Annex A

REVIEW TERMS OF REFERENCE

Coroners inquire into deaths reported to the Coroners Service for Northern Ireland (CSNI) where there is reason to believe that the deceased person died either directly or indirectly:

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

The Coroner will seek to establish the cause of death and will make whatever inquiries are necessary to do this e.g. ordering a post-mortem examination, obtaining witness statements and medical records, or holding an inquest.

CSNI is based in May's Chambers, 73 May Street, Belfast and provides coronial services to the whole of Northern Ireland. CSNI is headed by a Presiding Coroner with one Senior Coroner and two Coroners responsible for service delivery. Two solicitors and a Medical Adviser provide professional support to the Coroners as required. Administrative support is provided by dedicated teams including three Coroners Liaison Officers (CLOs) who are available to support bereaved family members.

Background

A number of concerns have been raised by CSNI personnel regarding current and potential future pressures in relation to resourcing. In response Ronnie Armour, NICTS Chief Executive, has instigated a review of all CSNI functionality and this will build on an earlier review of administration support completed in August 2014. The review will consider appropriate delivery models with a view to creating a coherent service delivery model that is properly resourced and provides a solid foundation to meet current and future demands. The centrality of CSNI users will be a fundamental tenet of the model which will also seek to secure just and speedy

outcomes, efficiency in the administration of justice and provide greater resilience across all functions.

Objectives

The objectives of the review are:

- to examine all aspects of CSNI and equivalent services in comparable jurisdictions in the UK and Ireland;
- to identify the issues to be addressed to ensure CSNI adequately meets the needs of the public;
- to define the organisational structure and future service delivery model within which the service is to be delivered; and
- to make specific recommendations for the short, medium and long term to implement the new service delivery model and make improvements ensuring effective on-going delivery and robust resilience.

Scope of Work

The outcome of the review will be a report setting out measures to improve efficiency and effectiveness and service delivery. In particular it will examine the following areas making recommendations for change focusing on short, medium and long-term actions:

- roles and responsibilities;
- judicial and administrative staffing structures, levels and deployment to meet the current and future demand;
- ways of working;
- procedures and processes;
- standards of service;
- use of technology and the court estate;
- funding and use of resources;
- training;
- communication and information provision;
- governance and accountability;
- key interfaces relating to internal functionality and external organisations; and

- issues raised in recent complaints, investigations, reviews, audits and by the Coroners and staff themselves and recommendations to address them.

Duration

The review will begin on 5 May 2015 and be completed by 26 June 2015.

Methodology

The evaluation methodology will consist of three parts, as outlined below:

- evaluation of existing documentation, processes and procedures;
- interviews, site visits and observations with key stakeholders and customers;
- benchmarking and identification of best practice and special considerations/limitations.

Process

The review will be progressed as follows:

- Week 1: familiarisation, induction and site visits;
- Week 2-3: gathering, assessment and testing of key data and evidence;
- Week 4: consultation with key stakeholders and customers;
- Week 5: present emerging findings, identify improvement proposals and service delivery options and test with CSNI;
- Week 6-7: draft findings including draft implementation plan and receive feedback; and
- Week 8: complete and submit formal report.

Review Team

The review will be led by Mandy Morrison, Acting Head of Tribunals and Enforcement Division (TED) who will be supported by a Grade 7 and staff from the NICTS Service Delivery Review Project. Ronnie Armour will have oversight of the review.

ANNEX B

MEETINGS

The Honourable Mr Justice Weir

His Honour Judge Brian Sherrard

Mr John Leckey, Senior Coroner, CSNI

Ms Suzanne Anderson, Coroner, CSNI

Peter Luney, Senior Business Manager, CSNI

Paula McCourt, CSNI

Ann McCandless, CSNI

Rosalind Johnston, Legal Officer, CSNI

Cathy McGrann, Legal Officer, CSNI

Dr Gemma Andrews, Medical Officer, CSNI

All CSNI Staff

Judge Peter Thornton, Chief Coroner, England and Wales

Ann Maginnis and Amanda Lennon, Belfast Trust

Dr Brian Herron, Neuropathologist, Belfast Trust

Dr Caroline Gannon, Dr Claire Thornton and Dr Daniel Hurrell, Paediatric Pathologists, Belfast Trust

Dr Peter Ingram, Assistant State Pathologist, State Pathologist's Department

Colette Pike, Nichola Murphy, Nick Browne and Cardell McIlroy, PSNI

Julie McMurray, State Pathology Division, DOJ

Jane Holmes, Legacy Unit, DOJ

Clare McVeigh, Prisoner Ombudsman's Office

Seamus McIlroy, Police Ombudsman's Office

Ronnie Russell, Malcomsons Funeral Directors

ANNEX C

JUDICIAL ROLES SINCE 2006

Presiding Judge

The Presiding Judge will carry out the functions of a Coroner as defined in the Coroners Act (Northern Ireland) 1959 and the Coroners (Practice and Procedure) Rules (Northern Ireland) 1963.

He will support the Senior Coroner in providing a guidance and leadership role in shaping the practice and procedure of Coroners in the functions of their office.
He will provide guidance on the interpretation of case law in respect of Coroners practice and procedure.

He will hear complex and or contentious inquests as and when deemed appropriate.

Senior Coroner

The Senior Coroner will carry out the functions of a Coroner as defined in the Coroners Act (Northern Ireland) 1959 and the Coroners (Practice and Procedure) Rules (Northern Ireland) 1963.

The Senior Coroner will be the case manager for the day-to-day business of the office. He will liaise with the Presiding Judge as necessary in the interpretation and application of good practice principles.

He will represent the public face of the Coroner Service in its operational dealings with external organisations and agencies.

Coroners (2)

Coroners will carry out the functions of a Coroner as defined in the Coroners Act (Northern Ireland) 1959 and the Coroners (Practice and Procedure) Rules (Northern Ireland)1963.

ANNEX D

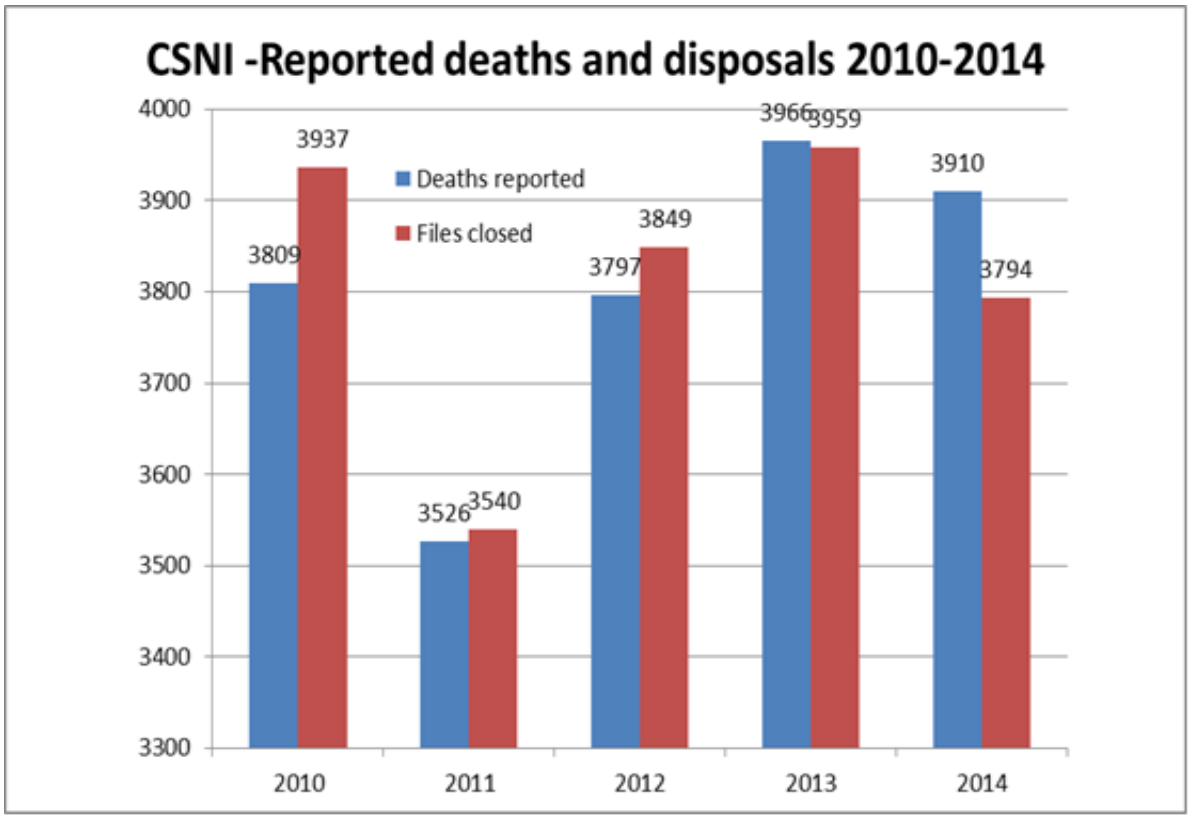
As of May 2015, CSNI have implemented 18 out of the 26 recommendations contained within the Internal Review Report 2014. An implementation plan has been developed to implement the outstanding recommendations, which are detailed below.

