Witness Statement Ref. No. 276/1

NAME OF CHILD: RAYCHEL FERGUSON (LUCY CRAWFORD)

Name: Maureen Dennison

Title: Mrs.

Present position and institution: Career break

Previous position and institution:
[As at the time of the child's death] EO1 Coroners Office

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 2000 – August 2012] None

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death]

Statement given 4th December 2004

OFFICIAL USE:
List of previous statements, depositions and reports attached:

Ref:	Date:	
115-033-001	7/12/2004	Statement to PSNI

IMPORTANT INSTRUCTIONS FOR ANSWERING:

Please attach additional sheets if more space is required. Please identify clearly any document to which you refer or rely upon for your answer. If the document has an Inquiry reference number, e.g. Ref: 049-001-001 which is 'Chart No.1 Old Notes', then please provide that number.

If the document does not have an Inquiry reference number, then please provide a copy of the document attached

I. Questions Arising out of your Statement to the PSNI [Ref: 115-033-001]

(1) *"Until April this year [2004] I worked in the Coroner's Office in Belfast. I had been based there since 1999 as a Civil Servant. My role was to take reports of deaths from either police, GPs or hospitals and then to report it on to the Coroner for his decision."* **[Ref: 115-033-001]**

Arising out of the foregoing please address the following questions:

(a) What was your job title and grade when you worked in the Coroner's Office? EO1

(b) What qualifications did you hold? GCE's + RSA typing

(c) Did you have a formal job description? If so, please provide a copy. -

(d) Did you receive any training to assist you in carrying out the duties associated with receiving reports of deaths? If so, describe the training which you received. I received on the Job training

(e) Describe the procedures applicable to the role of taking reports of deaths, and address the following matters:

(i) What information were you expected to obtain when a report of a death was received by you? - Details given by the Dr. DOB - Name, Address DOD + circumstances

(ii) Were you expected to record the information which you received, and if so, in what format were you expected to record the information eg. on a particular form, or into a computer file? - We recorded onto a notebook + then transferred neatly into book of Record of deaths

(iii) Were you expected to record any particular information or data in relation to the death or the circumstances of the death? - Brief details

(iv) Were you expected to ask any questions of the person reporting the death? - Where deceased died, circumstances

(v) Did you have any responsibility to provide advice or direction to the person reporting the death to you? - No

(vi) Having received a report of a death, how were you expected to report this to the Coroner eg. by written or verbal communication? Usually verbal

(vii) Having received a report of a death, how quickly were you expected to report this to the Coroner? Usually immediately or as soon as possible

(viii) Were there any arrangements in place in the event that the Coroner (Mr. Leckey) was unavailable to receive a report from you in relation to a death?
We usually rang State Pathology for advice if no Coroners available

Please answer the above questions in order to reflect the position as of April 2000.

(2) *"On 14 April 2000 I took the report of the death of Lucy Crawford, 5.11.98 of.... The death was reported to me by Dr. Hanrahan, from ICU at Children's Royal Victoria Hospital. I have written in the circumstances of the death as he reported to me."* [Ref: 115-033-001]

(a) At what time on the 14 April 2000 did you take the report of Lucy's death from Dr. Hanrahan?
Not recorded

(b) What was your understanding of Dr. Hanrahan's purpose in reporting the death of Lucy Crawford to the Coroner's Office? To report the death

(c) What did Dr. Hanrahan tell you about the cause of death? – I cannot recall

(d) Other than what has been recorded in your note, what did Dr. Hanrahan tell you about the circumstances of Lucy's death? – I cannot recall

(e) Did you give any direction or advice to Dr. Hanrahan? – Other than to issue a Death Certificate with Gastro Enteritis – I cannot recall

(f) What was your understanding of the steps that had to be taken by the Coroner's Office once the death of Lucy Crawford had been reported by Dr. Hanrahan? To speak to the Coroner to find out if PM or DC to issue

(g) Please describe all of the steps that you took in relation to the reported death of Lucy Crawford. I cannot recall

