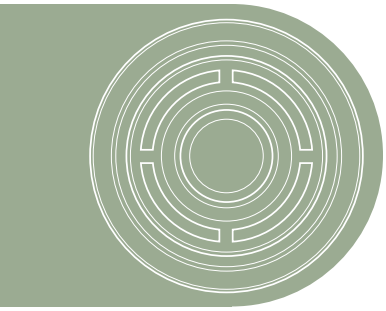
CORONIAL PROCESSES

An inspection of the arrangements in place in the Police Service of Northern Ireland to manage and disclose information in support of the Coronial process in Northern Ireland

December 2016

Criminal Justice Inspection
Northern Ireland
a better justice system for all



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Laid before the Northern Ireland Assembly under Section 49(2) of the Justice (Northern Ireland) Act 2002 (as amended by paragraph 7(2) of Schedule 13 to The Northern Ireland Act 1998 (Devolution of Policing and Justice Functions) Order 2010) by the Department of Justice.

December 2016

Contents

List of abbreviations

CJI	Criminal Justice Inspection Northern Ireland
'the Coroner'	The Coroners Service for Northern Ireland
COPFS	Crown Office and Procurator Fiscal Service (in Scotland)
CSO	Crown Solicitors Office
ECHR	European Convention on Human Rights
HIU	Historical Inquiries Unit
LSU	Legacy Support Unit (in the PSNI)
MoD	Ministry of Defence
NIPB	Northern Ireland Policing Board
PII	Public Interest Immunity
PSNI	Police Service of Northern Ireland
SFIU	Scottish Fatalities Investigation Unit

Chief Inspector's Foreword

The pain, suffering and anguish for the families of those who died during 'the Troubles' can be as raw today as it was at the time of their death.

The State has both a moral and legal responsibility to fully investigate the circumstances associated with their death and where possible, during an inquest, to come to conclusions about how the person came to their death. Inquests cannot apportion criminal or civil liability, but can refer cases to the Director of Public Prosecutions where appropriate.

As a society we have struggled to find acceptable and appropriate mechanisms for dealing with our past and it has largely fallen to the criminal justice system to try and find closure for those who seek it.

The Police Service of Northern Ireland (PSNI) is the primary source of information associated with all deaths during 'the Troubles.' It has a statutory responsibility to provide disclosure of all relevant material to the Coroners Service for Northern Ireland (the Coroner) in support of the holding of inquests for legacy cases. This inspection assessed the arrangements in place in support of this duty.

The processes that have developed to support this requirement are both intensive and extensive, as indeed is the scale of the task. They have developed organically in line with the inquest proceedings that have through time, become more adversarial in nature. This is particularly so in contentious cases, where there has been no reconciliation or balancing between protecting the interests versus the rights of the various parties.

The staff within the PSNI Legacy Support Unit (LSU) are building up their experience and confidence to fulfil their legislative obligations to support more effectively the Coroner in dealing with legacy inquests.

Untangling the various impediments to legacy inquests has proved complex to nigh on impossible. The processes leading to disclosure are unwieldy and risk averse and trust among the various parties is in short supply. We have identified a number of areas for improvement which if implemented in full, will reduce delay and provide some closure for families.

However, I am concerned that unless the political will to resolve the current situation becomes explicit through a combination of legislative reform, investment in IT solutions, and targeted resourcing, the likelihood of change occurring is limited.

This inspection was led by William Priestley and David MacAnulty from Criminal Justice Inspection Northern Ireland (CJI) with support from Peter Currie from Her Majesty's Inspectorate of Constabulary (HMIC). My sincere thanks to all who provided assistance to their work.

Brendan McGuigan
Chief Inspector of Criminal Justice in Northern Ireland

December 2016

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Executive Summary

An inquest is an inquiry into the circumstances surrounding a death to establish the identity of the deceased, and how, when and where they died. Legacy inquests, which refer to 'Troubles' related deaths that happened up to 40 years ago, are often controversial, complex, and in some cases include allegations of collusion.

Whether an inquest is held is dependent on the results of a Coroner's investigation. Results of inquests are made available in the form of findings. In certain circumstances a jury, comprising between seven and 11 people selected from the existing juror's list, may be appointed to decide upon the findings.

A small group of professionals is intimately engaged with all aspects of coronial inquests and is the foremost repository of expertise in legacy coronial matters. This group includes:

- coroners/judiciary;
- counsel for the courts, who may act on behalf of the Coroner in various cases and next of kin in separate cases;
- Crown Solicitors Office lawyers; and
- senior police officers.

There is obvious potential for the updating of legislation to be taken forward.

Although this will not solve the many issues encountered by the legacy inquest cases currently in the coronial system, it may be possible to update it to provide future clarity regarding:

- the prioritisation of legacy cases;
- relevance/potential relevance and scoping parameters;
- time limits for the provision of material; and
- identifying and narrowing issues between parties at the outset of inquests.

The resourcing of legacy inquests be it in terms of finances, staff or equipment to deliver more timely outcomes will require a holistic approach involving the criminal justice system, politicians, Government and Ministers. Inspectors believe providing additional resources to one link of the legacy inquest chain will only cause delay and blockages at other points. Financial resources deemed necessary to expedite existing legacy

coronial inquests should be utilised from a number of sources, including from other planned legacy structures as outlined in the Stormont House Agreement[1].

Other significant contributory factors include the complex and convoluted processes which are in place and result in protracted delay. Inspectors make several recommendations to streamline exiting processes aimed at reducing the potential for delay. Coroner's counsel should be involved much earlier in the disclosure process so that an early determination of the relevance of information to the inquest can be made.

There should be agreement between the Coroner's Service and the Police Service of Northern Ireland (PSNI) regarding the request process, the handling and management of requests, marking, assigning names and titles consistently, paginating and versioning of disclosed material. There needs to be more use of technology to transfer data onto electronic media which will adequately preserve it for future use. Researchers should be provided with adequate means of searching for and reading material stored on legacy systems, and the reliance on hard copy material should be reduced to provide for the seamless transfer of material between participating agencies.

Documents and records held on legacy information systems - both electronic and hard copy - retain their original security classification. Some of these records are more than 50 years old and details have in many cases, made their way into the public domain through books and other publications. The PSNI at present neither confirm nor deny the accuracy of information which has entered the public domain by other than official means. This has caused mistrust and confusion amongst stakeholders. Inspectors suggest that the PSNI should review the security classification applied to legacy documents and link this with its approach to redaction.

The Crown Solicitor's Office (CSO) deals with all suggested redactions emanating from the PSNI's Legacy Support Unit (LSU)[2]. With limited resources dealing with voluminous material, and the associated intra-organisational correspondence coordinated by the CSO, this has meant that delay is inevitable. Inspectors recommend that the PSNI should immediately review its procedures and processes, including its risk appetite for disclosure of the different categories of material, with a view to reducing the volume and type of material sent to the CSO for final checking.

Existing arrangements for dealing with legacy inquests are operating at capacity. Any increased demand would have to be serviced by increased resources across the system, if inquests were to have any chance of delivering findings within a reasonable time. Success in dealing with legacy inquests by this means may result in greater demand for the service, thereby adding to the total number of inquests and disclosure requests, requiring additional resource support. If outcomes for next of kin are to be improved, a balance between supply and demand must be struck and this will require a method of prioritisation.

1 The Stormont House Agreement was published in December 2014 after 11 weeks of talks involving political leaders in Northern Ireland. The agreement aimed to provide a new approach to dealing with a number of contentious issues including the Past in Northern Ireland. For further information please see https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/390672/Stormont_House_Agreement.pdf

2 The PSNI's LSU was established in 2009 and has primary responsibility for all aspects of disclosure of material to HM Coroner in legacy inquests

Recommendations

For the Police Service of Northern Ireland (PSNI):

1. The PSNI should, by the end of the 2016-17 financial year, review its approach to applying security classifications to legacy documents held and link this with its approach to redacting documents which have entered the public domain, through unofficial channels (paragraph 3.4).