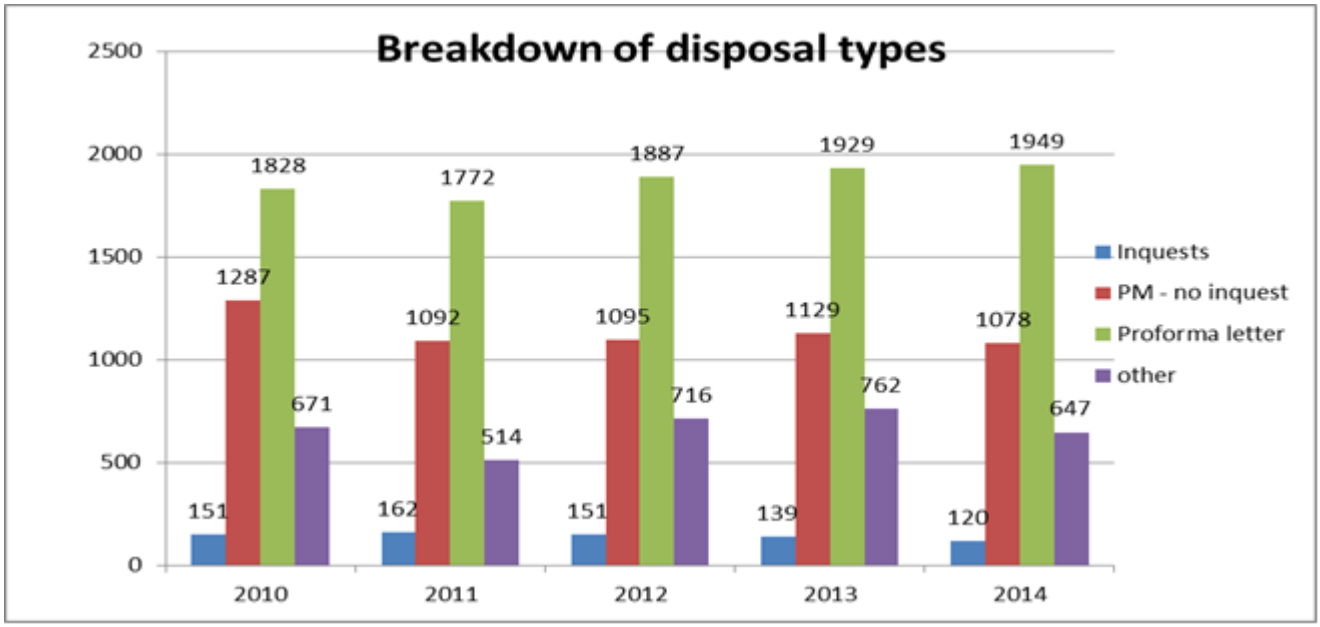
No.	Recommendation	Implementation Date
1.1	**CSNI management will consult with staff** to develop and deliver a training programme designed to create a shared skill base and a system of staff rotation across all business areas in CSNI.	June 2015
2.3	**CSNI management will consult with Coroners and staff** in reviewing current practice in relation to the issue of standard forms.	June 2015
2.5	**CSNI management will consult with staff** to develop and deliver a comprehensive training and induction programme for all new staff appointed to CSNI which will include quality assured reference/guidance material.	June 2015
3.2	**CSNI management will engage with the ICT team** to develop and implement an on-line solution for reporting deaths. In the interim staff will be encouraged to promote use of the pro-forma through routine contact with medical professionals and police officers.	September 2015
6.3	**CSNI management will consult with staff** to agree all job descriptions.	September 2015
10.1	**CSNI management will liaise with ICT Services** to explore the potential to either upgrade or replace the Mountain IT system to better meet CSNI needs	September 2015
12.1	**CSNI management will seek the views of the Coroners** in relation to setting a target for completion of Inquests, similar to that currently in place in E&W.	June 2015
13.1	**CSNI management will** review current controls/checking mechanisms and implement quality assurance compliance testing arrangements similar to those already in place in other business areas within BCC.	June 2015

As part of the review, the Review Team interviewed CSNI staff to gauge how well the recommendations that are complete have been implemented and if any further action was necessary. Further recommendations have been included in the body of the report in the appropriate section.

ANNEX E

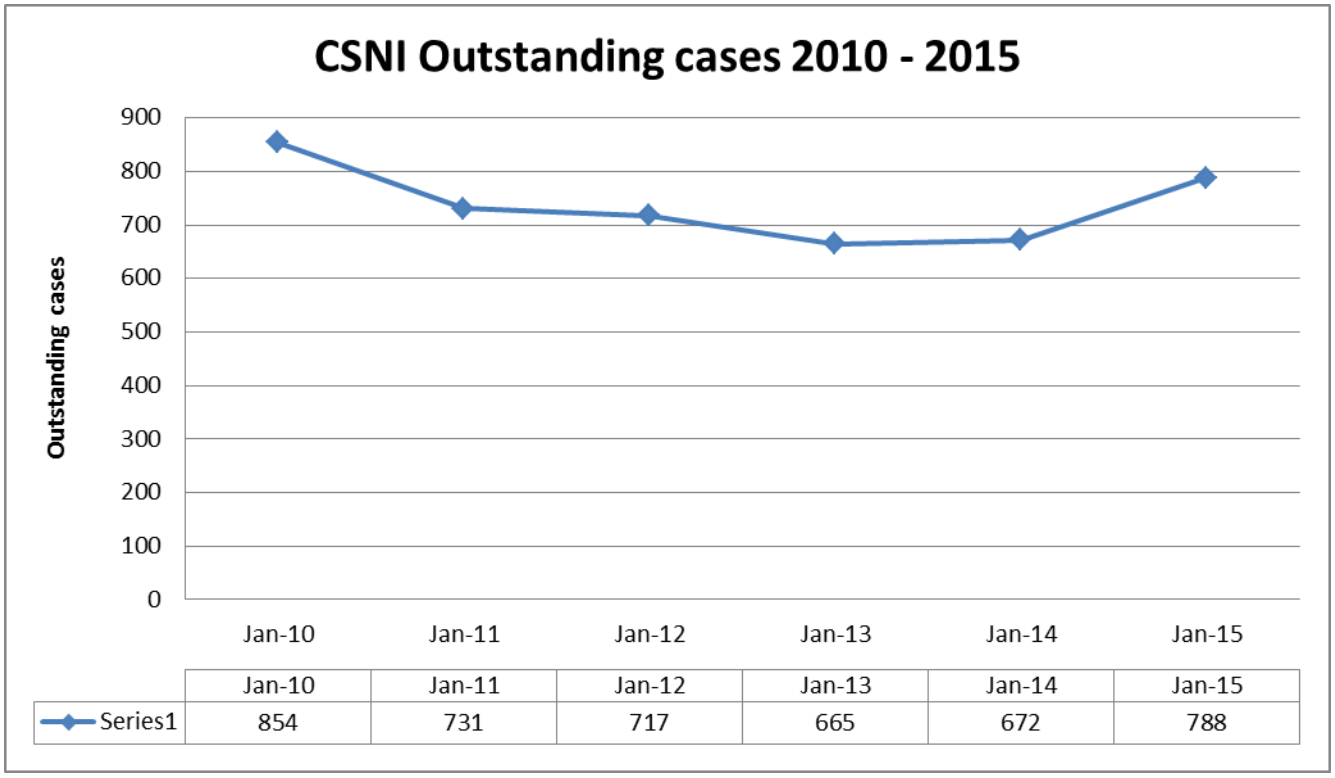
Graph below shows total number of deaths reported and disposed by CSNI from 2010 to 2014.During this period an annual average of 3,800 deaths were reported. An average 14, 000 deaths occur in Northern Ireland each year.





Breakdown of CSNI disposals over the last 5 years. Inquests are not held in respect to post mortem cases showing a natural cause of death or in which the Coroner directs no inquest. Pro-forma letters are accepted from medical practitioners if cause of death is known but a medical certificate of cause of death (MCCD) is unable to issue. Other - mainly refers to deaths reported but later recognised that a MCCD can issue.

Graph showing CSNI outstanding caseload over the last 6 years. On establishment of the CSNI in April 2006 there was an outstanding caseload of 1329 cases. As of January 2015 there has been a 40% reduction in outstanding cases compared to April 2006.



	Jan-10	Jan-11	Jan-12	Jan-13	Jan-14	Jan-15
Series1	854	731	717	665	672	788

The total number of CSNI outstanding cases at the 30th April 2015 was 784. The bar chart below gives an indication to the length of time cases have been outstanding from date reported to CSNI. It should be noted that the majority of those cases over 3 years relate to legacy files.

