas of responsibility and the co-ordination of investigation.

7. The information gathered as a result of a coroner's investigation, and any report made by the coroner during an inquest, may lead agencies to review their procedures. It is essential that any lessons learnt from a death are passed onto, and used by, agencies to prevent any further deaths.

Death Investigation

Current Situation

1. In most cases the police are responsible for investigating deaths on behalf of the coroner. The investigations currently undertaken by the police are into the factual circumstances surrounding a death. The primary purpose of these investigations is to ascertain whether there is any evidence of criminal conduct associated with the death. The evidence gathered by the police in the course of an investigation will be made available to the coroner in order to assist his own inquiry into the death. The coroner may also require additional investigations to be carried out, such as ordering a post-mortem report on the medical cause of death.

2. In some cases it may not be appropriate for the police to investigate a death, for example, when it is apparent that the police may themselves have been involved in the death. In these circumstances, the Police Ombudsman will investigate the death and the coroner will be provided with copies of witness statements and other relevant information concerning the death.

3. Other cases where police involvement may not be necessary include deaths in nursing homes and hospitals where there is no suspicion of neglect, malpractice or misconduct.

4. Support to coroners in the death investigation process is provided by Coroners Officers in England and Wales. In Northern Ireland, the PSNI presently carry out this role on behalf of coroners.

Proposals

5. We would like to hear the views of consultees on whether certain categories of death should be investigated by someone other than by the police or the Police Ombudsman.

6. One option would be to develop an investigative capacity within the coroners service. This might involve appointing suitably trained personnel who would assume responsibility for investigating the deaths and, if appropriate, refer cases to the police or other agencies. However, this could possibly result in investigative duplication and it would take significant time and resources to develop a comparable level of investigative expertise to that currently provided by the police.

7. It is important to establish whether there is a need for an investigative capability other than that currently provided for coroners by the police and the office of the Police Ombudsman and, if so, the best means of providing that capability. Our provisional view is that the police (and in appropriate cases the Police Ombudsman) are best placed, and have the necessary expertise and resources, to undertake the investigation of the majority of deaths reported to coroners. There may however be scope to develop improved liaison arrangements between the coroners service and other investigative agencies.

8. We would welcome views on the adequacy of the current arrangements for investigating deaths reported to coroners, and whether improved liaison arrangements should be put in place between coroners and other agencies.

Improving the Availability and Relevance of Management Information

Current Situation

1. A significant amount of statistical information about coroners' cases is already collected such as, the number of cases reported, the number of cases completed, numbers of outstanding cases etc. See Annex C.

2. However, the current structure of the coroners service in Northern Ireland means that the collection of information on the progress of cases is not as efficient as it might be and it does not always meet the requirements of service users.

What we are proposing

3. Information systems will be enhanced to enable more effective management of data.

4. Additional information collected will include:

   - the date when a death is notified to the coroner;
   - the date on which information in writing about the death is received from the police;
   - the date a final post-mortem report is received; and
   - the date a case is completed.

5. Data collection arrangements will be formalised in Coroners Rules.

Why we are proposing this change

6. Improving our management information systems will enable us to analyse the handling of cases, identify where delays are being caused, help us to make further improvements to the service and respond to queries from elected representatives and others more efficiently.

Introducing a Coroners Service Inspectorate

Current situation

1. Most criminal justice agencies are subject to oversight by an independent inspectorate. For most agencies this activity is co-ordinated by the Chief Inspector for Criminal Justice in Northern Ireland. The Northern Ireland courts are inspected by the Magistrates' Courts Service Inspectorate (soon to become the Independent Inspectorate of Courts Administration) for England and Wales.

What we are proposing

2. The Magistrates' Courts Service Inspectorate will be responsible for inspecting the performance of the coroners service in Northern Ireland.

3. Following the devolution of justice to the Northern Ireland Assembly, this inspectorate function may become the responsibility of the Chief Inspector of Criminal Justice for Northern Ireland.