2. Processes and procedures regarding disclosure requests and responses, how they are handled by the Coroner's team and the Legacy Support Unit and a system-wide methodology of marking, nomenclature, paginating and versioning disclosure documents should be agreed and implemented by the Coroner's Service and the PSNI before the end of the 2016-17 financial year (paragraph 3.20).

3. The Legacy Support Unit should establish an administration team by the end of the 2016-17 financial year, despite counter arguments that in performing administrative tasks, paralegals glean valuable information which aids their decision-making later in the process (paragraph 3.28).

4. Inspectors recommend that the PSNI should immediately review its procedures and processes, including its risk appetite for disclosure of the different categories of material, with a view to reducing the volume and type of material sent to the Crown Solicitors Office for final checking (paragraph 3.31).

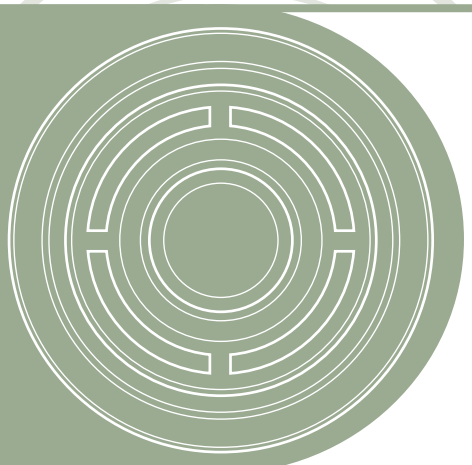
5. Within 18 months of publication of this report, the use of technology by the Legacy Support Unit needs to be expanded to:

   - transfer data onto media which will adequately preserve it for future use;
   - provide researchers with adequate means of searching for and reading material stored on legacy systems; and
   - provide for seamless transfer of material to be disclosed by reducing the reliance on hard copy material (paragraph 3.43).

For others:

6 Cross-departmental agreement should be pursued forthwith to provide the additional resources deemed necessary to expedite existing legacy coronial inquests from a number of sources, including from other planned legacy structures as outlined in the Stormont House Agreement (paragraph 2.39).

7 Coroners counsel should be involved in reviewing discovered material to determine its potential relevance before it is processed by the Legacy Support Unit with regard to suggested redactions (paragraph 3.40).



Inspection Report

1 Introduction and context

Commissioning

1.1 The Justice (Northern Ireland) Act 2002 outlines the circumstances under which inspection of organisations can be carried out by the Chief Inspector of Criminal Justice Northern Ireland. Section 46 lists the organisations which can be inspected and these include the Police Service of Northern Ireland (PSNI). Under section 47(3), the Minister of Justice may require the Chief Inspector to carry out an inspection of an organisation specified in s.46. Additionally, under section 47(4) the Minister of Justice may require the Chief Inspector to carry out a review of any matter relating to the criminal justice system in Northern Ireland (apart from a matter relating to a court or tribunal). Section 47(6) states that the Chief Inspector may not carry out inspections or reviews of individual cases.

1.2 On 4 December 2015, Criminal Justice Inspection Northern Ireland (CJI) received letters from the then Minister of Justice David Ford, MLA and the chair of the Northern Ireland Policing Board (NIPB) Anne Connolly, setting out proposals for the Chief Inspector of Criminal Justice in Northern Ireland to inspect the arrangements in place within the PSNI in support of the Coroner conducting legacy inquests. The Minister of Justice invited the Chief Inspector to:

'…review the efficiency and effectiveness of the arrangements in place in the PSNI to manage and disclose information to support the Coroner in undertaking legacy inquests'.

1.3 Terms of reference were developed by the Chief Inspector in direct response to the Minister's invitation and are reproduced in full at Appendix 1.

Context

1.4 The Stormont House Agreement 2014[3] stated that;

'Recent domestic and European judgments have demonstrated that the legacy inquest process is not providing access to a sufficiently effective investigation within an acceptable timeframe'.

3 Ibid https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/390672/Stormont_House_Agreement.pdf

Legacy cases continued to be a contentious and intractable issue and despite numerous attempts, a solution to the challenge presented by legacy cases in Northern Ireland had yet to be found. To meet the parameters of the Minister's request, this inspection focuses on how the PSNI manages and discloses information in support of legacy inquests. Concerns raised previously included:

- delay in disclosure processes;
- issues of redaction;
- how relevant material is categorised;
- resourcing of the PSNI's Legacy Support Unit (LSU);
- response to requests for assistance outside of section 8[4] responsibilities; and
- the use of agency staff.

1.5 The Lord Chief Justice was appointed President of the Coroners Court on 1 November 2015. In October 2015, prior to his appointment, the Lord Chief Justice had announced that Lord Justice Weir was to carry out a review of the state of readiness of 56 legacy inquests and this work was completed in January 2016.

1.6 The legacy cases currently in the system are at various stages of progress towards inquest. Lord Justice Weir's review assessed these cases and designated their readiness as one of three categories:

- Low (L) - requires substantial work;
- Acceptable (A) - some issues exist but being progressed; or
- High (H) - no critical issues.

The assessment also graded their degree of difficulty as; Moderate (M); Difficult (D); or Easy (E).

1.7 This inspection aims to complement the work of the review undertaken by Lord Justice Weir, and provide a fuller understanding of the issues involved in delivering an effective and efficient service in support of the Coroner.

4 Section 8 Coroners Act (Northern Ireland) 1959: Whenever a dead body is found, or an unexpected or unexplained death, or a death attended by suspicious circumstances, occurs, the district Inspector (now Superintendent or Chief Superintendent) within whose district the body is found, or the death occurs, shall give or cause to be given immediate notice in writing thereof to the Coroner within whose district the body is found or the death occurs, together with such information also in writing as he is able to obtain concerning the finding of the body or concerning the death. In the case of McCaughey (2007) the House of Lords held that section 8 imposed a continuing obligation to make disclosure.

Aims of the inspection

1.8 Whilst not reviewing individual legacy cases, the inspection examines the effectiveness and efficiency of the arrangements to manage and disclose information to support the Coroner in undertaking legacy inquests by:

- assessing current PSNI policy, practice and procedures with regard to disclosure of information in support of the Coroner in undertaking legacy inquests;
- examining the statutory obligations of the PSNI in disclosing information in support of the Coroner;
- evaluating whether current arrangements for managing and disclosing information are effective and efficient while fulfilling statutory obligations; and
- providing comparative analysis with current, relevant best practice models.

Methodology

1.9 The inspection focuses on assessing the performance of the PSNI through its LSU and the adequacy of any relevant policies, in providing support to the Coroner to undertake legacy inquests in compliance with Article 2 of the European Convention on Human Rights (ECHR)[5]. Any factors found to impact upon the performance of the LSU were examined.

1.10 Desktop research was conducted into the legislation, procedures and practice with regard to disclosure of information to the Coroner. Existing arrangements in Northern Ireland were compared with current practice in other relevant jurisdictions, including England and Wales. Information already in the public domain regarding issues of disclosure arising from previous and current cases was considered.

1.11 Fieldwork included an examination of the processes applied to requests for disclosure of information by the Coroner. Requests for disclosure of information were tracked in order to evaluate the processes currently undertaken and to identify potential improvements. Hard copy and computerised systems of discovery, retrieval, redaction and production were examined.

1.12 Engagement with relevant stakeholders followed the agency fieldwork and included meetings with representative organisations such as the Victims and Survivors Forum, the Law Society of Northern Ireland and the Bar Council. These discussions focused on issues of commonality rather than individual cases as CJI is not empowered to inspect specific cases. Relevant outcomes arising from the work of the review undertaken by Lord Justice Weir were also considered.