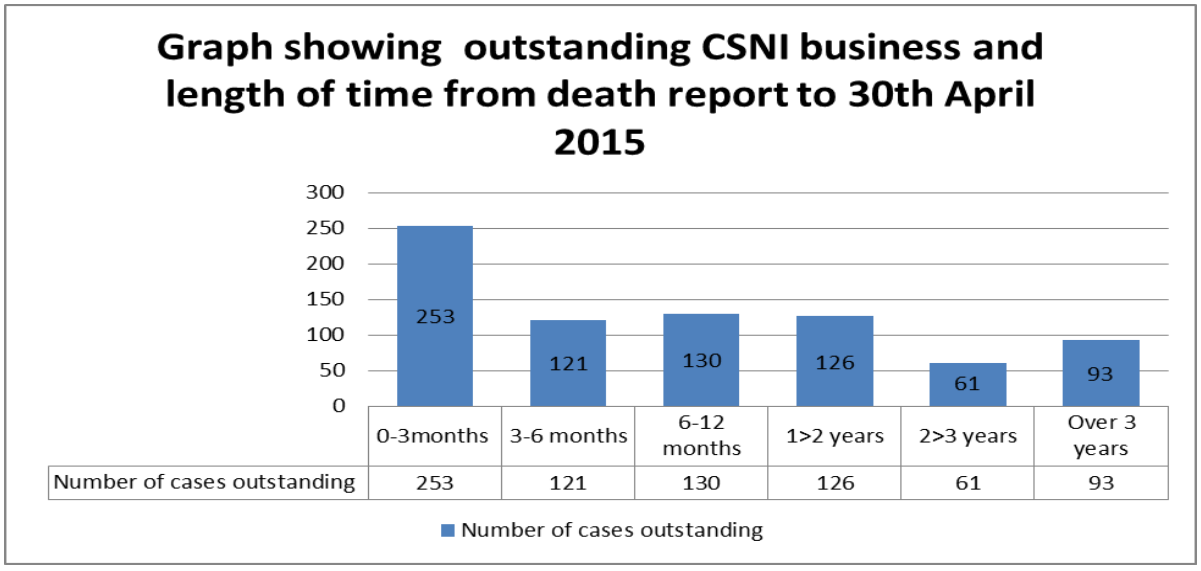
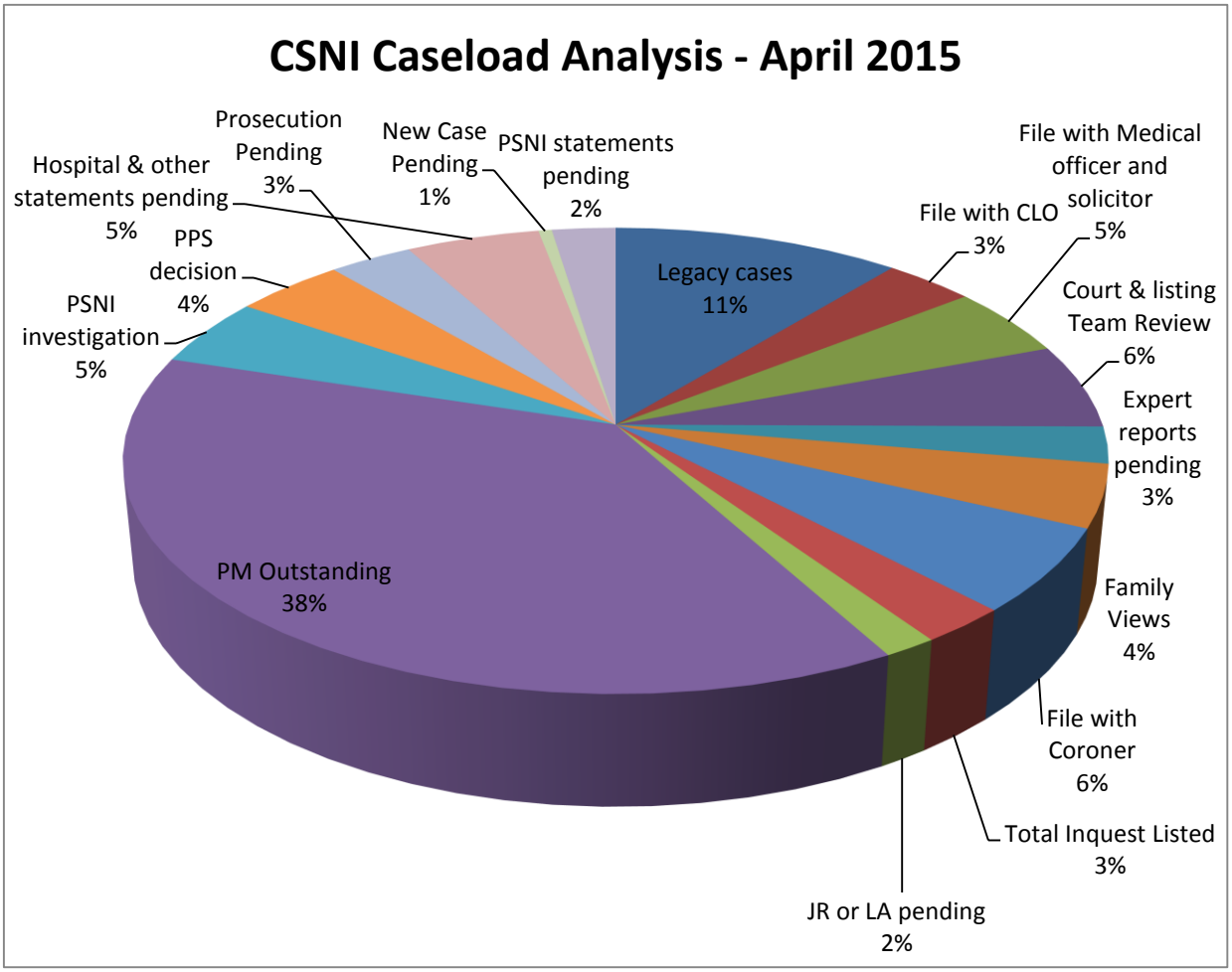
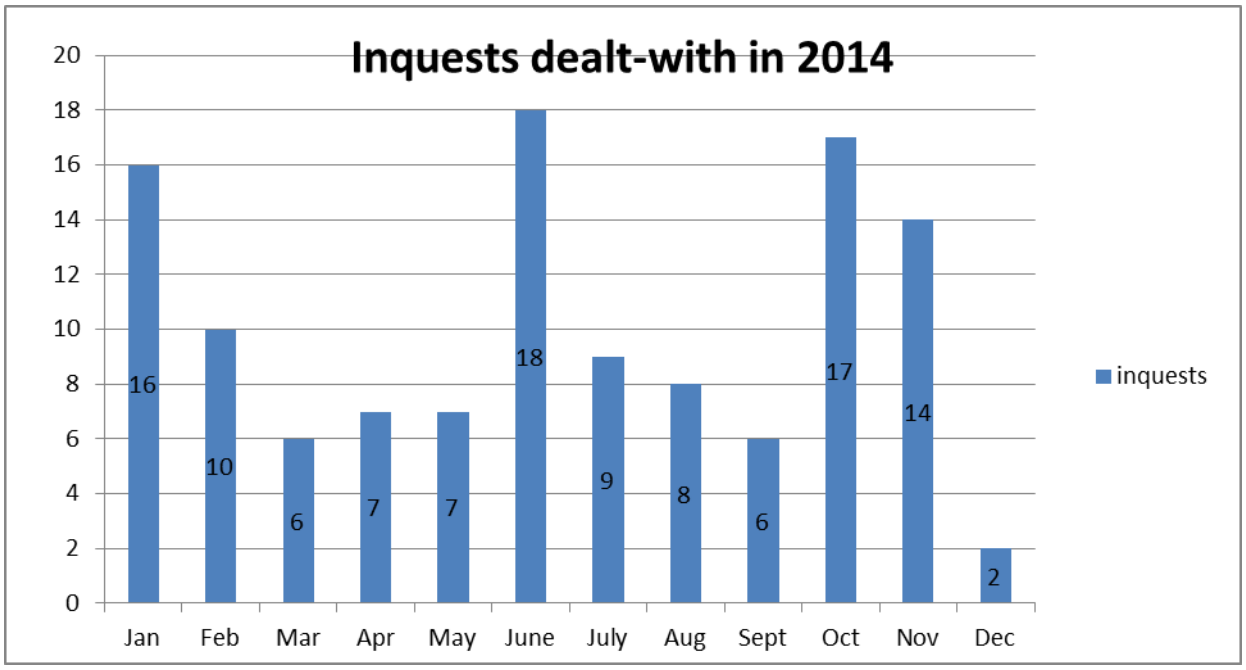


Table showing number of CSNI outstanding cases and present status at April 2015

STATUS	NUMBER	STATUS	NUMBER	STATUS	NUMBER
Legacy Cases	86	Expert reports pending	20	Judicial Review or Legal Aid pending	12
File with CLO	27	Family Views	34	PM Outstanding	297
File with Medical Officer / solicitor	38	File with Coroner	46	PSNI Investigation	37
File with listing team	46	Total Inquests listed	20	Awaiting PPS decision	33
Prosecution pending	25	Hospital and other statements pending	40	New case pending	4
PSNI statements pending	19				



The bar chart below shows the total number of inquests disposed in 2014.

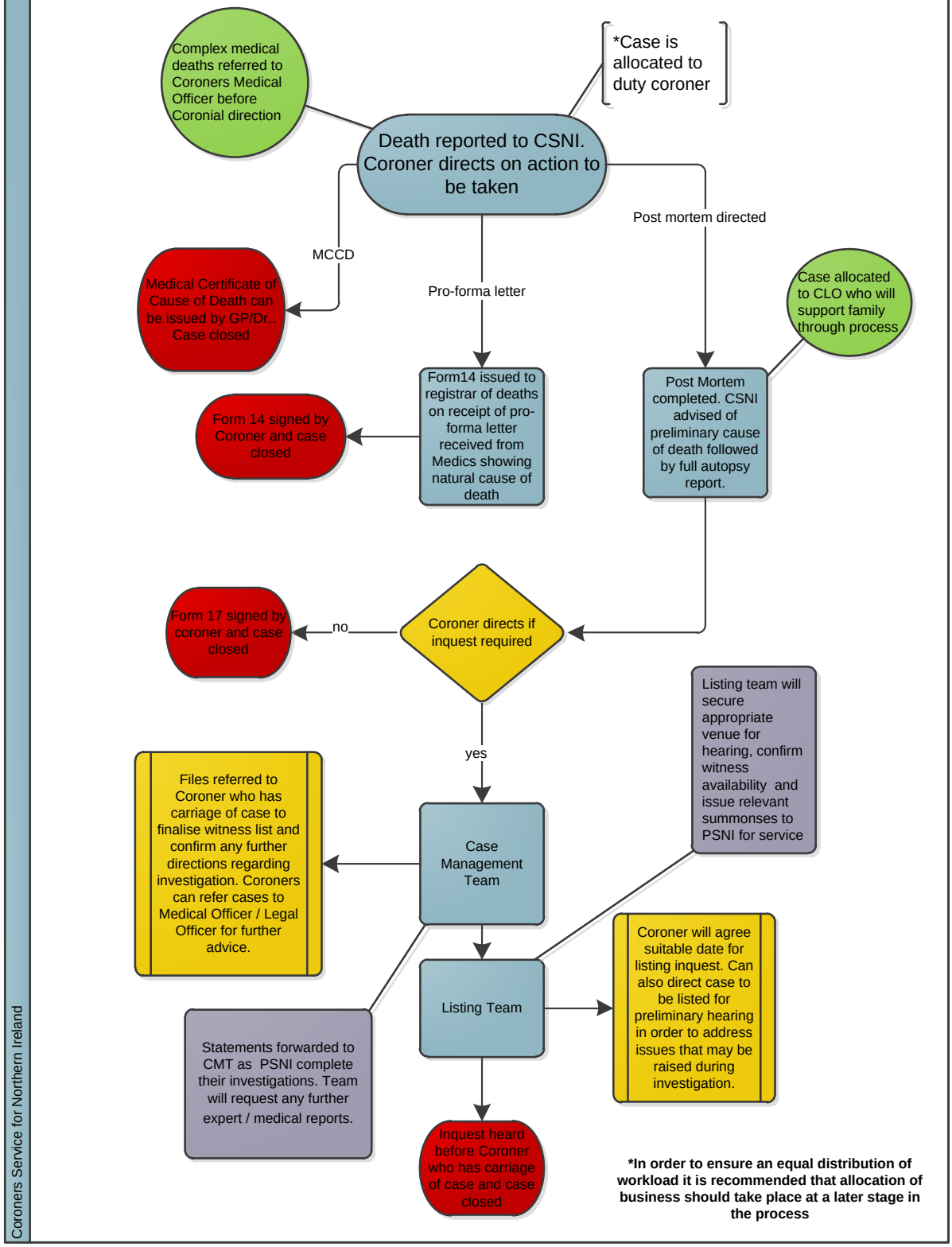


Number of inquests and preliminary hearings listed between January and May 2015 and subsequent adjournments.