(h) Did you speak to Dr. Hanrahan again after he had reported the death? If so, please address the following:

(i) When did this subsequent conversation took place?
I cannot recall

(ii) What was the purpose of this subsequent conversation?
I cannot recall

(iii) What was discussed during this subsequent conversation?
I cannot recall

(iv) Did you take any action on foot of this subsequent conversation?
I cannot recall

(3) *"I spoke to Dr. Curtis, Deputy State Pathologist, because I couldn't get in touch with the Coroner, that is why I have written Dr. Curtis name in the entry. I wrote DC in entry which means that Death Certificate was issued and giving gastro enteritis as the cause."* [Ref: 115-033-001]

Arising out of the foregoing:

(a) What arrangements were in place for contacting the Coroner?
We had the Coroners mobile

(b) In what circumstances were you expected to contact the Coroner?
On any death that we needed to speak to him or her

(c) Why was it not possible to get in touch with the Coroner?
I cannot recall

(d) What steps did you take in an effort to contact the Coroner? - I cannot recall

(e) Was the Coroner subsequently made aware that you were unable to get in touch with him? If so, who made him aware of this, and what was his response?
I don't remember

(f) Was there a deputy Coroner in post at the time to whom you could have reported the matter in the event that you were unable to get in touch with the Coroner? I cannot remember but I would have tried any Coroner before contacting State Pathology

(g) If the answer to (f) above is "yes" did you attempt to contact the deputy Coroner, and if so, with what result?

(h) Having been unable to get in touch with the Coroner at the time, did you at any time subsequently inform the Coroner about the death of Lucy Crawford? If so, please address the following:

(i) When did you inform the Coroner about the death of Lucy Crawford?
I cannot recall

(ii) How did you inform the Coroner about the death of Lucy Crawford? For example, was it orally or in writing?
I cannot recall

(iii) What information did you give the Coroner about the death of Lucy Crawford?
I cannot recall

(iv) What was the Coroner's response, if any, when you informed him about the death of Lucy Crawford?
I cannot recall

(i) Having been unable to get in touch with the Coroner at the time, did you at any time subsequently inform the Coroner about how the report of the death of Lucy Crawford had been handled by you, Dr. Curtis or Dr. Hanrahan, and the steps which had been taken following the reported death? If so, please address the following:

(i) When did you inform the Coroner about any of these matters?
I cannot recall

(ii) How did you inform the Coroner about these matters? For example, was it orally or in writing?
I cannot recall

(iii) What information did you give to the Coroner about any of these matters?
I cannot recall

(iv) What was the Coroner's response, if any, when you informed him about any of these matters?
I cannot recall

(j) What arrangements were in place which led you to contact Dr. Curtis?
If unable to contact a Coroner I would have phoned State Pathology

(k) What was your purpose in contacting Dr. Curtis?
To get advise about this death.

(l) What was your understanding of the role or function of Dr. Curtis, in the Coroner's absence?
Dr Curtis had no role

(m) What did you tell Dr. Curtis? - I cannot recall

(n) Did Dr. Curtis issue you with any direction or advice in relation to the death of Lucy Crawford, or did he otherwise provide you with any information?
I am presuming that after relayed the details to Dr. Curtis he thought that a DC could issue with la Gasho Intentus

(o) Did you speak to Dr. Curtis again after you first made contact with him in relation to Lucy's death? If so, please address the following:

(i) When did this subsequent conversation take place?
I cannot recall

(ii) What was the purpose of this subsequent conversation?
I cannot recall

(iii) What was discussed during this subsequent conversation?
I cannot recall

(iv) Did you take any action on foot of this subsequent conversation?
I cannot recall.

(p) Who told you that a death certificate was issued and that it gave gastroenteritis as the cause of death? – No one. After talking to Dr Curtis. I would have spoken to Dr Hanrahan + advised a DC could issue.

(q) When were you told that a death certificate had been issued giving gastroenteritis as the cause?
– We would not usually be told.