5 The right to life: http://www.echr.coe.int/Documents/Convention_ENG.pdf

Comparisons

1.13 Limited comparisons can be drawn between the approach to legacy cases in Northern Ireland and that taken by other jurisdictions. Cases such as the Hillsborough Inquiry[6] and the London ('7/7') bombings of 2005[7] did not, in the main, deal with issues such as allegations of collusion and protection of informants or of national security. However, it is possible to make comparisons between the coronial systems and founding legislation across the different jurisdictions. These comparisons are provided in the following chapters of this report.

1.14 The general observations of Inspectors are:

- legislation appears to be lagging behind changes in recent national law in all countries and in case law. Scotland and the Republic of Ireland have both seen very recent changes to their legislation which aimed to update their service;
- inquests into unexplained and sudden deaths were a localised service in regions throughout England and Wales, Scotland and the Republic of Ireland. Recent changes and proposals for reform hoped to address any inconsistencies of approach in these areas;
- there still remains a concern regarding the lack of centralised control and a single strategy to define national standards. In England and Wales, the Chief Coroner has made some attempts to unify practices. In the main these took the form of conferences and consultations, although written guidelines on the England and Wales Coroners' web page was a good start to regularise national practices. The concern remained that there still was not sufficient control over the regional practices;
- all three jurisdictions are clearly aware of the issues with the outdated legislation, and all are moving towards reform; and
- recent changes to procedures in England and Wales may have been a significant factor in the numbers of cases being dealt with and thereafter, a reduction in delay.

6 Inquiry into the deaths of 96 Liverpool Football Club fans following a human crush at the Hillsborough Stadium in Sheffield on 15 April 1989.

7 Inquiry into the coordinated terrorist suicide bomb attacks on the public transport system involving underground trains and buses in London on 7 July 2005.

2 Strategy and governance

Legislation

2.1 The Coroners Act (Northern Ireland) 1959 (The Act) and Coroners Rules 1963 (The Rules) set out what a Coroner is to do and counsel/legal team advise to ensure that the Coroner complies with the legal requirements. Coming into force in February 2016, schedule 11 to the Coroners and Justice Act 2009 amended The Act to allow the Coroner to require the production of evidence. The requirement on the police to make disclosure to the Coroner is contained in section 8 of The Act and by case law has been held to be a continuing obligation[8]. Disclosure to the Coroner is the responsibility of the Chief Constable, but the decision as to relevance of material and application of redactions, whilst handled by the police, remains the responsibility of the Coroner.

2.2 There is obvious potential for an updating of legislation. In Jordan v Senior Coroner 2009[9], Lord Justice Girvan stated:

"The current state of coronial law is extremely unsatisfactory. It is developing by means of piecemeal incremental case law. It is marked by an absence of clearly drafted and easily enforceable procedural rules. Its complexity, confusion and inadequacies make the function of a coroner extremely difficult. He is called on to apply case law which does not always speak with one voice or consistently. One must sympathise with any coroner called on to deal with a contentious inquest of this nature which has become by its nature and background extremely adversarial."

2.3 In June 2011, the Northern Ireland Law Commission's draft second programme was submitted to the Minister of Justice. Contained within it was a proposal for a law reform project in the area of coronial law. However, in its annual report of 2012 the Law Commission reported that:

'It was decided by the Department of Justice that further consideration of the parameters of a law reform project in the area of coronial law was required at Departmental level.'

8 McCaughey v Chief Constable.

9 Jordan v Senior Coroner [2009] NICA 64.

2.4 Legislation was a recurring bone of contention amongst the majority of stakeholders interviewed, and Inspectors were repeatedly told that the 1959 Act is archaic and unfit for purpose. However, defining ways in which the law should be changed presented a greater challenge. Whilst many participants and contributors to this inspection stated that the law needed to be brought up to date, few were able to specify how that should be done and even those who offered suggestions accepted that it would be a legal and procedural minefield. That is not to say that this issue should be avoided.

2.5 Some suggestions were made to Inspectors as to which issues should be legislated for. These included:

- a clear definition of relevance/potential relevance;
- clarification around the inquisitorial nature of inquests (it was suggested that they have become adversarial);
- the format in which disclosed material should be provided - discs or encrypted memory sticks as opposed to hard copy;
- a framework for prioritisation of legacy cases;
- setting time limits for the provision of material to benefit all stakeholders;
- setting criteria for incorporation of closed material hearings into legislation;
- clarification of powers to bring inquests forward for example, Attorney General powers; and
- securing agreement around the relevance of material early in the inquest process.

In this regard it is informative to compare legislative developments in neighbouring jurisdictions.

Other jurisdictions

2.6 Coroner services in England and Wales are governed by Part 1 of the Coroners and Justice Act 2009[10] (the 2009 Act), which came into force in July 2013. This replaced the Coroners Act 1988. The 2009 Act has two main objectives. Firstly, in relation to each death reported to them, Coroners explain the previously unexplained circumstances of a death. Coroners will investigate if a death is not from natural causes, was violent, occurred in custody or is of unknown cause, so that answers are sought, both for bereaved families in the first place, but also for the wider public. Secondly, Coroners also report to prevent future deaths.

2.7 The 2009 Act created an Office of The Chief Coroner, head of the Coroner system, tasked with providing national leadership for Coroners in England and Wales. The appointment of the Chief Coroner is made by the Lord Chief Justice in consultation with the Lord Chancellor. The main responsibilities of the Chief Coroner include:

- the provision of leadership;
- producing national standards (including new inquest rules and reforms);

10 www.legisaltion.gov.uk/2013?title=coroners.

- producing guidance for Coroners in England and Wales;
- keeping a register of Coroner investigations lasting more than 12 months; and
- reducing unnecessary delays.[11]

2.8 The Chief Coroner was also obliged to provide an Annual Report to the Lord Chancellor. At the time of the first Chief Coroner's appointment in 2012, the then Lord Chancellor, Kenneth Clarke MP, said:

'Everyone is agreed that the priority is to ensure coroners provide a high standard of service at what can be a difficult time for bereaved families. I am therefore giving the Chief Coroner the full range of powers to drive up standards, including thorough coroner training, and to tackle delays within the system.'

2.9 In the Republic of Ireland, the Coroners Act 1962 sets out the rules relating to the Coroners Service and provided for the establishment of a network of Coroners located country wide. The Coroners' core function was to investigate sudden and unexplained deaths so that a death certificate can be issued. The Coroners Service focused on providing a public service to the next-of-kin and friends of the deceased and performed a wider public service by identifying matters of public interest that can have life or death consequences.

2.10 In 2015[12], the Irish Government aimed to review the Coroners Act, following previous efforts in 2007 which were overtaken by the financial crisis in the Republic of Ireland. The 2015 Bill aimed to address the fragmented nature of the coronial process in the Republic of Ireland, and identify how best to deliver an integrated, reformed structure to support Coroners more effectively, within the Government's current financial possibilities. The 2015 Bill also hoped to bring up-to-date legal and forensic developments, and ensure full compatibility with the ECHR. At the same time, it aimed to improve support structures for bereaved families. The review was to continue into 2016 with significant amendments required, which meant that there was no timeframe provided as to when new legislation would be in place.

2.11 Scotland had a different system for dealing with unexpected or suspicious deaths. Within the Crown Office and Procurator Fiscal Service (COPFS), the Scottish Fatalities Investigation Unit (SFIU) had responsibility for investigating all sudden, suspicious, accidental and unexplained deaths, with a designated SFIU team situated in the North, East and West of Scotland. The SFIU only became involved when a Doctor was unsure about the cause of death. However, early enquiries within the SFIU usually established that death was due to natural causes. The Lord Advocate had responsibility to investigate any death which required further explanation.

11 The Office of the Chief Coroner provides full details of all roles and responsibilities at: https://www.judiciary.gov.uk/related-offices-and-bodies/office-chief-coroner/.