Month	Preliminary Hearing Listed	Inquest Listed	Total Listed	Preliminary Adjourned/ Cancelled	Inquest Adjourned/ Cancelled	Total Adj/Canc	% Adjourned/ Cancelled
Jan	24	20	44	5	7	12	27%
Feb	25	6	31	13	3	16	57%
Mar	20	26	46	8	13	21	45%
Apr	8	19	27	5	8	13	48%
May	10	9	19	7	3	10	52%

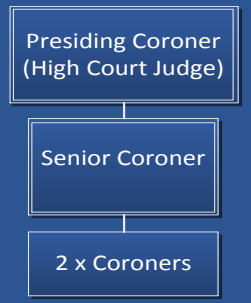
Annex F

CSNI - Death Report to Disposal

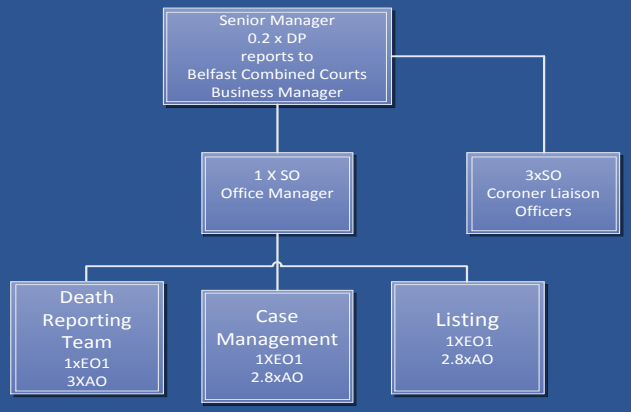


Annex G

Judicial Complement

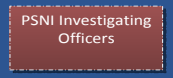


CSNI- Administrative Support

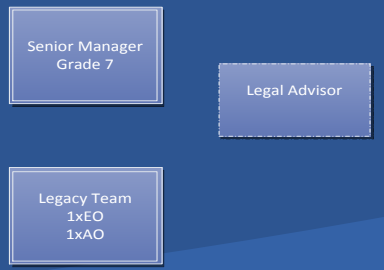


CSNI - Coronial Support

PSNI - Support



CSNI - Legacy Team



ANNEX H

Benchmarking Report

Introduction

1. To assist with determining the complement of coronial support required in the Coroners Service for Northern Ireland (CSNI), the Review Team undertook a benchmarking exercise to provide a comparative analysis of coronial structures, processes, and key areas of reform together with support services and training in the England and Wales (E&W), Republic of Ireland (ROI) and Scotland. As Northern Ireland has a centralised Coroner Service it has been difficult to directly compare jurisdictions in terms of geographical mix (urban and rural) coupled with population numbers.

2. The Review Team gathered information from a number of areas (Hertfordshire, Birmingham, & Solihull, Northamptonshire, Kent, Cumbria, Dublin and Kildare) which have some of the similar characteristics and which were identified by the Coroners themselves; a synopsis of the findings is below. Each of the areas that were examined publish details of inquests on their websites, including the name of the deceased, date of death, nature of death, inquest date and duration.

3. Consultees included Coroners in Northern Ireland, the Coroners Implementation Team in Ireland, the Head of the Scottish Fatal Investigation Unit at the Crown and Procurator Fiscal's Office in Scotland, the Head of Coroner Service in Hertfordshire and the Professional Lead of the Coroners Service in Cumbria. Research and statistics contained within this report have been provided by the offices concerned and/or have been taken from specific published statistical reports https://www.gov.uk/government/.../**Coroners-statistics-2014**. A comparative table is contained in Annex 3.

Republic of Ireland (ROI)

Structure and Caseload

4. ROI currently has 45 Coroner jurisdictions with 41 Coroners; only one of those Coroners is full-time Coroner (Dublin) who has a dedicated office and support staff. The remaining 40 Coroners are part-time or known as Acting Coroners who work from busy practices as lawyers or doctors and have insufficient time and resources to allocate to supporting relatives throughout the full cycle of Coroner activity. They are paid a basic retainer which is intended to cover on-call duty and office services; and a fee per case which is paid in relation to the work carried out. A number of existing Coroners (16) were appointed under the Coroners Act 1962 which means they can only be a Coroner within their assigned area, while Coroners (25) appointed after the amendment to legislation can work in others areas, as long as it remains within the same local authority. It is hoped that as Coroners retire the number of jurisdictions and Coroners can be reduced. There are currently 41 Coroners who service 45 Coroner jurisdictions. Some Coroners cover two jurisdictions, normally within the same county. It is anticipated that this number will reduce with the retirement of Coroners. Each Coroner is responsible for delivering and managing their workload.

5. The Coroner for the Dublin area is the only full-time Coroner who has a dedicated office and support staff. This Office is funded by the Dublin local authorities. All administrative functions relating to the Dublin Coroner i.e. death recording, jury summoning etc., are carried out in this office by his staff. The Dublin Coroner is paid a fixed salary.

6. Section 13(1) of the 1962 Act specifies that each Coroner shall appoint a deputy Coroner. All deputy Coroner appointments must be approved by the relevant local authority and, following a statutory amendment in 2011, by the Minster for Justice and Equality. Under section 13(4)(1) of the Act a person appointed as a deputy Coroner may act for the Coroner during the illness or absence of the Coroner or where, for example, the office of the Coroner is vacant. A deputy Coroner acting as a Coroner has all the duties and powers

of a Coroner. One of the recommendations in the Report of the Coroners Review Group in 2000, was the introduction of Coroners Officers, however due to lack of funding none have yet been appointed

7. In the ROI there were 15,833 deaths reported and 2053 inquests held in 2014. **County Kildare** has a population of 210,312 and is served by a part-time Coroner who is a Barrister. In 2014, there were 534 deaths reported, with 101 requiring a post-mortem and 74 inquests held. Generally it takes a minim of 5 months after the date of death before an inquest is held. In more complex cases this may take between 6-12 months.

Death Reporting

8. Ireland has a population of 4.59m Reportable deaths are reported directly to the Coroner in whose coronial area the death has occurred, usually by a member of An Garda Siochana.

9. There appears to be no timeframe for the release of bodies. However, once a post-mortem has concluded the Coroner generally releases the body. In exceptional circumstances, a second, or defence, PM is carried out, which may delay release. This second post mortem is paid for by the Department.

10. At the time of the Report there were approximately 32,000 deaths annually in Ireland of which approximately 7,250 are reported to Coroners. Statistical information records the average number of deaths recorded in Ireland over the last 5 years at 28,800. In 2014 there were 15,833 deaths reported to Coroners in Ireland. The 2014 statistics are available at Annex 1.

Remuneration

11. Apart from the Dublin Coroner who is paid a fixed salary by Dublin District Authority, payments made to other Coroners are made by the relevant local authorities. In this context remuneration is made up of a basic retainer which is intended to cover on-call duty and office services; and a fee per case which is paid in relation to the work carried out on the following basis:

Death reported	£129.68
Death certified following post mortem	£188.54
Death certified following post mortem and inquest	£522.97

Legislation

12. The Irish Coroners Service (ICS) is governed by the Coroners Act 1962 and remains largely unchanged apart from minor changes through the Coroners (Amendment) Act 2005 (sec 26 summonsing of witnesses; sec 36 serving of summons; and sec 37 non- attendance of jurors and witnesses).

13. In 2007 the Department of Justice and Equality published the Coroner's Bill 2007 which has two main objectives. One is to comprehensively reform the existing legislation relating to Coroners by replacing the Coroners Act 1962 with modern updated provisions taking into account the jurisprudence of our courts and the European Court of Human Rights. It also takes account of developments in the legal system and of the ongoing reform of Coroner services in other common law jurisdictions. The other main objective of the Bill is to establish a new full time Coroner Service. The new service will comprise a Chief Coroner, Deputy Coroner, Coroners and a lesser number of part-time assistant Coroners and will be organised on a regional basis.

14. Further legislative amendments included in the Civil Law (Miscellaneous Provisions) Act 2011 to allow for the improved use of Coroner resources, including the amalgamation of adjoining coronial districts within the same local authority area when vacancies arise.

Governance and Training

15. No one Coroner has any management role in the co-ordination of the workload of any other Coroner or Assistant Corner nor do they have any responsibility for the training of Coroners. However, the Coroners Society of Ireland holds in-training days, meetings and seminars for all Coroners which they can avail of. The current Jude of the Coroners Society of Ireland is Coroner for Cork City.

England and Wales (E&W)

Structure and Caseload

15. The population of England and Wales is approximately 57m. There are currently 99 coronial areas in E&W, with 90 Senior Coroners; Coroners and support staff are appointed by the local authority. Under Section 2 of the Coroners and Justice Act 2009 (2009 Act) the Lord Chancellor can make an order setting and altering the boundaries of Coroner areas for England and Wales which enables the amalgamation of areas; using this power the Chief Coroner is hoping to reduce the number of areas to 75 or less.

16. Some 220,000 deaths are reported to Coroners each year, circa 95,000 will involve a post-mortem examination. Each Coroner should have approximately 3,000 – 5,000 reported deaths each year; currently 60% of Coroner areas have fewer than 2,000. Most inquests will be held within six months, and if they are over 12 months they must be reported to the Chief Coroner. A Coroner area may also have an Area Coroner (who may function as a deputy to the Senior Coroner). Each Coroner area has one Senior Coroner and one or more Assistant Coroners. Research shows that salaries for full-time Coroners are based on the population size of the area they cover and range between £83,000 and £104,000 a year. Part-time coroners and deputy coroners can be paid a fee according to the number of cases they take on each year, ranging from around £10,000 for 200 cases to £50,000 for 2000 cases, again depending on the district within which they work. An Assistant Coroner can expect to work a minimum of 15 days per year and depending on the district which they work, is normally paid a flat daily rate.