(r) Who made the decision that a death certificate would be issued giving gastroenteritis as the cause of death? – I cannot recall

(4) Did you receive any information in terms of whether Dr. Curtis and Dr. Hanrahan had engaged in a discussion about the death of Lucy Crawford? If so, please address the following:

(a) Who made you aware that such a discussion had taken place?
I cannot recall

(b) When were you told that such a discussion had taken place?
I cannot recall

(c) Insofar as you are aware, what was the purpose of this discussion?
I cannot recall

(d) Insofar as you are aware, who arranged for this discussion to take place?
I cannot recall

(5) *"When I initially received the report of the death I recorded it in a shorthand notebook, and then transferred details in the main register for deaths. I don't have this notebook now, I disposed of it when I left the Coroner's office. I have no particular memory of this entry other than what I have read in the register."* [Ref: 115-033-001]

Arising out of the foregoing:

(a) Please confirm that the document contained at [Ref: 013-053a-290] is a copy of the main register for deaths containing the entry made by you in respect of Lucy Crawford's death?
Yes

(b) Did you enter the information *"D.C."* and *"Gastro Interitis"* at some later point, after the main entry setting out the date and circumstances of the death? If so, when did you enter this information? – No

(c) Can you recall the circumstances in which you came to make the entry *"D.C."* and *"Gastro Interitis"*? If so, please outline those circumstances.

No

THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signed: Maureen Dennison Dated:

JOB DESCRIPTION

EXECUTIVE OFFICER

CORONERS OFFICE – MAYS CHAMBERS (5.4 posts)

1 Background

1.1 The Coroners Service for Northern Ireland is part of Belfast Combined Courts at Laganside however the office is situated at Mays Chambers in Belfast. The main responsibility of the Coroners Service for NI is to facilitate the work of 4 full-time Coroners in conducting investigations into deaths reported to them. The Coroners Service covers all of Northern Ireland.

- General Office Team
- Court Team

1.2 It is recognised that this is a challenging post in terms of the daily work bringing the post holder close to circumstances where death has occurred. It has the potential to cause distress and it is accepted that not everyone will be suited to the work. It is therefore desirable that only officers who want to work in this area are asked to do so.

1.3 The primary role of an EO is to ensure that the business is processed effectively and efficiently in accordance with qualitative and quantitative targets annexed to the Coroners Service for Northern Ireland Business Plan.

1.4 To contribute to the organisation's drive for continuous improvement and customer focus in accordance with targets and objectives in the Coroners Service Business Plan.

1.5 He/She will have responsibility for management and supervision of Administrative Officers, in accordance with all people management policies and dealing with day to day management problems which occur concerning both staff and the work, with only limited reference to a more senior officer.

1.6 The post holder will scrutinise documentation and the application of the legislation i.e. The Coroners Act (NI) 1959 and The Coroners (Practice and Procedure) Rules (NI) 1963 and ensure compliance with protocols. They will contribute to the organisation's drive for continuous improvement and customer focus in accordance with targets and objectives set out in the CSNI Business Plan.

1.7 The post holder has delegated authority from the Business Manager in respect of ensuring cases are managed appropriately.

2 Knowledge and Skills

2.1 The post holder requires NVQ Level 2 in Administration or GCSE/CSE O Level (A, B or C) in five subjects, one of which must be English Language.

2.2 The post holder requires 3 years' work experience. The post holder must demonstrate the full range of competences for the EO grade.

2.3 The post holder is required to have an understanding of medical terms and conditions.

3 Main Activities

3.1 The precise nature of the work and the degree to which some or all of the following is applied will be dependent on the team to which the post holder is assigned. (See full list of activities attached) Duties will typically include:

- Managing Administrative Officers, supporting them in the achievement of their objectives and monitoring performance to ensure that business is disposed of in accordance with quantitative and qualitative targets.
- The post holder assures the quality and standards of work carried out by the AOs in the team and provides appropriate desk training to ensure that objectives are achieved.
- Organising and facilitating training for Administrative officers to ensure they have the necessary skills/competences to perform their role.