12 Speech by Minister of State for Ireland, December 2015, found at: http://www.justice.ie/en/JELR/Pages/SP15000641.

2.12 The Fatal Accidents and Sudden Death Inquiry (Scotland) Act, 1976 replaced previous legislation and gave wide powers to the Lord Advocate regarding fatal accident inquiries. A fatal accident inquiry was a fact-finding exercise carried out in the public interest. The rules of evidence and the standard of proof were the same as for civil cases in Scotland and the role of a Sheriff was to determine where and when the death and any accident resulting in the death took place, and the cause or causes of the death or such accident.

2.13 A number of recommendations for reform were made by Lord Cullen in the 2009 Review of Fatal Accident Inquiry legislation. It was hoped to modernise the way in which fatal accident inquiries were handled in Scotland, to improve on efficiency to the system and extend the categories of death in which to hold a fatal accident inquiry. There were other recommendations which hoped to align practices with other jurisdictions and keep legislation up-to-date with case law and changing national laws. The Scottish Government consulted on proposals to reform the entire system in 2014, and The Inquiries into Fatal Accidents and Sudden Deaths Act 2016 was passed by the Scottish Parliament on 10 December 2015 to replace the 1976 Act, and came into force on 1 December 2016.

Northern Ireland

2.14 Coronial law in Northern Ireland has evolved since 1959 by virtue of court or judicial decisions made over the years. Those decisions now provide the direction for current inquests but are to be found in a myriad of places. The evolution of coronial law has led to a system which is more adversarial in nature as opposed to inquisitorial. Inspectors acknowledge that the matter of legislative review is under consideration by the Department of Justice and at the time of drafting this report, a scoping paper had been written. The completion of this project would be beneficial in its impact.

2.15 However, this may, in the fullness of time, only serve to provide a more clearly defined legal framework rather than addressing the many procedural difficulties which beset legacy inquests. We discuss the more significant problems elsewhere, but, at the risk of repetition, include here some possible considerations for those tasked with reviewing coronial legislation.

2.16 Although updating of legislation will not solve the myriad of issues affecting cases currently in the legacy inquest system, consideration should be given to updating it to incorporate case law and practice directions which may:

- provide a framework for prioritisation of legacy cases;
- provide a clear definition of relevance/potential relevance and scoping parameters;
- clarify the nature and purpose of inquests;
- set time limits for the provision of material to benefit all stakeholders; and
- set a legislative, time-bound imperative to identify and narrow the issues between parties at the outset of inquests.

2.17 Currently, there is no statutory provision, instrument or rule governing the Coroner's approach to disclosure. The Coroner can adopt a case by case approach, based on particular circumstances, when determining whether material is of 'general', 'potential' or 'core' relevance. This can impose a significant burden upon those charged with disclosure, which can involve lengthy searches of deteriorating material held in hard copy or legacy storage medium. It was suggested to us that consideration could be given to introducing more clearly defined scoping parameters through legislation. Inspectors believe this suggestion is worthy of consideration.

2.18 Undoubtedly, protracted disclosure impedes the whole legacy inquest process, ultimately to the detriment of the next of kin. We appreciate that preparation for disclosure is a very time consuming process but accept the suggestion that legislation could also introduce time constraints for providing material.

2.19 All this presupposes that legacy inquests will continue in their present format. There had been widespread criticism about the current process, which frequently falters despite the resolve of the parties involved. We have considered the potential merits of the 'linked inquest' system and concur with the views expressed by the Lord Chief Justice:

"I can see the potential benefits of linking certain cases and we might therefore decide that it would make sense to group a number of the cases together where there are common themes, to ensure that the wider picture is available."[13]

2.20 This approach would not only help with issues of disclosure but would also have the potential to reduce the number of occasions on which witnesses, who feature in a number of linked cases, have to attend court.

2.21 However, if a 'linked inquest' or, indeed, any system is to function effectively it will need to be adequately resourced. This will come at a cost and will require the political will to deliver progress so that cases can be concluded within the lifetimes of those most affected. The current case load and the operation of disclosure processes means that the PSNI and Coroner's staff are operating at capacity and often have to abandon tasks in progress to react to new requests regarded as more urgent.

2.22 Coroners' inquests into legacy deaths arise from a variety of circumstances. Some more recent deaths had been opened by the Coroner on the date of death and remained open. Others had been directed by the Attorney General following submissions from, for example, next of kin legal representatives. The power of the Attorney General to direct inquests was set out in a briefing paper to the Northern Ireland Assembly[14].

13 Belfast Telegraph 13 February 2016.

14 Research and Information Service Briefing Paper 28/15 06 February 2015 NIAR 48-15.

2.23 The flexible approach adopted by the Coroner with regard to scope and relevance reflects the employment of the system as a whole in undertaking inquests in pursuit of the State's Article 2 and Article 8 (ECHR) responsibilities. There is no shortage of inputs to the coronial service which properly require investigation. These inputs include directions made by the Attorney General as well as information provided to the service by groups representing the interests of next of kin. In the absence of any other way to deal with legacy deaths linked to 'the Troubles', the coronial service has become the avenue by which next of kin seek answers from the State about the circumstances of their relatives' deaths.

Prioritisation

2.24 At the time of drafting this report there were 57 legacy deaths in the system requiring inquests. A total of 56 had been reviewed by Lord Justice Weir in January 2016 and the suggestions of the Lord Chief Justice to deal with legacy inquests referred specifically to this magnitude of cases. There is potential for many more legacy deaths to be referred to the Coroner for inquest. That is not to say that all such cases will necessarily be referred. However, it was obvious to Inspectors, and the many stakeholders consulted during the inspection, that a substantial increase in the volume of legacy cases would result in the system being unable to cope.

2.25 Given that the present systems are operating at their capacity, increased demand would have to be serviced by increased resources across the system if inquests were to have any chance of delivering findings within a reasonable time. The natural consequence of this is that success in providing answers to next of kin and in dealing with legacy inquests by this means, may result in greater demand for the service, thereby adding to the total number of inquests in the system and disclosure requests, requiring additional resource support. If outcomes for next of kin are to be improved, a balance between supply and demand must be struck and this will require a method of prioritisation.

2.26 Invariably, those who we interviewed at all points of the system, including the LSU, highlighted prioritisation as a particular problem. They claimed that there was no clearly defined process for the order in which legacy inquests are dealt with. Inspectors' observations of how requests for disclosure can be superseded by additional, later requests, as and when they arise, confirm that there was no systematic prioritisation of legacy inquest cases.

2.27 We acknowledge that in January 2016 the Coroners Service produced a 'state of readiness' index based on the work of Lord Justice Weir for 56 legacy cases. However, this will not serve to address long-term issues of prioritisation with regard to any new cases that may be later added to the list. There is potential for additional cases to be added when the planned Historical Inquiries Unit (HIU) begins to report.

2.28 In the absence of a recognised process to determine the order in which inquests are to be held, the LSU and CSO are unable to plan ahead and are continually reacting to demands for material as it arrives. Furthermore, as priorities change on a daily basis, staff frequently had to put aside a case they had been working on to deal with issues relating to another case.

2.29 The question of prioritisation is a contentious one: how can one death be afforded precedence over, and thus seem more important than, another? We would contend that it is not a question of 'importance' but a means of introducing a transparent process, which is clear to all. We have considered the views expressed to us and agree that the most obvious solution would be a chronological one, where the oldest cases are heard first.

2.30 This would ensure that those who have waited the longest, who are quite possibly amongst the oldest of the bereaved, are dealt with first. In the meantime other families can plan for the future, no matter how distant the horizon.

2.31 That said, as ever there would be exceptions to the rule. We discuss in paragraphs 2.19 to 2.21 the merits of 'linked inquests' and acknowledge that, on occasions, linked cases would have to be heard out of sequence. We believe the benefits of this outweigh the negative aspects, not least because potentially linked cases frequently have to be considered in conjunction with a number of other inquests.