Why we are proposing this change

4. The Luce Review recommended that, *"There should be a small Coroner Service Inspectorate to monitor standards of interaction with families and the standards of the service's physical environment"*.

5. The Inspectorate will monitor the performance of the coroners service and provide feedback, in a published Annual Report, on performance and the quality and effectiveness of the service provided to the public.

6. The Inspectorate will pay particular attention to reports made by coroners to other agencies to help prevent future loss of life. It is important that where a coroner makes such reports these are followed-up and acted upon. The Inspectorate will ensure that this happens.

Planning the Future Policy on the Reform of the Coroners Service

Current situation

1. At present there is no independent body with a strategic, reporting and guidance role in respect of the coroners service in England, Wales and Northern Ireland. However, the establishment of such a body – a Coronial Council – is currently being considered.

What we are proposing

2. If a Coronial Council for England, Wales and Northern Ireland is established it will help take forward further improvements that can be made, but do not require new legislation. Nominated representatives from Northern Ireland should sit on this Council.

3. Alternatively, or in addition to Northern Ireland participation in a national Coronial Council consideration will be given to the desirability of establishing a separate Coronial Council for Northern Ireland to advise on the operation of the coroners service.

Why we are proposing this change

4. The Luce Review recommended that, *"There should be a Statutory Coronial Council with powers to monitor the general performance of the new structure in death certification and investigation, and to give statutory guidance on issues of policy and process".*

5. It is important that agencies involved in any aspect of the death investigation and certification process have the opportunity to agree the best methods of implementing the Government's reforms.

6. Furthermore, any new system will benefit from scrutiny by an independent council to monitor the general performance of the new structures on death investigation and certification.

7. Participation in the England, Wales and Northern Ireland Coronial Council would ensure that Northern Ireland is represented at national level and lead to uniformity of practice.

Administrative Redesign Timetable

Public consultation period	February 2004 – April 2004
Publication of a response to the consultation exercise	May 2004 – June 2004
Implementation of agreed recommendations	May 2004 – March 2005

Annex A

PRINCIPAL RECOMMENDATIONS OF THE REVIEW OF DEATH CERTIFICATION AND INVESTIGATION IN ENGLAND, WALES AND NORTHERN IRELAND

Terms of reference

In respect of England, Wales and Northern Ireland:

- To consider the most effective arrangements for ascertaining and certifying the medical cause of death for public health and public record purposes, having regard to proposals for a system of medical examiners.

- To consider the extent to which the public interest may require deaths to be subject to further independent investigation, having regard to existing criminal and other statutory and non-statutory investigative procedures.

- To consider the qualifications and experience required, and the necessary supporting organisations and structures, for those appointed to undertake the duties for ascertaining, certifying and investigating deaths.

- To consider arrangements for the provision of post mortem services for the investigation of deaths.

- To consider the consequences of any changes arising from the above for the registration service and the role of coroners under the Treasure Act 1996, and to consider where Departmental responsibilities for the arrangements should be located, having regard both to coherence for bereavement services and effective accountability.

Background

1. The Death Certification and Investigation in England, Wales and Northern Ireland review was set up by the Home Secretary on 26 July 2001 to undertake a root and branch review of the existing coroner system including post mortems and inquests. It also examined the case for the introduction of medical examiners to supervise the certification of deaths by natural causes.

Annex A

2. The review covered the death certification and coroner system in England, Wales and Northern Ireland.

3. Tom Luce, former Head of Social Care Policy at the Department of Health, was appointed chair of the team. Other review team appointees were: Mr Anthony Heaton-Armstrong, a barrister; Professor Sir Colin Berry, Professor Emeritus of Morbid Anatomy at the University of London; Mrs Elizabeth Hodder, formerly Commissioner for the Equal Opportunities Commission; Mrs Deidre McAuley, formerly a Citizens Advice Bureau advisor in Ballymena and chair of the local Peace and Reconciliation Partnership; and Mr Iqbal A.K.M Sacranie OBE, Secretary General of the Muslim Council of Britain.