- Ensuring the effective deployment of Administrative Officers by establishing work flow patterns and work place routines to facilitate the achievement of office targets/objectives.
- Reviewing and evaluating the effectiveness of workplace routines, involving liaison / consultation with team members and senior managers.
- Processing delegated work load in line with Legislation, Practice Directions and Protocols.
- Conducting validation checks to provide assurance of compliance with Legislation, Protocols, Practice Directions and Audit Compliance Standards.
- Representing the interests of the branch at internal and external working groups, meetings and user forums.
- Conducting / overseeing record purges in accordance with the Departmental Records management policy.
- Support and be a participant in the Office's continuous improvement programme, volunteering and taking an active role in one or more of project groups that exist within the organisation
- The post holder is required to ensure that all business is effectively processed on a daily business and to monitor work to ensure that all business objectives are achieved.
- The post holder will develop proficient IT skills in the operation of the Coroners Service database and other Microsoft applications and will be responsible for providing training to new staff.
- The post holder processes reports of deaths via telephone calls from the medical, legal and other professions on a daily basis to progress Coroners business in accordance with the Coroners Service Charter. This includes recording the death on the Coroners database, making recommendations to the Coroners if an autopsy is required and making arrangements for said autopsy to be carried out also referring and discussing cases with the Coroner's Medical Officer where appropriate. The post holder is required to undertake this duty without supervision during week end and bank holidays on a rota basis
- The post holder deals with a variety of counter, telephone and written queries on a daily basis from professional witnesses, service providers, Registrars of Death and bereaved families in accordance with the Coroners Service

Charter. In addition the post holder will assure the quality of customer service delivery for their team.

- The post holder will undergo training in all tasks to ensure effective business disposal and teamwork. This training will include medical terminology, court clerk training and any job specific training as identified in the Coroners Service Training Plan and Personal Development Plans

3.2 To act as court clerk in preliminary hearings and case management hearings. This involves court preparation, manually recording details of Coroner's directions, recording of the Court, and follow up actions taken to implement directions made. In respect of the Coroners inquest Courts the post holder will open the court, read statements and make notes on relevant points in the inquest process. If a jury is to be called the post holder will be responsible for making the necessary arrangements for calling the jury and swearing them in.

- To comply with all NICS and local policies
- To participate in the learning & development plan, best practice groups and improvement projects
- To undertake any other duties delegated by the office manager or as required.

3.3 The post holder will be expected to take on additional responsibility e.g.;

- Health & Safety Officer
- Records Manager (closed files, live files and the amalgamation exercise)

4 Contacts and Communications

4.1 The post holder is required to have an understanding of medical terms and conditions and demonstrate excellent oral & written communication skills as he/she is required to communicate with internal customers i.e. colleagues of all grades & various offices within the NICtS. (HRU, Finance, court offices, Customer Services Group, the Office of the Lord Chief Justice and Communications Group), for example consultation with HRU in relation to staff management issues, requests to Customer Service Centre to summons jurors and liaising with court offices regarding the listing dates and booking Court rooms, arranging Court clerk cover of inquests and extra security for controversial inquests if required. The post holder must also respond to press

queries and requests for information from the Communications Team. This can involve the provision of statistical information, reports following inquests or details of cases which the Coroner's have dealt with. The post holder must deal with queries promptly and ensure information provided is accurate.