2.32 It was obvious to Inspectors that a prioritisation process should be introduced, regardless of the format. Only by doing so could a more proactive approach to preparing disclosure material be adopted in readiness for forthcoming cases. It has become obvious that a more focused approach, such as that adopted in the Kingsmill[15] case increases the chances of progressing to final inquest earlier, with the possibility of resolution. Albeit that the police investigation into this particular case had been reopened following the late discovery of additional evidence requiring the adjournment of inquest proceedings.

2.33 The LSU disclosure process may be seen as a supply chain, with specific tasks to be completed at intervals to deliver an end product. The process is reliant upon tasks being completed at the right time and if it is disrupted in any way, the end product is unlikely to be delivered.

2.34 We found that there was a very real likelihood of disruption, much of which was due to the lack of a prioritisation process which resulted in both the PSNI and Coroner's Unit blaming each other for delay and other problems. In order to meet fluctuating demands, individuals were moved from their allocated tasks to fill gaps elsewhere. Paralegals, for example, who quality assured the redaction work undertaken by researchers, were repositioned to deal with purely administrative tasks. This created backlogs at the point where a paralegal should be working. If there is to be a steady supply of material for the coronial process, adequate resources must be made available at the appropriate level and stage of the process.

2.35 However, the question of resources does not only apply to the PSNI. Each and every agency involved must be adequately resourced to ensure a free flowing process from start to finish; merely supplementing the resources in one area will only cause a bottleneck in another.

15 The Kingsmill case relates to the shooting of 11 Protestant workmen near the Co Armagh village of Kingsmill on 5 January 1976.

2.36 Inspectors also believe it is essential that people concentrate upon the particular role they are employed to do. It was surprising to find that the LSU's researchers, who redact material, spend a lot of their time collating material and scanning it onto a computerised system before starting the actual redaction and disclosure process. Of greater concern was the fact that, on occasions, paralegals, who are qualified solicitors, did likewise. We understand that both researchers and paralegals also spend a lot of time photocopying. Despite the counter argument that immersion in these tasks provided researchers with intimate knowledge of the material from the outset, this was not the best use of resources.

2.37 There would be considerable merit in establishing a team of administrative officers to perform these functions. Working to a list of prioritised cases, they could prepare a case in advance so that when the time came for it to be further processed, researchers and paralegals would be in a position to do so.

2.38 But where would the money come from? In the absence of anything resembling a truth commission, legacy inquests, in whatever form, will continue to be an essential element in the way in which we deal with the past. Even if a HIU were to come to fruition, in accordance with the Stormont House Agreement, the number of legacy inquests would be unlikely to diminish. On the contrary, the HIU's work may well lead to more inquests being opened.

2.39 A fully functioning legacy inquest process, on the other hand, incorporating 'linked inquests', could reduce the work of the HIU as families achieve resolution through the Coroner's Court.

Recommendation

Cross-departmental agreement should be pursued forthwith to provide the additional resources deemed necessary to expedite existing legacy coronial inquests from a number of sources, including from other planned legacy structures as outlined in the Stormont House Agreement.

3 Delivery

The Disclosure Process

3.1 During this inspection, Inspectors looked into the systems and processes that the PSNI has adopted for supplying material for legacy inquests. Sensitive and non-sensitive functions which form part of the process were examined along with the process of making public interest immunity applications. A range of staff were interviewed and an extensive number of files reviewed alongside the various computer systems that the LSU employs for these purposes.

3.2 The LSU had adopted a comprehensive quality assurance process with regard to both non-sensitive (Figure 1) and sensitive material (Figure 2). These were illustrated as linear processes, however, in practice, they contained several decision-making loops which added to the complexity and potential for delay in providing material for disclosure. Both these processes are examined in greater depth later in this chapter, but it was evident to Inspectors that the processes were extremely complex.

3.3 The terms 'sensitive' and 'non-sensitive' can be confusing. The fact that non-sensitive material is subjected to a redaction process whereby certain elements are frequently 'blacked out' (rendered indecipherable) tends to indicate that it, too, may contain information that is actually considered sensitive. Inspectors found that, in reality, non-sensitive and sensitive material contained information which was likely to constitute different levels of risk if revealed. The PSNI regarded sensitive material as that which would be considered for Public Interest Immunity (PII)[16].

3.4 Additionally, it was apparent that material held in legacy systems had retained its original security marking designation. Thus, material several years old which, in the meantime may have entered the public domain through media exposure or otherwise, was still dealt with under its original designation. Inspectors were advised that the PSNI approach to this issue was that if the material had not entered the public domain by being officially released, then it would continue to be managed according to the original classification. This caused confusion and mistrust amongst next of kin and their representatives.

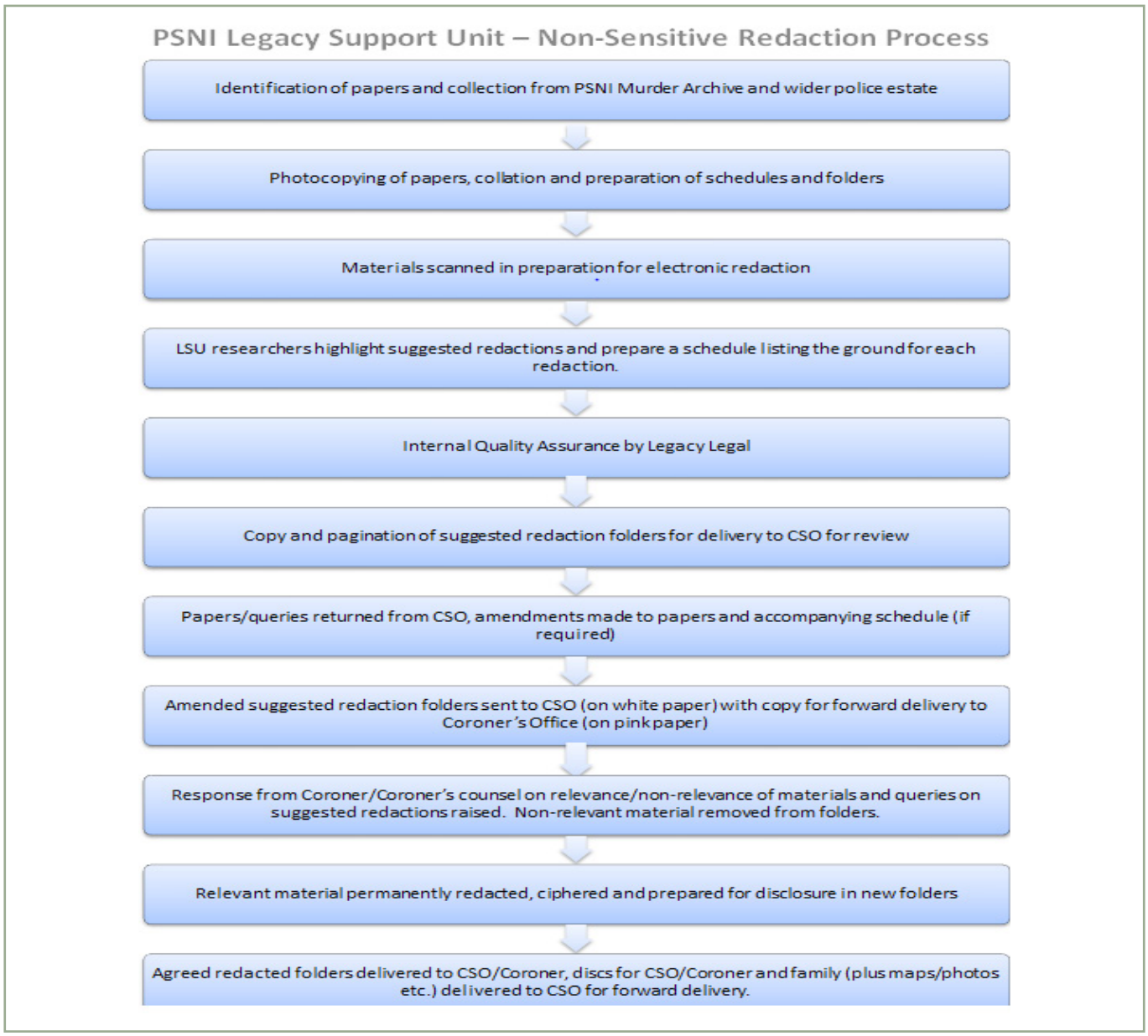
16 A principle by which the Government can request that sensitive documents are not disclosed on the grounds that to do so would be against the public or national interest.