Legislation

17. The principle legislation governing Coroners is the Coroners Act 1988 and the Coroners Rules 1984. Key coronial reforms were proposed in 2006. A review led to Ministry of Justice's proposals for the implementation of Part 1 ('Coroners') of the (Part 1 of the Coroners and Justice Act 2009 which

introduced a number of structural changes to the Coroner system. Central to these reforms was the introduction of a Chief Coroner to coordinate the system, exercise wider public health responsibilities and deliver a national framework of standards designed to deliver greater consistency and improved services for bereaved people. The relevant parts of the Coroners and Justice Act 2009 and new Coroner Rules and Regulations, introduced by the Ministry of Justice were implemented on 25 July 2013.

18. Part 2 of the Coroners (Inquests) Rules 2013 were drafted. This provision encourages early disclosure and requires Coroners to disclose information at any stage of an investigation on application by an interested person, including information that comes to light during the inquest itself. The Coroner will have some say over what information is relevant and may redact a document before disclosing it. Electronic disclosure is common place and the rules expressly permit it.

Governance and Training

19. The Ministry of Justice is responsible for the law and policy governing Coroners and deal with the operation of the current Coroner system. The Chief Coroner for England and Wales is responsible for the training of Coroners. This training is provided by the Judicial College www.judiciary.gov.uk. Newly appointed Coroners in England and Wales undergo compulsory Coroner induction training. This training is compulsory and it is organised by the Chief Coroner under the auspices of the Judicial College although some liaison with Senior Coroners may be required to ensure that mandatory courses are completed. All Chief Coroner's guidance and advice can be accessed through the judicial intranet. The Judicial Conduct Investigations Office (formerly the Office for Judicial Complaints) supports the Lord Chancellor and the Lord Chief Justice in their joint responsibility for judicial discipline.

Coroners Officers and administrative support staff

20. There are a number of positions within the Coroner's Office in England and Wales that assist the Coroners Service to manage the day to day running of their districts. The staff is employed in some, but not all, by local authority areas.

They include (but are not exclusive of):

- **Senior Coroner's Officer -** To assist the Head of Coroner Service to manage and oversee the day to day running of the Service in order to ensure the effective and accurate investigation of sudden deaths referred to the Coroner for the District in which they are assigned. It is also the role of the Senior Coroner's Officer to manage the workload of Coroner Service staff to ensure that this work is distributed effectively in order to deliver the relevant investigatory and administrative tasks to ensure the effective and delivery of coronial business.

- **Coroner's Officer -** Coroner's Officers are directed by the Coroner to gather evidence for the purpose of the investigation under the remit of the Coroners and Justice Act 2009 in order to assist the Coroner in the execution of his/her legal and public protection duties in accordance with the Coroners Act 1988. These duties include receiving information with regard to sudden, violent, suspicious or unnatural deaths and establishing contact with relatives of the deceased and their representatives. Coroner's Officers also make recommendations to the Coroner as to the appropriate action to be taken, in accordance with legislation. They investigate causes of death by obtaining written statements and assembling evidence from various authorities including Police Officers, Medics, Health and Safety Inspectors and, as required arrange post mortems and ensure that the body is released to the appropriate party as soon as possible.

- **Senior Support Officer -** This officer manages the administrative tasks carried out within the team. These duties include dealing with general and complex correspondence, payment of invoices, timesheets, expenditure research, completing briefing notes and reports and to provide support to Senior Officers and Managers in dealing with confidential and sensitive matters.

Statistics and Waiting Times

21. The Ministry of Justice published statistics on deaths reported to Coroners in England and Wales in 2014 were published on 14 May 2015. The average number of deaths reported in England and Wales over the past 5 years was

496,778. The average number referred to Coroners in England and Wales during that period was 226,502.

22. The report records that the number of inquests opened by Coroners has fallen by nearly 15%. This reduction is noted as likely to be as a result of the increased use of preliminary inquiries under section 1(7) of the Coroners and Justice Act 2009. The average time from report of death to inquest is recorded as having remained the same at 28 weeks.

23. The average number of deaths registered annually is 8700 with 3200 cases (39%) referred to the Coroner. There are an average number of 370 inquests held, with up to 5 juries called, per year. PMs recorded for 2014 were recorded as 1418, representing 48.5% of all referrals. Statistics for England and Wales can be accessed using the following link https://www.gov.uk/government/statistics/Coroners-statistics-2014.

Specific areas

24. As part of the review, Coroners suggested specific areas for us to benchmark due to similar characteristics to NI and also researched a few additional areas.

Hertfordshire

25. The Hertfordshire Senior Coroner covers an area of 630 square miles with a population of over 1,100.00. His salary is £99,664. The number of deaths reported to the Coroner during 2014 was 4,200 and the number of inquest conclusions totalled 76. This Coroner's Service retains a budget of £0.8m, which includes all pathology and staffing costs. The Senior Coroner is supported by 4 assistant Coroners who cover for the Senior Coroner when he is on leave etc. The Chief Coroner is responsible for the training of Coroners. This training is provided by the Judicial College. Induction training for new Coroners is mandatory, with at least one follow up course per year. However, the Chief Coroner does issue guidance and requires Coroners to conform towards a national drive towards consistency of practice. Training for all staff,

including Coroners, is arranged by Coroner Service staff in their area. This includes membership of the Coroner's Officers Association.

26. Coroners are not supported by an office based medical officer. It is the duty of the Coroner's Officer to take the details of referrals on behalf of the Coroner and, in the event that they require assistance to understand complex or difficult medical information, they make contact the pathologists at the local NHS Trusts.

27. The Head of the Coroner Service manages the service team, accommodation, contracts and budget. The Senior Coroner is also supported by 6 Coroner's Officers, one Senior Coroner's Officer and 2 full time Senior Support Officers. The Coroner's Service guides families through the coronial process but do not provide bereavement support. The Coroners Court Support Service provides support to all court attendees on court days. These employees are paid by the Coroners Service (on zero hours contracts) and are referred to as Deputy Registration Officers. Performance targets are included in Annex 2.

28. Hertfordshire have a number of contracts for the transportation of bodies. In general, when a death is referred that requires a PM, the body will be removed to the mortuary the same day and the expectation is that the PM will be conducted the following morning. The result of the PM will be conveyed to the next of kin by telephone and the body released, usually, within 2 days of the death.

On call/out of hours arrangements

29. Coroners deal with out of hours referrals and are available out of hours by telephone. In non-suspicious cases the Police have the body removed to hospital by the contract undertakers and send a sudden death form electronically to the Office. Police also forward any statements taken at the scene. In the event that a GP attends a non-suspicious death the family have the body taken by their own undertakers and the GP will make a formal referral the next working day. Hospital bereavement offices do no operate out of hours and their referrals are made in hour electronically in hours. The

Office works closely with the Police and as a result, once sufficient evidence has been taken at the scene they will remove the body without the necessity of disturbing the Coroner. The exception to this is when permission is needed in organ donation cases. No administrative staff are on call out of hours. In the Senior Coroner for Hertfordshire job description it states that "Basic hours of 37 per week over 5 weekdays. However this is a whole time appointment and the exigencies of the service determine whatever hours are necessary to fulfil the full duties of the appointment. There is a statutory requirement to be available at all times to address matters relating to an investigation into a death which must be dealt with immediately and cannot wait until the next working day. Such matters will usually be addressed by telephone.

Birmingham and Solihull

30. The Birmingham and Solihull Coroner cover an area with a population of over 1.3m. There are two full time Coroners who are supported by 6 part-time assistant Coroners who cover for the Coroners when they are on leave etc. The number of deaths reported to the Coroner in 2014 was 4,205 with 499 inquests held. List of inquests appear on website and include the deceased name, date of death, date of inquest, hearing date, time and location and hearing type i.e. final hearing.

On call/out of hours arrangements

31. At present time, the Senior Coroner, or one of her Assistant Coroners is available between 10.00am and 12.00noon every Saturday, Sunday and Public Holiday throughout the year excluding both Christmas Day and Boxing Day. The Coroner provides this service voluntarily and it is intended only for the issuing of 'Out of England' forms – for people who wish to take a deceased person's body out of England for a funeral overseas rather than proceeding with the burial as soon as possible. In the event that the Coroner cannot be contacted out of normal office hours, then a Police Force Control Room number is provided on the website.

Northamptonshire

32. The Northamptonshire Senior Coroner covers an area of 913 square miles with a population of circa 629,000. The number of deaths reported to the Coroner during 2014 was 2,578. The number of PMs carried out was 937, 36% of the deaths reported. During 2014 there were 206 inquests heard which equates to 8% of all reported deaths.

Kent

33. The Kent Senior Coroner covers an area 1,442 square miles with a population of circa 1.5m. The number of deaths reported to the Coroner during 2014 was 7,292, inquests held approximately 740. The average length of time between PM and inquest varies depending of the type and complexity of the case but averages between 2 and 9 months. However, in cases where there is an investigation by a third party such as the Health & Safety Executive or Prison & Probation Ombudsman this may take longer.

Kent is split up into 4 areas:

North East	-	1 Senior Coroner 3 Assistant Coroners 4 Coroners Officers 1 Clerk in administration
North West	-	1 Senior Coroner 1 Assistant Coroner 3 Coroners Officers
Central & South East	-	1 Senior Coroner 1 Assistant Coroner 3 Coroners Officers 2 Part-time Clerks
Mid Kent & Medway	-	1 Senior Coroner 6 Assistant Coroners 1 Coroners Clerk 1 PA 1 Clerk in Administration 2 Ushers

Remuneration

34. Assistant Coroners are paid a flat fee of £200 per day for office cover and £400 per day when sitting in Court. Assistant Coroners are given their own workload and new cases are provided to them when their cases are concluded.