4. The Review appointed a Northern Ireland Reference Group. The report, 'Death Certification and Investigation in England, Wales and Northern Ireland' 'The Report of a Fundamental Review 2003' which followed an extensive period of research and investigation during which the review team consulted widely not only with coroners and other professionals within the system, but the families and the bereaved who use it, was published by the Home Office Minister Paul Goggins on 4 June 2003.

5. A synopsis of the six major changes envisaged by the review are:

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

- *A national coroner jurisdiction for Northern Ireland;*
- *A statutory Coronial Council should oversee the working of the death certification and coroner services to ensure that they work properly together and have consistent standard;*
- *Each national jurisdiction should be headed by a Chief Coroner;*
- *Each of the new national coroner jurisdictions 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 levels;*
- *Establishment of a Rules Committee;*
- *Structured and mandatory training for all key personnel; and*
- *A new statutory basis for the service.*

(ii) Consistency of service to families.

- *Establish a Family Charter;*
- *Measurement and audit of times for the completion of investigations and inquests;*
- *A right to formal review of decisions by coroners;*
- *Fuller and more reliable links with providers of bereavement services; and*
- *A mechanism for making complaints.*

(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.

- *Appointment of a doctor to act as Statutory Medical Assessor;*
- *Create appropriate and effective links between the coroner's office and public health and other public safety networks; and*
- *There should be standing protocols between the coroner and the various children' services and child protection agencies.*

(iv) In death certification, a common process to replace the "three-tier" cremation process with a "two-tier" certification system applying to all deaths equally whether the body is buried or cremated.

- *Second certifiers will be from a panel chosen and supported by the Statutory Medical Assessor based in the coroner's office; and*
- *Families will have a defined right to pursue any anxieties about a death with the second certifier or the coroner's office.*

(v) More information and accessible outcomes to coroners' death investigations.

- *More detail and transparency in those relating to the large majority of cases which are not subject to a public inquest;*

Annex A

The retention of the public inquest in cases where deaths occur in situations of restraint or special vulnerability, where there is a need for the judicial examination of evidence, or there is otherwise a public interest in a judicial examination;

More authoritative handling of exceptionally complex inquests through the selective involvement of the permanent and higher judiciary in the conduct of inquests;

Fuller conclusions from inquests with a stronger bias towards narrative and preventive findings, and less inappropriate imputation of liability through short-form "verdicts";

Fairer and more consistent rules on disclosure of evidence in inquests; and

Clarity as to the legality of investigative support to coroners by the Northern Ireland Police Ombudsman.

(vi) A proper recognition of the work of coroner's officers.

In Northern Ireland the creation of a coroners officer service from scratch; and

Coroners' officers should have a wide skill base including, health care skills to supplement the essential investigative and family liaison skills.

Annex B

DAME JANET SMITH'S REPORT ARISING FROM THE SHIPMAN INQUIRY

1. Harold Shipman was convicted at Preston Crown Court on 31 January 2000 of the murder of 15 of his patients while he was a general practitioner at Market Street, Hyde, and on one count of forging a will. He was sentenced to life imprisonment. On 1 February 2000 the then Secretary of State for Health announced that an independent private inquiry would take place to establish what changes to current systems should be made to safeguard patients in the future. The inquiry would be held in private but its report made public. The private inquiry began work on 10 March 2000 and was to report its findings and recommendations to the Secretary of State for Health and the Home Secretary by September 2000.

2. Many of the families and sections of the British media sought a judicial review in the High Court, which found in their favour and recommended that the Secretary of State for Health reconsider his decision that the Inquiry should be held in private. In September 2000, the Secretary of State for Health announced that the Inquiry would be held in public under the terms of the Tribunals of Inquiry (Evidence) Act 1921. Both Houses of Parliament ratified this decision in January 2001.