4.2 Externally, the post holder is required to communicate effectively orally with medical professionals including hospital consultants and is required to ensure that customer service standards are achieved in their team. This includes discussing causes of death with doctors, medical professionals and PSNI officers to ascertain details on the case. The post holder must understand the medical terminology used in order to ask relevant probing questions and obtain full information on the circumstances of the death which are required by the Coroner. Additional communication orally and in writing is required with PSNI, Solicitors, PPS, Hospital Trusts, Health and Safety Executive, Forensic Science Department NI, The Regulation and Quality Improvement Authority other government departments e.g. Department of Health and Social Services, Department of Regional Development, Pensions Branch and Inland Revenue and the Northern Ireland Legal Services Commission and advice bodies answering queries or processing inquests by telephone and by letter. The post holder will inevitably deal with the more complex issues for the team and will be responsible for advising the office manager of any risks associated with the achievement of objectives. The post holder will have responsibility for liaising with other outside bodies such as St. George's drugs study group, PRONI, Historical Enquiries Team, the General Registrar's Office, Cemeteries Office, State Pathologist's Department, Electoral Office, Centre for Maternal and Child Enquiries, Meteorological Office, Marine Accident Investigation Branch, Air Accident Investigation Branch, Prison Ombudsman and PSNI Ombudsman to request information and reports and to provide these bodies with timely and accurate information. The post holder will also deal with correspondence from the general public sent directly to the office. Requests for information may require time consuming research and / or interpretation of legislation before a full response can be provided. On occasion the post holder may refer complex issues to a Coroner before responding.

4.3 The post holder will also provide monthly reports for the Staff Officer on their area of work. This includes analysis of statistical information and current workloads to provide an update on progress of cases and any follow up actions taken. The post holder will also be responsible for facilitating visitors to the Coroners Office e.g. victims Commissioner visiting from England and also arrange talks on behalf of the Coroners e.g. presentation to doctors.

5 Problem solving

5.1 The post holder is expected to ensure that staff and self process the Coroners business daily including answering queries on the telephone, counter, email and by letter. Many customers will be distressed and may be irate / frustrated therefore a high level of interpersonal skills, professionalism and initiative must be displayed at all times. In addition to this, many witnesses may be distressed because of the nature of the inquest process and the post holder is expected to be sensitive and understanding. The post holder will be responsible for ensuring the quality of the team's response to problem solving and will ensure that all solutions are within the legislative framework for Coroners business.

5.2 The problems to be resolved and the decisions to be made by the post holder arise mainly in deciding / recommending appropriate action to take on operational issues. He/She is expected to resolve conflicting priorities such as the allocation of staff and work, interpretation and implementation of legislation and staffing issues without undue reference to senior management.

5.3 The post holder is required to ascertain fully the circumstances of a death with PSNI or medical professionals in order to provide the necessary background information to enable the Coroners to make decisions as to whether an autopsy is required on reported deaths. The post holder will seek clarification from the duty coroner in more complex circumstances and will be required to discuss complex cases with the Coroner e.g. in sudden death

cases they will ascertain the circumstances surrounding the death from PSNI in order to determine if the death is suspicious and compile relevant details for the Coroner so that the Coroner can make an informed decision regarding the case. Once the Coroner has provided directions the post holder will advise the PSNI / pathologists/medical professions of the decision. The post holder is expected to exercise judgment and interpretive ability where the work falls within certain criteria and where past precedent and experience is generally available. The post holder is expected to discuss complex medical issues and refer to the Medical Advisor when appropriate.

5.4 The post holder is expected to deal with urgent requests from witnesses or legal professionals in relation to inquests to ensure that applications are before the Coroner in a timely and appropriate manner. This will often, due to the urgent nature of the request, require the post holder to be able to read, assess and prioritise the request. The post holder is expected to have the confidence to discuss the issues with the office manager and coroner as appropriate and to ensure that the team meet the service delivery standards.

5.5 The post holder is expected to examine Inquest files or reports provided by PSNI and other agencies to fully inform the Coroners of relevant issues relating to the inquest e.g. make recommendations in respect of witness to be called. This will include very high profile inquests where liaison between the agencies involved will be at a senior level. The post holder is expected to support the Coroner during preliminary court hearings by providing copy documentation, making a note of the proceedings and to provide information for the Coroner.