On call/out of hours arrangements

35. Coroners are on call 24/7 but only take calls in emergency cases i.e. homicide, multiple fatalities and organ donation.

Cumbria

36. The Cumbria Senior Coroner covers a predominately rural area of 2,613 square miles with a population of circa 498,000. The Senior Coroner holds inquests in Council buildings in approximately 4 to 5 locations and conducts hearings in Council chambers. There are 7 Assistant Coroners, one of whom is a doctor. According to published statistics the number of deaths reported to the Coroner during 2014 was as follows:

	Deaths	Post-mortems	Inquests
South & East Cumbria	952	476	126
North & West Cumbria	1,210	553	118

The average length of time between PM and inquest is 27 weeks.

Remuneration

37. The Senior Coroner salary is £110k.
Assistant Coroners are paid as follows:

£400 - per day
£200 - ½ day
£60 - hourly rate
£40 - Inquest preparation (administrative work)

Coroners Officers and Administrative staff

38. In this jurisdiction Coroners Officers are police officers. There are also 2 part time business support officers (1.2) who are retired police officers with experience in this area, together with 5 full time administrative officers who deal with Court listing, summonsing witnesses and jurors etc.

Training

39. Training is provided via the Judicial College. Induction training is mandatory with approximately 2-4 top up courses per year.

On call/out of hours arrangements

40. The Senior Coroner is available out of hours and general deals with referrals via the telephone. It was reported that it was very rare for him to be called out. The Senior Coroner has a laptop and has access to the IT system.

Scotland

41. The population of Scotland is 5.3m. In Scotland there are no Coroners. Deaths are investigated by Procurators Fiscal. This office dates back 600 years. Procurators Fiscal mainly qualified lawyers who are employed by Crown Office and Prosecutor Fiscal Service (COPFS) in specialist units and offices around Scotland. They are appointed in the same manner as any other Civil Servant. The Crown Agent is the Head of the Department and the Lord Advocate and Solicitor General are the Ministers in charge.

42. Where necessary, Procurators Fiscal Deputes direct the police in investigating crime. They investigate all sudden and suspicious deaths, conduct Fatal Accident Inquiries and handle criminal complaints against the police. The role of the Procurator Fiscal in the investigation of deaths originates from the Lord Advocate's constitutional responsibilities in devolving responsibility in respect of both the prosecution and investigation of deaths.

43. The structure within the Procurator Fiscal's Unit is that there is a National Unit (based in Glasgow) which is responsible for policy, administration etc. There are also 3 Scottish Fatal Investigation Units (SFIU) situated in the West, East and North of Scotland who deal with all referred deaths arising in their

geographical areas. Staff are based in Glasgow (West), Edinburgh (East) and Inverness, Aberdeen and Dundee (North). There are 45 members of staff in SFIU including lawyers and members of support staff. The largest number of staff are concentrated in the West, being the area of greatest population (approximately half the population of Scotland).

44. The staffing structure consists of the Head of the Unit (who is a Senior civil servant), and the Procurator Fiscal, and the Head of SFIU, 4 Principal Procurator Fiscal Deputes, 4 Procurator Fiscal Deputes (but many more Procurator Fiscal Deputes who also work on these and other matters including prosecution matters) together with 19 legal staff; the reminder of the staff are support and administrative staff.

45. In SFIU West there are 10 legal staff (3 part time lawyers), 2 Precognition Officers (Investigative Officers), 1 administrative manager and 10 administrative assistants. Administrative assistants take calls from doctors notifying the SFIUs of deaths. Administrative staff ascertain relevant details and pass those on to the lawyers for legal assessment. In addition there is an officer known as a VIA (Victim Information and Advice) Officer who deals with bereaved families in those cases that require further investigation and which may go to Court. VIA have no role in liaising with the pathologists and police. Liaising with the Police and pathologist is a role fulfilled by the Procurators Fiscal.

46. SFIU East there are 5 legal staff (1 part time), 1 administrative manager and 5 administrative officers. The population is approximately 1.5m.

47. In SFIU North there are 4 Procurators Fiscal (2 part time) and 2 administrative assistants. The population is approximately 1.25m.

Death Reporting

48. As in England and Wales not all deaths notified are investigated but those investigated are subject to police inquiry with a resulting comprehensive police report. COPFS receives reports of deaths through similar mechanisms to that of Coroners in England and Wales. Death reports received by the

Procurator Fiscal are considered by members of the legal staff who will direct the nature and level of investigation required. Some of the deaths reported are deaths which, while they require to be reported, will be accepted by the Procurator Fiscal on foot of any proffered death certificate.

Post Mortem examinations fall into 3 categories:

- *Double doctor PM* – where it is anticipated that they may be a prosecution or there are significant elements of suspicion surrounding death.
- *Single doctor PM* – where the above does not apply but where an intrusive examination is required to identify the cause or causes of death.
- *View and grant PM* – where the pathologist will conduct a detailed examination of the body and medical records and may thereafter provide a Medical Certificate of Causes of Death without the need for an intrusive examination. It is a matter for the individual pathologist to determine whether such an examination is appropriate as it is they who have the professional responsibility to certify the cause of death to 'the best of their knowledge and belief'.

49. The COPFS is in the process of developing a process of electronic reporting from NHS doctors. At the time of writing this process is in place for primary care i.e. GP reported deaths. It is anticipated that this process will roll out to the whole of the NHS later in 2015. Delays are currently being experienced due to the multiple IT systems used by differing NHS Boards.

Allocation of case work

50. The Principal Deputes in charge of each geographical area manage and allocate the case work within that area. There is no average number of cases assigned to individual Procurator Fiscal. What happens in practice is that those routine certificate of deaths are dealt with in an administrative manner once the PM report is available, which is approximately 6-8 weeks after examination. At this time if no further action is required the case will be closed and the nearest relatives advised. Other cases which require more intensive investigation may be allocated at the time of death or, potentially, after the PM report is received. At that time the Principal Deputy will allocate to individual deputes or precognition officers (Investigative Officers) according to the nature of the death, the work load of the individual.

Court listing arrangements

51. The Procurators Fiscal considers the cases that should be referred to a Sheriff (Judge) and he/she presents a petition to the Sheriff which sets out the circumstances of the death. In these cases Procurators Fiscal provide details of the deceased and highlight the potential issues for the Inquiry. The Sheriff signs the petition and fixes the dates. This authority is provided to the Procurator Fiscal who cites witnesses and produces all physical and documentary evidence. There are no summonses in the Fatal Accident Inquiries (FAI) process.

On call arrangements

52. On call arrangement are via the prosecution side of COPFs who deal with those suspicious deaths such as homicide or culpable homicide. They do on occasion deal with more routine deaths inquiries where the question whether a death certificate offered by a GP might be accepted and if not when arrangements have to be made to transport that body from an out of the way location. However, where there is a difficulty or urgent matter such as requests for authority in organ transplantation cases or in circumstances where a body has to be transferred from an out of the way location and where there may be an urgency to find out if the Procurator Fiscal to direct a PM or accept an proffered death certificate. The Head of SFIU is the only person who is on call in respect of all these matters and is available to be consulted by less specialist deputes who require guidance.

Legislation

53. Sudden Deaths and Fatal Accident Inquiry (Scotland) Act 1976

Waiting Times and Statistics

54. There are approximately 55,000 deaths per year in Scotland. Generally there are between 11,000-13,000 deaths reported to the Procurator Fiscal. The Procurator Fiscal instructs approximately 6,500 PM examinations per annum.

Of this number approximately 600 may require significant further investigation. Of the approximately 600 cases requiring further investigation, 72 Fatal Accident Inquiries were held.

55. Mandatory inquiries are undertaken where death has occurred, for example, in custody or as a result of an accident at work. In addition the Lord Advocate has discretion to petition the Court for an Inquiry where he considers it expedient in the public interest to do so. Judges have no authority to refuse applications.

56. There is a lead in time of 5 days or less for PM examinations; although this can vary due to the number of deaths referred, public holidays etc. A body will be released immediately after the PM examination has been concluded; except where it has been necessary to retain it for further investigation.

57. In view and grant cases the pathologist is not required to prepare a report and the office will receive a Medical Certificate of Cause of Death. In all other cases where a PM report is required, it is expected that the report will be available within 12 weeks of the date of the examination.

58. There are no set times for FAIs to take place. Some cases are more amenable to a speedy resolution e.g. natural death in custody. Others that rely on specialist investigative agencies such as the Air Accident Investigation Branch, Marine Accident Investigation Branch or complex medical cases take longer.

59. Statistics below detail the number of FAIs held from 1.4.11until 31.3.15:

Mandatory FAIs	No
1.4.11 - 31.3.12	47
1.4.12 - 31.3.13	34
1.4.13 – 31.3.14	30
1.4.14 – 31.3.15	61

Discretionary FAIs	No
1.4.11 - 31.3.12	17
1.4.12 - 31.3.13	11
1.4.13 – 31.3.14	3
1.4.14 – 31.3.15	7

Pathology and medical arrangements

60. Pathologists are employed by way of contract and come from a number of different areas. In Aberdeen, Dundee and Glasgow they are employees of

the Department of Forensic Medicine. In Edinburgh they are forensic pathologists employed by NHS Lothian. Additional assistance is provided by NHS pathologists (non-forensic) who deal with certification type investigations in Dumfries and Galloway, Ayrshire and Arran, Highlands, Fife and Forth Valley. Pathologists also provide advice and assistance to the Procurator Fiscal beyond the provision of the death certificate i.e. as to what further investigations may be required and assist in suggesting medical experts who may be required to be consulted. SFIU do no employ members of the medical profession within their units.

Training

61. Training in generally carried out in-house. SFIU were established 3½ years ago to bring a degree of specialism to this area of work. Prior to that, death investigations were carried out in local offices as an addition to the central role of prosecution. All current staff have been in post for a number of years and have a significant level of knowledge. Training courses are provided by forensic pathologists, police officers and by Senior staff within the unit. Electronic training packages are available on the Crown Office Intranet. All staff have undergone training in delivering difficult messages to assist them in dealing with relatives of deceased persons.