3. Dame Janet Smith DBE was appointed Chairman of the Shipman Inquiry and the work of the independent public inquiry began in February 2001. The Inquiry has been divided into two separate phases. In Phase I the Inquiry considered how many patients Shipman killed, the means employed and the period over which the killings took place. The public hearings into Phase I began on 20 June 2001 and the Inquiry's First Report was published on 19 July 2002.

4. The public hearings into Phase 2 began on 7 May 2002. Phase 2 is in four stages. The first stage dealt with the police investigation of March 1998 (Dame Janet Smith's Second Report). The second stage dealt with death and cremation certification. The issues included in this stage were: the roles of the informant, medical practitioners, medical referees, the registrar and coroner; custom and practice generally, and in Hyde; the role of funeral directors; good practice and the practices followed in the Shipman cases; and proposals for change.

Annex B

5. The Second and Third Reports were published to the House of Commons on 14 July 2003. The Third Report covers death and cremation certification and makes specific recommendations on the future of the coronial system.

6. The main recommendations in the Third Report with reference to the coronial system and death certification and registration are:

The Coroner Service

- *All deaths should be reported to the coroner service.*

- *The coroner service must be, and must be seen to be, independent of Government and of all other sectional interests. It should not be administered, therefore, from within a Government Department. Instead, it should be a body at 'arms length' from Government, that is an Executive Non-Departmental Public Body.*

- *The coroner service requires medical, legal and investigative expertise.*

- *The coroner service should have a corps of trained investigators who would be the mainstays of the new system. The coroner's investigator would replace the coroner's officers but have a greatly enhanced role. More routine functions, at present performed by coroners' officers, would be performed instead by administrative staff.*

- *The coroner service should be administered through a regional and district structure, with a regional medical coroner and at least one judicial coroner assigned to each region.*

- *Each region should be divided into between three and seven districts, each with a population of about a million. Each district office would have a medical coroner, one (possibly more than one) deputy medical coroner (who might work part-time), a team of coroners' investigators and a small administrative staff.*

Coroners' investigators should be trained to recognise the type of circumstances that make it appropriate for a death to be investigated by the medical coroner.

Any recommendation made by a judicial or medical coroner, whether in the course of an inquest or a written report, should be submitted to the Chief Coroners.

Judicial coroners should be given powers to order entry and search of premises and seizure of property and documents relevant to a death investigation. The medical coroner should be given powers to order the seizure of medical records and drugs. The judicial coroner should hear appeals from decisions of the medical coroner in relation to those powers of seizure.

Judicial coroners who have to conduct inquests should be relieved of the day-to-day responsibility for the pre-inquest investigation. They should direct the investigation, but responsibility for the collection of evidence should devolve onto a legally qualified person in the regional office.

Cases of medical error or neglect transferred to the regional coroner's office would be investigated under the direction of a legally qualified person.

The medical coroner must have the power to order retention of organs and tissue if such retention is necessary for the purpose of his/her investigation. Families should have the same rights to object and appeal as in respect of an autopsy.

The Service should also have an Advisory Council, the function of which would be to provide policy advice on all issues.

Annex B

Death Certification and Registration

- *There should be one system of death certification applicable to all deaths, whether the death is followed by burial or cremation.*

- *The basis of the certification system would be the completion of two forms. The first (Form 1) would provide an official record of the fact of death and the circumstances of death. The second (Form 2) would be completed by the doctor who had treated the deceased person during the last illness or, if no doctor had treated the deceased in the recent past, by the deceased's usual medical practitioner. Form 2 would contain a brief summary of the deceased person's recent medical history and the chain of events leading to death.*

- *A new certificate of cause of death should be designed for completion by a coroner's investigator or, where an investigation has been undertaken by the medical coroner.*