5.6 The post holder must plan and prioritise his/her daily workload. Once multi skilled, the post holder will take decisions on operational delivery on a daily basis without referral to the office manager. Based on factual information, the post holder will be responsible for taking decisions on the urgency of the work received and whether referral is necessary. Referring file, post, faxes, calls to the appropriate person. The post holder is expected to routinely monitor workload and measure service delivery against targets e.g. follow up on

outstanding reports in order to progress the case. The post holder will communicate the risks associated with the achievement of objectives to the office manager as appropriate and provide reasoned solutions**.**

6 Decision Making

6.1 The post holder takes responsibility for the information presented to the Coroner in respect of death reporting - they will be responsible for collating all relevant facts from a variety of sources (hospital, PSNI, Pathologist etc from which the Coroner will base their decision regarding the case. They may be required to follow up on specific issues to clarify details and liaise with the Coroner and Medical Officer in complex cases.

6.2 The post holder will decide if a claim for expenses is valid and authorise or refer back to claimant if necessary e.g. witnesses attending inquests

6.3 The post holder will liaise closely with the Coroners and make recommendations regarding the location of inquests the witnesses to be summonsed, the use of video link within the required timeline to meet office targets.

6.4 The post holder is responsible for processing all monies received for inquest documentation e.g. photocopying

7 Autonomy

7.1 The post holder will exercise a reasonable degree of autonomy for his/her particular area of work. He/she reports to an SO but is expected to make routine decisions and demonstrate initiative in business disposal and performance target achievement. Outside of normal office hours the post holder has total autonomy or works directly to the judiciary to make the appropriate decisions.

7.2 The post holder is responsible for monitoring and managing performance against office targets for their area of work. They are expected to take pre-emptive action where appropriate and must report exceptions to the office manager (SO) with recommended solutions.

7.3 The post holder will be responsible for running, verifying and analysing reports on the Coroners database and other Microsoft applications to inform the SO of business target compliance. The post holder will be involved in one or more of the following areas;-

Learning & Development Team
AO Focus Group

8 Management of People

8.1 The post holder has staff management responsibilities for up to 2 AOs. They will be responsible for staff training and oversight of their work.

9 Financial Management

9.1 The post holder has no budgetary responsibility but is expected to effectively manage resources and to contribute to the efficient management of the budget and comply with guidance and rates regarding Coroners Witness Expenses including travel and subsistence allowances and production of receipts. The post holder is responsible for the processing of all monies in respect of payments and fees regarding copy documents. They are also responsible for checking payments to Funeral Undertakers regarding the removal of bodies and to ensure compliance with the appropriate guidance and rates so that the principles of corporate governance are adhered to. Invoices are checked against PSNI information to confirm the undertaker and a reasonableness check clarifies the removal details and waiting time. Invoices are often not received timely therefore a thorough check is required to avoid duplicate payments.

10 Impact

10.1 The post impacts on the operational efficiency and output of the business area and will affect the adequacy of service delivery to a wide range of external customers. The nature of the Coroners work is often very high profile and can attract a great deal of media attention - it is essential that all staff within the office carry out their duties diligently and sensitively and respond appropriately and timely to queries. The consequences of errors regarding

autopsies, cause of death or inquests can delay burials, cause unintentional distress to families or delay the business of other stakeholders e.g. State Pathology Dept and negative publicity for the Coroner's Office. The post holder must manage various relationships (PSNI, doctors, undertakers and families) in order to provide an efficient and respectful service to all its customers. The efficiency and reliability of the post holder impacts on internal colleagues as the post is reliant on teamwork for operational efficiency and good customer service.

Generic EO Activities

- To identify training and development needs and agree methods of meeting those needs
- Review performance periodically with line manager and evaluate activity.
- The implementation of all aspects of the Performance Management System to the standard expected and within agreed timescales.
- To contribute to the setting and agreeing of targets/objectives.
- The adherence to the Dignity at Harmony at Work policy
- The effective and timely training of new staff or staff new to a post and adhere to induction.
- To operate the managing attendance policy effectively
- To contribute to team briefing
- To fulfil the people focus competencies.
- The implementation of action points arising from customer survey and courts inspectorate report.
- To adhere to Courts Charter standards
- To adhere to complaints procedure
- To encourage comments on customer service
- To facilitate outreach activities e.g. jobshadowing Coroner's