ANNEX 1

	2014			
Area	Report only	Report and Post Mortem	Report/Post Mortem and Inquest	Total Completed Cases
Carlow	103	31	31	165
Cavan	159	30	33	222
Clare	314	59	37	410
Cork Co. Borough	566	159	192	917
Cork North	263	72	36	371
Cork South	353	74	50	477
Cork West	119	28	27	174
Donegal North East	74	43	2	119
Donegal North West	271	43	34	348
Donegal South East	101	18	14	133
Donegal South West	115	8	17	140
Dublin	2838	1236	666	4740
Galway East	234	68	35	337
Galway North	44	21	12	77
Galway West	488	171	79	738
Kerry North	67	24	3	94
Kerry South East	162	28	12	202
Kerry West	171	56	34	261
Kildare	359	101	74	534
Kilkenny	184	67	31	282
Laois	103	54	17	174
Leitrim	59	23	10	92
Limerick City	49	28	35	112
Limerick South East	228	81	40	349
Limerick West	129	1	27	157
Longford	63	17	11	91
Louth	256	93	55	404
Mayo East	20	10	5	35
Mayo North	44	12	21	77
Mayo South	178	118	58	354
Meath	245	104	40	389
Monaghan North	39	13	6	58
Monaghan South	47	1	11	68

Offaly	157	32	19	208
Roscommon	149	6	31	186
Sligo	182	97	41	320
Tipperary North	179	29	14	222
Tipperary South	177	66	28	271
Waterford City	125	108	26	259
Waterford East	104	22	5	131
Waterford West	14	9	6	29
Westmeath	231	55	33	319
Wexford	394	67	56	517
Wicklow East	164	24	33	221
Wicklow West	38	5	6	49
Total	**10359**	**3412**	**2053**	**15833**

ANNEX 2

Herefordshire

MOJ Targets	Actual 2013/14	Target 2014/15	Target 2015/16	Target 2016/17
1. Death investigated where there was no inquest in which certificates were issued within one week *(MoJ statistics).*	92%	95%	95%	95%
2. Deaths on which inquests are to be or were opened in which disposal certificates were issued within one week *(MoJ statistics).*	97%	90%	90%	90%
3. Deaths on which inquests were concluded within six months *(MoJ statistics).*	63%	75%	75%	75%
6. Percentage rate of post mortem examinations against referral rate *(MoJ statistics).*	49%	46%	46%	46%
7. Percentage inquest rate against referral rate *(MoJ statistics).*	11%	10%	10%	10%

ANNEX 3

Comparative Table

2014	Northern Ireland	E&W Hertfordshire	E&W Kent				E&W Birmingham & Solihull	Northamptonshire	Cumbria	Ireland (all)	Ireland Kildare	Scotland
Population	1.8m	1.1m	1.49				1.3	629,000	498,000	4.5	210,312	5.3
No of Deaths Referred to Coroners	3,900	3,200	NE 1,838	NW 1,661	Central & SE 1,526	Mid Kent & Medway 2,267	4,205	2,578	2,162 S&E – 952 N&W – 1,210	15,833	534	9,549
No of Coroners	3	1	NE 1	NW 1	Central & SE 1	Mid Kent & Medway 1	2	1	1	16	1 (part time)	None Procurator Fiscal (lawyers) 16
No of Deputy/Assistant Coroners	Nil	4	NE 3	NW 1	Central & SE 1	Mid Kent & Medway 6	6	No information	7	25	None	None
Number of Inquests	Approx. 120	67	NE 198	NW 157	Central & SE 155	Mid Kent & Medway 305	1,089	272	244 S&E – 126 N&W – 118	2053	74	No information Approximately 600 cases requiring further investigation.
Length of time between PM and Inquest	No figures available	Between 2-9 month. With the exception of very complex cases.	No information available. However, should be linked with MOJ Performance Standards. (Annex 2)				No information available.	No information available.	27 weeks	Average 6-9 months	No set time but generally between 6-9 months	Dependent upon complexity. In England and Wales the Chief Coroner expects a report and justification for any case taking over 12 months to complete.

<table>
<tr><td>Performance Standards</td><td></td><td>MOJ Performance Standards are available. (Annex 2)</td><td colspan="4">MOJ Performance Standards are available. (Annex 2)</td><td>MOJ Performance Standards are available. (Annex 2)</td><td>MOJ Performance Standards are available. (Annex 2)</td><td>MOJ Performance Standards are available. (Annex 2)</td><td>MOJ Performance Standards are available. (Annex 2)</td><td>None listed</td><td>80% of Investigation of deaths to occur within 12 weeks of death with the results being provided to the next of kin.</td></tr>
<tr><td>Support Staff</td><td>3 SOs Coroners Liaison Case Management Team: Coroners Liaison Officers (CLO), 0.2 DP, 1 SO, 1 EO & 3 AOs. Death reporting team: 1 EOI, 2.8 AOs. Listing Team: 1 EOI & 2.8. AOs. Legacy Team: 1 G7, 1 EOI and 1AO.</td><td>6 Coroners Officers, 1 Senior Coroner’s Officer and 2 full time Senior Support Officers.</td><td>NE

4 Coroner Officers

1 Clerk</td><td>NW

3 Coroners Officers</td><td>Central & SE

3 Coroners Officers

2 part time Clerks</td><td>Mid Kent & Medway

6 Coroners Officers

1 PA
1 Clerk
2 Ushers</td><td>No information</td><td>No information</td><td>2 part time business support officers (1.2) and 5 administrative staff.</td><td>None</td><td>None</td><td>SFIU West:
10 legal staff (3 part time), 2 Precognition Officer (Investigative Officers), 1 admin manager and 10 admin assistants

SFIU East:
5 legal staff (1 part time), 1 admin manger and 5 administrative officers.

SFI North:
4 legal staff (2 are part time) and 2 admin assistants</td></tr>
<tr><td>Case Allocation and Management</td><td>Allocated to Duty Coroner (weekly) – progress them through – others covering Inquests and own cases.</td><td>Allocated to Assistant Coroners by Senior Coroner.</td><td colspan="4">Allocated to Assistant Coroners by Senior Coroner</td><td>No information</td><td>No information</td><td>Allocated by Senior Coroner.</td><td>All referred directly to the Coroner.</td><td>All referred directly to the Coroner</td><td>Principal Deputes in charge of each geographic area will manage and allocate the case work within that area. There is no average number of cases assigned to individuals but is dependent upon incoming casework.</td></tr>
</table>

On Call Arrangements	CLO – working hours at weekends and public holidays. AO – come into office 9.30-12.30 during weekends and public holidays – clear answer machine of any reported death.	Coroners are on call by telephone.	No information	Senior Coroner or one of the Assistant Coroners is available between 10.00 am and 12.00 noon every Saturday, Sunday and Public Holiday excluding both Christmas Day and Boxing Day. It is intended only for the issuing of 'Out of England' Forms.	No information		In principle Coroners are on duty 24/7. However, it was reported that it would be very unusual for a Coroner to be notified of a death out of hours. Generally deaths are reported on the following morning by the Gardaí.	In principle Coroners are on duty 24/7. However, it was reported that it would be very unusual for a Coroner to be notified of a death out of hours. Generally deaths are reported on the following morning by the Gardaí.	Out of hours referrals are dealt with by prosecution side of COPFS in cases of homicide or culpable homicide. Cases relating to organ donation or other complex queries are dealt with only by the Head of SFUI.

Annex I

JOB DESCRIPTION EXAMPLE

ASSISTANT/DEPUTY CORONER

ROLE

To support the Coroner in delivering a high quality Coroner service. The post holder will, as required, cover the full range of duties and responsibilities in accordance with the legislation, guidance issues and locally agreed practice. Working hours are a minimum of 15 days per annum; daily fee £440.

MAIN AREAS OF ACCOUNTABILITY

1. Support and work closely with the Coroner to provide a high quality effective and efficient Coroner service in accordance with the legislation, guidance issues and locally agreed practice.

2. Make enquiries and if necessary investigate the circumstances of the deaths of all persons whose bodies are lying within the Coroners areas where he/she has reason to suspect that the death was violent or unnatural or took place in custody or other state detention, or where the cause of death is unknown.

   Decide whether a post-mortem examination or other form of non-invasive examination is necessary and, if so, to give directions to a suitable practitioner.

   Hold an inquest with or without a jury, where he/she is satisfied that one is required.

   Notify, as appropriate, the relevant Registrar of Deaths of the findings of the inquiries, or if no inquest is held, of the fact that the death reported does not need to be subject to an inquest.

3. Be sensitive and responsive to the needs and requirements of those who engage with the Coroner service, including the bereaved, witnesses, the media, police and other interested persons in the process.

4. Submit accounts for approval to the Coroner of relevant fees and allowances incurred by witnesses and/or jurors during investigations or inquests, spent within the financial and budgetary requirements and constraints associated with public sector funding.

5. Support the Coroner to make statistical information available as required, in connection with the inquests held and deaths he/she has enquired into; investigations which have not been concluded or discontinued within a year.

6. Support the Coroner to manage the relationships with key stakeholders to ensure a safe and harmonious working environment.

7. Undertake any relevant training and development as required, keeping up to date with any legislative changes.

8. Deal with claims for treasure, in accordance with the statutory provisions.

9. Ensure that the service takes full account of the ethnic and cultural diversity of the population within the Coroner area and seeks to be responsive to the varying religious and cultural needs of their diverse communities.

POST REQUIREMENTS

This is a part-time post, but when working at the Coroner's Court the post holder will be required to work the hours necessary to meet the demands of the post. The post holder will be required to undergo relevant pre-appointment checks as required. The post holder will be required to support the out of hours cover service and may be required out of hours at short notice. This will include the urgent release of bodies to meet the expectations of the diverse faiths as far as is compatible with the relevant law and liaison with other stakeholders.

The post holder is expected to live within a reasonable travelling distance to the Coroner area for which he/she is appointed and will have access to the use of a car for business

use. Due to the nature of the post, conviction/s whether spent or unspent, must be declared.