Annex C

Table: Coroners' caseload 2002

	Coroners' caseload		Cases disposed of				
	Outstanding at end of 2001	Deaths Reported	Inquest Held (Form 21)	No Inquest with Post-Mortem (Form 17)	No Inquest and No Post-Mortem	Other Disposals of Registered Entries	Outstanding at end of 2002
Londonderry[1]	122	206	38	75	70	0	145
North Antrim	131	233	9	92	81	65	117
Greater Belfast	771	2,430	142	912	888	495	764
East Tyrone & Magherafelt	222	147	0	18	66	0	285
Fermanagh & Omagh	120	144	21	55	59	0	129
Armagh	103	262	14	74	129	56	92
South Down	100	141	6	69	62	3	101
Northern Ireland	1,569	3,563	230	1,295	1,355	619	1,633

[1] Londonderry have recalculated their number of outstanding cases at the end of 2001 (previously 450)

Annex D

Equality Impact Assessment

1. This policy has been submitted for equality screening in accordance with the obligations contained in Section 75 of the Northern Ireland Act 1999, as detailed in the Northern Ireland Court Service Equality Scheme.

2. No potential differential adverse impact on persons of different religious belief, political opinion, racial group, age, marital status, sexual orientation, men and women generally, persons with a disability and persons without and persons with dependants and persons without was identified.

Annex E

LIST OF CONSULTEES

Judiciary

The Lord Chief Justice of Northern Ireland
All Northern Ireland Judiciary
Association of District Judges (NI)
Council of Her Majesty's County Court Judges (NI)
Resident Magistrates Association (NI)
Society of Masters (NI)
Holders of the title Queen's Counsel (NI)
All Coroners (NI)

Legal Professions

Belfast Solicitors Association
General Council of the Bar in Northern Ireland
Law Society of Northern Ireland

Other Main Representative Groups

Anglo Irish Bank
Bank of Ireland
CBI Northern Ireland
Children's Law Centre
Co-Operative Bank
Equality Commission for Northern Ireland
Funeral Directors NI
First Trust Bank
General Consumer Council for Northern Ireland
Halifax Bank
Human Rights Commission for Northern Ireland
Irish Permanent
NI Law Centre
Northern Bank
Northern Ireland Chamber of Commerce and Industry
Northern Ireland Citizens Advice Bureau
Northern Ireland Committee of the Irish Congress of Trade Unions
Northern Ireland Federation of Small Business
Northern Ireland Institute of Directors
Progressive Building Society
Ulster Bank

Government Departments, Public Bodies and Others

Age Concern Northern Ireland
Coalition on Sexual Orientation
Commissioner for Judicial Appointments for Northern Ireland
Criminal Justice Board Members
Crown Solicitor for Northern Ireland
Department for Regional Development
Department for Social Development
Department of Agriculture and Rural Development
Department of Culture Arts & Leisure
Department of Education
Department of Employment and Learning
Department of Enterprise, Trade and Investment
Department of Finance and Personnel
Department of Health, Social Services and Public Safety
Department of Public Prosecutions
Department of the Environment
DFP Departmental Solicitor
Disability Action
Employers Forum on Disability
European Commission Office in Northern Ireland
Guardian ad Litem Agency
Help the Aged (NI)
Institute of Professional & Legal Studies (NI)
Judicial Studies Board (NI)
Land Registers of Northern Ireland
Law Reform Advisory Committee
Lay Observer for Northern Ireland
Legal Aid Advisory Committee
Legal Services Commission
NI Council for Ethnic Minorities
NI Economic Council
NI Ombudsman
NICVA
Northern Ireland Local Government Association
Northern Ireland Office
Northern Ireland Political Parties
Northern Ireland Prison Service
Northern Ireland Women's Aid Federation
Office of Law Reform, Northern Ireland

Annex E

Office of the First Minister and Deputy First Minister
Official Solicitor's Office (NI)
Police Ombudsman (NI)
Policing Board of Northern Ireland
Probation Board for Northern Ireland
QUB Law School
State Pathologists Department
The Chief Constable of the Police Service of Northern Ireland
The Compensation Agency
Training for Women Network
University of Ulster
Youth Council for NI