General Office Team

50% as follows:

- Record details of deaths reported onto the Coroners database

- Liaise with PSNI and medical profession and ascertain details of death to inform duty Coroner's decision (post-mortem, death certificate or pro forma letter)
- Instruct PSNI or medical practitioner regarding Coroners decision
- Instruct PSNI to move bodies when PM required
- Advise mortuary staff of Coroners direction
- Fax Form 16 to pathologist
- Advise funeral director of decision, if appropriate
- Issue burial or cremation order
- Issue Out of Country Orders
- Run end of month reports in preparation for monthly Business Report
- Advise staff in more complex cases

15% as follows:

- Check processed Form 14 and ensure accurate case closure on Coroners database with all fields accurately updated
- Liaise with and advise Registrars of Death regarding acceptance of death certificate in cases referred by them
- Prioritising urgent correspondence and referring to appropriate person
- Monitor office targets to ensure Form 14 issues within 3 working days
- Phone doctors to chase up any pro forma letters not received
- Answer queries by post or telephone from a large variety of customers
- File Checks ensuring all forms and correspondence has been fully actioned

10% as follows:

- Complete weekly sick leave returns
- Arrange car parking for weekend staff cover
- Prepare and circulate rota for weekend staff cover
- Ensure copy of duty coroners rota is issued to State Pathology
- Ensure answering machine is updated with duty coroner details
- Updating and ensuring weekend rota staff are advised and understand any changes to practice of recording and dealing with deaths
- Check and authorise invoices from Funeral Directors to ensure compliance with agreed rates for payment

- Reviewing and approving stationery orders
- Process staff and Coroners travel claims

5% as follows:

- Oversee record/document purges in accordance with Departmental Records policy and ensure PRONI are informed
- Management of the mass fatalities disaster plan for Coroners in conjunction with affiliated organisations

10% as follows:

- Consistent and timely application of the Performance Management System, Managing Attendance Policy, Induction Policy
- Identify and agree training needs with staff and liaise with Learning Advisor to agree best way to address needs

10% as follows:

- Update Coroners database ensuring case closed correctly with all fields completed
- checking all death certificates and F14's against monthly reports from the system

Court Team

10% as follows:

- Prioritising urgent correspondence and referring to appropriate person
- Monitor office targets to ensure inquests are listed within 4 weeks of Coroners decision
- Run reports using Coroners database and Microsoft applications to monitor and establish if targets met
- Provide exception reports to SO

10% as follows:

- Oversee all file progression undertaken by AO and ensure any backlogs are addressed and notified to SO if required

- Validation check on correspondence issued by AO due to sensitive nature of the content
- Answer queries by post or telephone from a large variety of customers
- Research suitable medical exports in particular fields of medicine and approach to ascertain if they will prepare report for Coroner

50% as follows:

- Review files in order to effectively progress cases for inquest
- Liaise with professional witness – PSNI, doctors, Forensic Science NI, Health & Safety Executive, experts – to secure their attendance at inquest
- Assess appropriateness of court venue and liaise with staff at that location to secure the use of a courtroom
- Assess any potential difficulties/sensitivities of any inquest and inform Coroners Liaison Officers and Resource staff when appropriate
- Deal with queries regarding attendance at inquest
- Deal with any issues arising when inquest listed e.g unavailability of witnesses, summonses not being served etc
- Draft and issue letters on behalf of the Coroner
- Deal with adjournments
- Liaise with appropriate coroner on any developments/progress
- Court Clerk duties

25% as follows:

- Consistent and timely application of the Performance Management System, Managing Attendance Policy, Induction Policy
- Identify and agree training needs with staff and liaise with Learning Advisor to agree best way to address needs
- Conduct validatory checks to ensure compliance with legislative requirements and practice directions

5% as follows:

- Close inquest files by completing Form 21 and 22 within 5 working days of inquest
- Update Coroners database ensuring case closed correctly with all fields completed

JD agreed by postholders:

[redacted]

Sharon McAleenon (line Manager)

On /November/2010