Recommendation

The PSNI should, by the end of the 2016-17 financial year, review its approach to applying security classifications to legacy documents held and link this with its approach to redacting documents which have entered the public domain, through unofficial channels.

3.5 The coronial landscape is cluttered with various legal interventions. The processes are described in Figures 1 and 2.

Figure 1: Non-sensitive redaction process



Process as supplied by PSNI LSU.

3.6 On request, the LSU searched for and discovered documents held in archives. Having copied papers and prepared schedules and folders, they then scanned the papers so that they were available for redaction in electronic format. Schedules, providing rationale for the suggested redactions were prepared and electronic versions were passed to paralegals for internal quality assurance (first decision-making loop). Whilst suggested redactions were marked electronically the papers containing all the suggested redactions were copied, paginated and then passed to the CSO, in hard copy, for comment on suggested redactions (second decision-making loop). The documents were then returned to the LSU for marking in accordance with comments made by the CSO and the updating of schedules if required. The amended documents, still showing suggested redactions, were then sent to the CSO with a copy for onward transmission to the Coroner. These were then assessed by Coroner's counsel/solicitor.

3.7 Any disagreement or other query was subject to correspondence involving the CSO and the Coroner's team and may also have involved communication with the LSU before final determination was reached on relevance (third decision-making loop). The decision of the Coroner as to what material was potentially relevant was informed by Coroner's counsel, with some assistance from the Lord Chief Justice's guidance published around five years ago. Material considered not relevant was removed by the LSU on the direction of the Coroner before final redaction, ciphering[17], if required, and preparation of new folders. The new folders were sent to the CSO and the Coroner.

3.8 The LSU provided the rationale for any redactions suggested, but the method by which this was recorded could vary dependent upon the method preferred by the paralegal in the case. We comment further on this in paragraph 3.34.

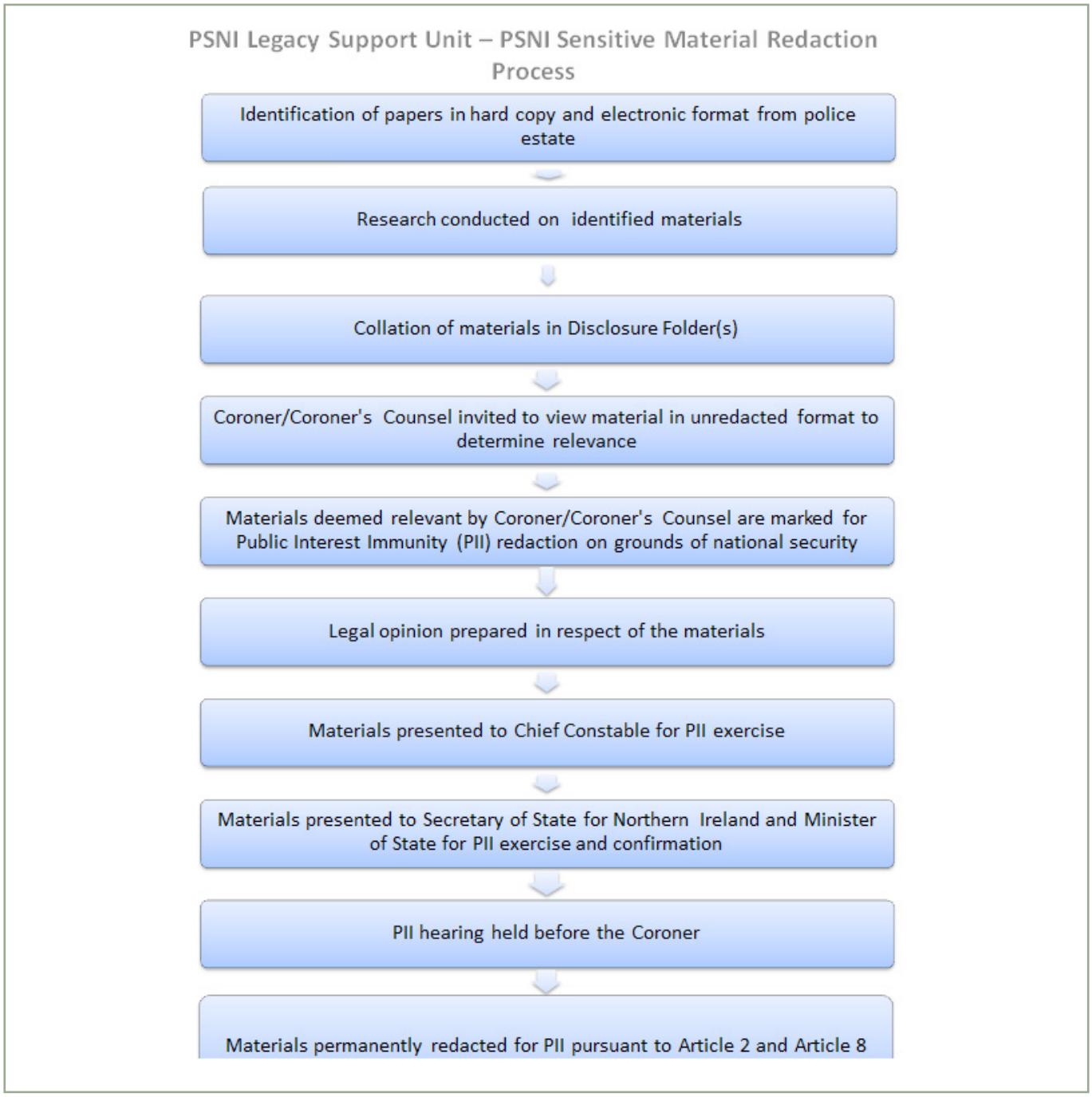
3.9 Sensitive material held on legacy systems was searched for and discovered by researchers at PSNI headquarters under the supervision of the head of the LSU. The provision of sensitive material by researchers was subject to close supervision and had quality assurance systems in place, but there was very little spare capacity within the team, so little resilience.

3.10 The work of the sensitive material researchers, apart from being supervised internally, was also open to scrutiny by the Coroner's counsel. A memorandum of understanding was in place which enabled unlimited access to registry and archives. These files were held in different formats, including microfilm and microfiche. The storage media were ageing and the quality of material held diminishing. Assuring the provision of information into the future would require back record conversion which is potentially extremely resource intensive and would require substantial funding.

3.11 The process described in Figure 2 (for sensitive material) also included several decision making loops which were not immediately apparent. For example, the relevance decision made by Coroner's counsel, followed by redaction decisions, legal opinion and the Chief Constable's PII assessment.

17 Ciphering refers to the process by which an anonymous identity is given to an individual which is then consistently applied across all cases.

Figure 2: Sensitive material redaction process



Process as supplied by PSNI LSU.

3.12 As regards PII schedules, a system of recording was available on the papers for counsel to indicate PII material and the underlying reasoning for applying PII. However, recording of reasons was not done consistently, and sometimes sticky labels were used which introduced a risk of them becoming detached and/or lost.