Northern Ireland Luce Review Reference Groups

Committee on the Administration of Justice
Families Acting for Innocent relatives
Irish Council of Churches
NSPCC
Relatives Reference Group
Shankill Stress Centre
The Omagh Support and Self Help Group
The Pat Finucane Centre
The Samaritans
The WAVE Trauma Centre

serving
the community
through the
administration
of justice

The Coroners Service of Northern Ireland Proposals for Administrative Redesign

Response Form

The Coroners Service of Northern Ireland
Proposals for Administrative Redesign

Response Form

Annex F

We would welcome your comments on all the proposals in this consultation paper. Please respond by using the table below:

Name:

Organisation:

Address:

Telephone Number:

(i) Creating a single Northern Ireland coroners jurisdiction (page 8)

It is proposed that the seven coroners' districts should be amalgamated into a single district covering the whole of Northern Ireland. Inquests will continue to be held across Northern Ireland, as required. The coroners service will have its administrative headquarters in Belfast.

Comments:

UTV

(ii) **Revising the judicial structure (page 10)**

It is proposed that, when the single Northern Ireland coroners jurisdiction has been created, it should be headed by a senior presiding judge at High Court level. There should also be a full-time coroner and two full-time deputy coroners.

Comments:

(iii) **Providing an improved service to the public (page 12)**

- *Improved Family Liaison*
- *Enhanced Administration and Information Technology*
- *Better Public Relations Facilities*
- *Court Hearings*
- *Training for Coroners*
- *Liaison between the coroners service and other agencies*

Comments:

(iv) **Establishing protocols with other agencies (page 14)**

It is proposed that the coroners service should establish a working group with the relevant agencies to develop protocols in relation to child deaths.

A protocol with the Police Ombudsman will be formalised.

The current informal arrangements with other agencies should be formalised by written protocols.

Comments:

(v) **Death investigation (page 16)**

We would like to hear the views of consultees on whether certain categories of death should be investigated by someone other than by the police or the Police Ombudsman for Northern Ireland.

We would welcome views on the adequacy of the current arrangements for investigating deaths reported to coroners, and whether improved liaison arrangements should be put in place between coroners and other agencies.

Comments:

(vi) **Improving the availability and relevance of management information (page 18)**

It is proposed that our management information systems are enhanced to enable the more effective management and interrogation of data.

Comments:

(vii) **Introducing a Coroners Service Inspectorate (page 19)**

The Magistrates' Courts Service Inspectorate will be responsible for inspecting the performance of the coroners service in Northern Ireland.

Following the devolution of justice to the Northern Ireland Assembly, this inspectorate function is likely to transfer to the Northern Ireland Criminal Justice Inspectorate.

Comments:

(viii) **Planning future policy on the reform of the coroners service (page 20)**

It is proposed that nominated representatives from Northern Ireland should sit on the Coronial Council, when established.
Consideration will be given to the desirability of establishing a separate Coronial Council for Northern Ireland to advise on the operation of the coroners service.

Comments:

(ix) **Are there any other comments you would like to make about the provision of coroners services in Northern Ireland?**

Comments:

UTV

Please enclose additional pages if necessary

Reply Details

Please send your response to:

The Consultation Co-ordinator
The Northern Ireland Court Service
Windsor House
9-15 Bedford Street
Belfast BT2 7LT

Fax No: (028) 9041 2390
E-mail: informationcentre@courtsni.gov.uk

By 30 April 2004

Further Information

Should you require any further information about the Court Service please visit our website at **www.courtsni.gov.uk** or alternatively contact us at our Information Centre.

The consultation document will be made available in a wide range of alternative formats. Requests for alternative formats should be made to the Information Centre.

Northern Ireland Court Service
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Windsor House
Bedford Street
Belfast BT2 7LT

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