PERSON SPECIFICATION

EDUCATION, TRAINING AND WORK

Applicants must be a barrister, solicitor or fellow of CILEX and satisfy the judicial-appointment eligibility condition on a 5 year basis and be under the age of 70. Either worked as a Senior Coroner, Area Coroner or Assistant Coroner in a busy Coroner area, or can demonstrate and evidence significant equivalent skills and/or experience.

KNOWLEDGE

- Thorough, up-to-date knowledge of legislation relating to a Coroner's duties, including particularly the law of evidence, the administration of the legal system and the procedures of courts.
- Knowledge of the extent to which cultural and religious requirements can be met within the constraints of Coroner law and practice.
- Knowledge of the structures and procedures of local authorities.
- Knowledge of structures and procedures of the Police, in particular those relating to the investigation of sudden or suspicious deaths.
- Must be able to recognise discrimination in its many forms and respond to the religious and cultural needs of diverse communities

SKILLS AND ABILITIES

- Excellent analytical, decision making and administrative skills
- Ability to deal with emotionally charged situations that require sensitive handling and confident/positive judgement.
- Excellent interpersonal skills demonstrating the ability to deal with the bereaved and those under great stress with tact, diplomacy and compassion.
- Speaks fluently and writes articulately, expresses information and key points of an argument clearly undertakes public speaking with skill and confidence, projects authority and credibility.
- Ability to distil complex medical, legal and other technical information into a format easily understood by all.
- Ability to work in and manage conflict/sensitive situations involving competing personal and organisational priorities, with a wide range of stakeholders.
- Ability to and experience of regularly reviewing and challenging processes to ensure standards are always maintained and systems remain efficient.
- Ability to assist the Coroner in service strategy and steer the service through change and challenge to achieve positive outcomes.
- Demonstrates excellent judgement skills under competing priorities and pressure.
- IT literacy, including experience of using Microsoft Office package and familiarity with email and internet systems.

RELEVANT EXPERIENCE

- Experience of analysing complex situations resulting in clear decisions and positive outcomes.
- Experience of conducting investigative enquiries including demonstrating clarity of thought in identifying issues relevant to the investigation.

Annex J

JOB DESCRIPTION EXAMPLE

SENIOR CORONER'S OFFICER

ROLE

- To assist the Head of Coroner Service to manage the service.
- To oversee the day to day running of the Coroner Service.
- To Assist Head of Coroner Service to ensure the effective and accurate investigation of sudden deaths.
- To ensure the effective administration of the service in accordance with the Coroners Act 1988.
- To assist/deputise for the Head of Coroner Service to supervise Coroner's Officers and Senior Support Officers.

MAIN AREAS OF RESPONSIBLITY

1. To manage the workload of Coroner Service staff to ensure a fair distribution of work and adequate provision of staff to provide investigatory and administrative services.
2. To investigate causes of death by obtaining written statements and collating and assembling evidence from Police Officers, Medics, Health & Safety Inspectors and other authorities. Arrange for removal of the body by following the Coroners' procedure. Arrange for identification of the deceased and ensure that the property of the deceased is dealt with. To lead on particularly complex and difficult cases
3. To be part of the wider management team, and working closely with the Head of Coroner Service to ensure the Coroner Service is one that is quality focused. To assist in setting the service standards and objectives and to monitor these objectives.
4. To assist the Head of Coroner Service to monitor the quality management of the services.

5. To work with the Head of Coroner Service to supervise and motivate the staff in the service in order to ensure they can deliver an effective and efficient service.
6. To represent the Coroner Service on multi-agency initiatives to ensure appropriate protocols are agreed.
7. To lead or oversee high profile and complex investigations.
8. To represent the service and lead on partner training and steering groups.

KNOWLEDGE, EXPERIENCE AND TRAINING

- Educated to A-level standard or equivalent.
- CPD Coroner's Law and Practice.
- Previous experience in a supervisory role.
- Minimum of 2 years experience of Coroner's work.
- Previous experience of training new Coroner's Officers.

Annex K

JOB DESCRIPTION EXAMPLE

CORONER'S OFFICER

ROLE

To represent the interests of HM Coroner for Hertfordshire by providing an investigative service and assisting in the execution of the Coroner's legal and public protection duties.

MAIN AREAS OF RESPONSIBLITY

10. To receive information of sudden, violent, suspicious or unnatural deaths for which no death certificate has been issued. Assess, analyse and make recommendations to the Coroner as to the appropriate action.

11. Establish contact with relatives of the deceased and their representatives and keep them informed of procedures and progress.

12. To investigate causes of death by obtaining written statements and collating and assembling evidence from Police Officers, Medics, Health and Safety Inspectors and other authorities. Arrange for removal of the body by following the Coroners' procedure. Arrange for identification of the deceased and ensure that the property of the deceased is dealt with.

13. To arrange Post Mortems as required, obtaining details of medical history, hospital notes, doctor's notes and any other relevant material. Prepare and produce relevant documentation. Ensure that the body is released to the appropriate party as soon as possible.

14. To work with the Senior Support Officers to ensure inquests are organised. To supervise and attend at inquests, when required, acting as usher and administering all oaths and attestations. Ensure all parties understand fully

the process of the inquest. Ensure the security of the witnesses and jury. To record the proceedings.

15. To attend the scene of major incidents / multiple fatalities to represent Coroner. To support Emergency Planning Officers on the resources team of the Temporary Mortuary. To represent Coroner on the Temporary Mortuary Management Team.

16. To ensure that deaths involving UK citizens abroad are investigated correctly when the body arrives within the Coroner's jurisdiction. To arrange for deaths involving the transport of bodies from England and Wales to be dealt with as efficiently as possible.

17. To present training sessions on the work of the Coroner Service to Probationer Police Officers, Health Service workers and other organisations including 'Cruise Bereavement Care'.

18. To monitor the compliance of contractors to the Mortuary Services and Body Removal contracts. To inform the Head of the Service of any non-compliance.

19. To fully contribute to the Quality Management System and the continual improvement of service delivery.

PERSON SPECIFICATION

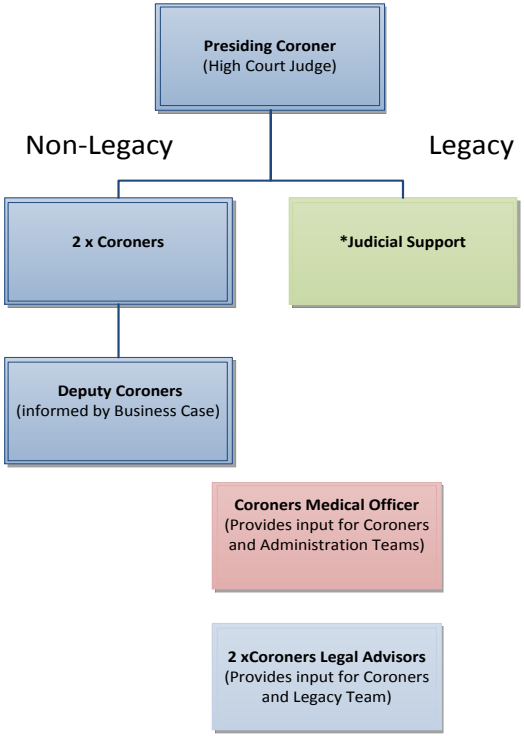
- **Excellent Communication and interpersonal skills** – ability to communicate regarding sensitive issues.
- **Teamworking -** work effectively as part of a team and support and be supported by colleagues in order to deal with traumatic and distressing cases.
- **Analytical and Investigative Skills -** ability to quickly become familiar with, and work within, all relevant procedures and legislation, and your ability to investigate and closely analyse information received in order to make decisions.

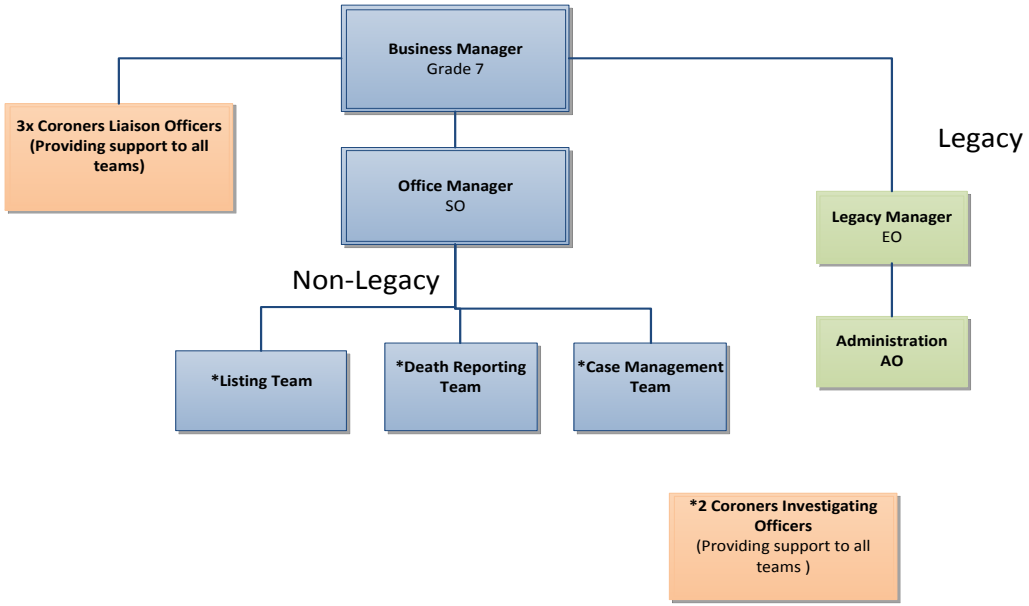
- **Planning and Organising Skills -** ability to remain on top of a heavy caseload, prioritising effectively and ensuring that all cases are dealt with as promptly and thoroughly as possible.
- **Legislation -** knowledge of Coronial legislation and your experience of working within a legislative framework and ability to interpret legislation.
- **IT Skills and Administration Experience -** ability to use Windows applications, in particular word processing and familiarity with using a database; administration including setting up meetings and events and gathering and managing information.

CSNI – Administration

ANNEX L

Judicial Structure





*Based on SHA and supporting Business Case. Additional legal and administrative support potentially required