3.13 Redaction had been applied to sensitive and non-sensitive papers. Inspectors were unable to quantify redaction disagreements, but the examination of requests for disclosure indicated that there was substantial correspondence held in each file which referred to disagreements on suggested redactions. The issues raised were mixed, on occasion the CSO had highlighted issues of under-redaction by the LSU and on other occasions, the issue was one of over-redaction. However, as previously stated, all material, in unredacted form, was forwarded to the Coroner for the final decision. The process of agreeing suggested redactions meant that there may be several versions of material in the system and this can, and did, lead to mistakes.

3.14 Papers were sent in pdf format from the PSNI to the Coroner on discs which may not have been easily searchable or indexed in an agreed format. Inconsistencies in nomenclature standards had also caused problems. For example, referring to the rank of Detective Chief Superintendent as; D.C.Supt.; C/Supt; D. Chief Supt; D.C.S.; and so on. There were also occasions where blank papers were scanned on and provided with the file of material. The rationale for this approach was that where blank, sometimes numbered, pages form part of a file then for completeness these were included in order to avoid suggestions of incomplete disclosure. This risk adverse approach was evident throughout the disclosure process. Some material provided had been illegible which resulted in more delay whilst requests to provide better quality material were made and responded to.

3.15 When the coronial team reordered documents supplied by the PSNI to the Coroners Service this involved additional resources being allocated to the task of repaginating and had led to mistakes.

3.16 The role of the CSO was broad and variable. Material was submitted to it by the PSNI, having already been processed and marked with proposed redactions by the LSU. This material was then subject to checking by the CSO with regard to redactions and associated rationale. Inspectors saw occasions when proposed redactions were challenged by the CSO, for example, when information redacted was regarded as already being in the public domain. On other occasions, the CSO suggested redacting material that had not originally been subject to such treatment by the LSU.

3.17 In the main the CSO performed a checking and coordinating role. Representing many of the State bodies that were involved in disclosing information when requested by the Coroner, enabled it to exercise a degree of control over the process, albeit responsibility for the timely provision of information rested with the various agencies involved.

3.18 The role of the CSO was described to Inspectors as being important in providing a proper legal audit trail to underpin redaction decisions. Inspectors understand the importance of providing assurance that material has been thoroughly assessed with regard to disclosure and the Article 2 and 8 (ECHR) obligations. However, we question whether this is absolutely necessary in every case given the legal expertise available at all stages of the current processes.

3.19 When the Coroner did set time scales for example, for the reading of sensitive material, the deadlines were often missed with no explanation provided by those responsible. There was also no sanction available.

3.20 Inspectors found there were no systematic, standard operating procedures with regard to disclosure requests going from the Coroner's Office to the PSNI, or as to how they were progressed, handled or finalised. Across the range of correspondence examined by Inspectors, disclosure requests were made to the PSNI without delay or filtering. This process operated on a case by case basis as and when issues were raised on behalf of next of kin or by the Coroner.

Recommendation

Processes and procedures regarding disclosure requests and responses, how they are handled by the Coroner's team and the LSU, and a system-wide methodology of marking, nomenclature, paginating and versioning disclosure documents should be agreed and implemented by the Coroner's Service and the PSNI before the end of the 2016-17 financial year.

3.21 Requests were handled efficiently by the Coroner's Service team, with requests for police disclosure often being made on the same day as they were received by the Coroner's Office. There was no method of prioritising requests for disclosure either within the Coroner's Office or, at the other end of the supply chain, by the LSU. In the absence of such ranking, the LSU dealt with requests on the basis of the highest pressing need.

3.22 The assessment of which request should take priority was not based upon consistent criteria. A looming preliminary hearing may have been the trigger in one instance whilst on another occasion the LSU may have based their actions upon a direct urgent instruction to act from the Coroner. This situation had resulted in pressures and disruption on limited resources within the LSU where requests identified as requiring immediate or urgent response took priority over requests that were already being processed. LSU staff dealing with disclosure, which could take several weeks or months, had been reassigned to deal with those cases assessed as being more urgent, often to the detriment of work already in progress on previous requests.

3.23 When notified of a forthcoming inquest, LSU staff had taken steps to identify and draw together all potentially relevant material. In doing so, they searched through both paper files and computer systems to identify the archived material required. Those working in the non-sensitive arena uploaded the material onto the LSU's own database, which meant that paper files had to be scanned on to the system. This was a laborious but seemingly necessary process.

3.24 Researchers examined the non-sensitive material and redacted information which, in their opinion should not be disclosed because of Article 2 and Article 8 (ECHR) considerations.

Their work was quality assured by paralegals before submission to one of the LSU's three solicitors. It should be noted that whilst only three individuals held the official position of solicitor in the LSU, in reality the two paralegals were themselves also qualified solicitors. Neither was employed to carry out the functions of a solicitor and neither held a practising certificate from the Law Society to do so.

3.25 All material was then submitted to the CSO for consideration. Following any necessary discussion between the CSO and the PSNI, and any amendment deemed appropriate, the material was then submitted to the Coroner's office.

3.26 This was very much a reactive process, with the LSU responding to requests for material as they arose. A recognised process for prioritising cases however would allow the LSU to work more pro-actively, preparing cases in advance.

3.27 Inspectors examined correspondence files associated with several requests for disclosure. It became apparent that delay was commonplace, occurred across the whole spectrum of stakeholders involved, and was sometimes protracted.

3.28 As previously discussed, the disclosure process was delayed by a lack of, and inefficient use of available resources, which led to individuals performing tasks which were not strictly within their remit. For instance, LSU paralegals spent time collating, scanning and photocopying material, all administrative functions.

Recommendation

The LSU should establish an administration team by the end of the 2016-17 financial year, despite counter arguments that in performing administrative tasks, paralegals glean valuable information which aids their decision-making later in the process.

3.29 The entire process also suffered because of the involvement of so many different agencies. In many cases the LSU was reliant upon the Ministry of Defence (MoD) for checking of material belonging to them. If such material has not been so checked, the PSNI is under obligation not to release it. This was entirely necessary but had led to further delay. Although not within the remit of this inspection, as a result of observations, specifically delay in responding to requests and references contained in correspondence, it appeared that the MoD was also under-resourced in this respect.

3.30 Sensitive material was not itself scanned onto a computerised system but was copied and later provided for PII Hearings, via the Chief Constable and his legal advisers. Researchers charged with the discovery of material for disclosure which is classed as sensitive were based at PSNI headquarters, but report to and are supervised by the LSU manager.

3.31 Inspectors considered whether the involvement of so many participants was strictly necessary in every case and found the whole process to be very risk averse, with numerous quality assurance levels and legal advice/intervention at every stage. It is questionable for example, whether the CSO needs to be involved in assessing each and every suggested redaction or whether the PSNI could request its input only to cover sensitive material for PII or where material has been provided by different agencies and requires coordination and management. Moving to less oversight by the CSO would require the introduction of enhanced quality assurance processes by the LSU. By implementing CJI's recommendation regarding the formation of an administrative unit, researchers and paralegals should be available to perform this task.

Recommendation

Inspectors recommend that the PSNI should immediately review its procedures and processes, including its risk appetite for disclosure of the different categories of material, with a view to reducing the volume and type of material sent to the CSO for final checking.

3.32 The Chief Constable was personally expected to read and approve all PII applications by the police. Only when the Chief Constable was absent may the Deputy Chief Constable fulfil this function. In view of the multiple layers of quality assurance, Inspectors consider that the Chief Constable should be able to delegate this function. It was unclear whether this practice was operating as a result of interpretation of case law or was established custom and practice aimed at providing the highest assurance of the necessity of PII cases brought to the relevant Government Minister. At this level, applications for PII certificates were approved by a Minister or a Permanent Under Secretary.

3.33 Inspectors were surprised to find as part of this inspection that when six documents contained exactly the same piece of information, all were required by the Coroner to be provided for disclosure purposes. This involved each of the six documents undergoing the redaction process.

3.34 Inspectors also found various inconsistencies in the redaction process. In the first instance, researchers and paralegals working on non-sensitive material recorded the rationale behind their decisions in different ways. Inspectors were told that staff were permitted to adopt whatever approach suited their own style of working. Inspectors have no objection to this approach provided records are retained in a retrievable format, to ensure there is an auditable process.

3.35 The way in which material was presented to the Coroner's counsel also differed, at the insistence of the individual lawyers concerned. Some wanted the reasons for proposed redaction displayed in the existing format available on the papers while some wanted them indicated on separate documents. Again, some legal representatives were prepared to accept material from computer discs, whilst others insisted on 'hard copy'.

3.36 These differences need to be ironed out and a consistent approach needs to be adopted, particularly in relation to the use of discs. Providing numerous copies of material in paper format not only to counsel but also to others, such as families' solicitors, was both time consuming and expensive.

3.37 Inspectors discuss elsewhere that setting parameters for an inquest at an early stage would help expedite the process. Following on from this Inspectors suggest that Coroner's counsel should be involved in the selection of material for redaction or PII application. As it stands, all material was processed before it reached counsel, when a sifting exercise at a much earlier stage would save a lot of nugatory work.

3.38 The movement of Coroner's counsel closer to the discovery end of the disclosure process would have the added benefit of providing assurance of the search for relevant material. Where sensitive material was concerned, this process had already been subject to such scrutiny when Coroner's counsel had been involved early in the discovery process and had access to data, enabling them to follow an audit trail of searches performed.

3.39 Inspectors accept the argument that it may not always be immediately apparent that material will be of relevance to an inquest and that, as things progress, information may unexpectedly become relevant. However, a secondary scoping exercise could be conducted at a later stage to confirm that previously excluded material has not become relevant. Whilst this would entail revisiting some material, we believe it would be preferable to simply processing all material in the first place.

3.40 Inspectors also suggest that all material which needs to be viewed by counsel be made available at suitable premises, rather than delivering it to counsel. This is already the case for sensitive material when counsel visits the LSU and we see no reason why the practice should not be extended to non-sensitive material. Not only would it reduce the security risks associated with moving material about, but it would also provide for more ready access to original documents.

Recommendation

Coroners counsel should be involved in reviewing discovered material to determine its potential relevance before it is processed by the LSU with regard to suggested redactions.

3.41 Inspectors found that there were frequent complaints about the legibility of copied documents, and particularly those produced from originals which were in a poor condition. As legibility diminishes with each generation of copying, the best chance of reading a document lies with the original version.

3.42 Issues with IT, though, were not confined to providing discs and photocopying documents. Much of the information which was relevant to legacy inquests was contained on computer systems, which were now obsolete and not compatible with each other. They were often difficult to search and may require that a researcher enters precise detail to identify relevant material. More modern systems can search on much wider, and even imprecise, parameters.

3.43 Inspectors understand that computer software is available which would help to address this problem. Similarly, systems for reading material stored on microfiche should be made more readily available to those who need them. Currently, researchers working on sensitive material used a microfiche reader located in another department which was not always immediately available. We also noted that the LSU had adopted the HOLMES[18] system for document management. This system is primarily an investigative tool and is not ideally suited to this purpose.

Recommendation

Within 18 months of publication of this report, the use of technology by the LSU needs to be expanded to:

- **transfer data onto media which will adequately preserve it for future use;**
- **provide researchers with adequate means of searching for and reading material stored on legacy systems; and**
- **provide for seamless transfer of material to be disclosed by reducing the reliance on hard copy material.**

Other jurisdictions

3.44 The system for dealing with inquests examined in Northern Ireland bears no direct comparison with those delivery systems in place in England and Wales, Scotland and the Republic of Ireland, which reflects their different founding legislation.

3.45 In England and Wales, the relevant provisions of the Coroners and Justice Act 2009 came into force in July 2013 along with the Coroners (Investigations) Regulations 2013, the Coroners (Inquests) Rules 2013 and the Coroners Allowances, Fees and Expenses Regulations 2013.

3.46 A relatively small number of cases (25,000) required investigation in 2014-15[19], down 15% from 2013-14. This was partly attributed to greater use of preliminary inquiries[20], to determine whether there was a statutory requirement for an investigation.

18 HOLMES is an abbreviation for the Home Office Large Major Enquiry investigation management computer system. It is commonly used to assist law enforcement organisations in their management of the complex process of investigating serious crimes.

19 Chief Coroner's report, 2014-15.

20 Under section 1(7) of the 2009 Act.

3.47 The provisions for jury inquests were also made more flexible under the 2009 legislation. For example, not all deaths within a prison required an inquest with a jury and in some cases, deaths of staff and visitors as well as detainees who died of natural causes did not need a Coroners investigation at all. Overall, jury inquests had reduced and represented around 1% of all inquests.

3.48 The 2009 Act and the Coroners (Inquests) Rules 2013 also aimed to address concerns regarding delay. Rule 8 required Coroners to complete inquests within six months of the date on which the Coroner is made aware of the death 'or as soon as reasonably practicable after that date'. In order to keep a check on older cases, section 16 of the 2009 Act required all Coroners in England and Wales to notify the Chief Coroner of any investigation which had not been completed (or discontinued) within a year. The Chief Coroner required Senior Coroners to produce an annual return of all cases outstanding after 12 months, detailing the number of days over, the reason for the delay and remedial steps taken.

3.49 Similar to England and Wales, in the Republic of Ireland Coroners were independent officeholders, either doctors or lawyers, appointed by a local authority. Deaths were normally certified by a registered medical practitioner. Those deaths that appeared to be due to unnatural causes may require a post mortem examination to be carried out.

3.50 The Coroner decided whether a death was due to natural or unnatural causes. Unnatural deaths required an inquest to be held which may thereafter require a jury. At an inquest, evidence was taken from witnesses to assist the Coroner to identify the deceased and where, when and how death occurred. The Coroner, or jury, may make a general recommendation designed to prevent similar deaths, but do not decide on fault or whether there was a criminal offence.

3.51 In Scotland most sudden and unexplained deaths were reported to the Procurator Fiscal in the event of a Doctor being unable to confirm cause of the death. Procurators Fiscal were qualified lawyers employed by the COPFS, and acted on instruction of the Lord Advocate. Where the death appeared to be due to a criminal act, a Procurator Fiscal initiated investigation by the police or other appropriate public authorities, to assist the identification of suspects and evidence, to enable the case to be prosecuted.

3.52 Fatal Accident Inquiries were held for work accidents, death in legal custody, and other circumstances thought to be in the public interest. Only deaths which had occurred in Scotland were dealt with, unlike in England and Wales where a Coroner could investigate a death where the body lies within a local district, irrespective of where the death occurred.

4 Outcomes

4.1 No attempt has been made to compare the outcomes of the inquest processes in Northern Ireland with that elsewhere. The issues encountered during legacy inquests in Northern Ireland are not replicated in any of the other jurisdictions examined.

4.2 From the next of kin perspective outcomes in legacy cases have been poor, as measured by the delivery of completed inquests. There had been much coordinated effort to progress cases to final inquest following Lord Justice Weir's review of the state of readiness in January 2016. Indeed, some cases did progress to final inquest. However, due to a variety of intervening factors, including the discovery of new evidence in a case, outcomes in the shape of inquest findings, had not been delivered.

4.3 The PSNI does not have any specific outcome targets for the delivery of its services in support of the Coroner. In the absence of prioritisation, setting of such outcomes and their associated targets would be meaningless. As stated earlier in this report, the LSU reacts to requests for disclosure as they are received. Unless a prioritisation framework is implemented, then outcome measures for the PSNI element of legacy inquests remains at the mercy of ad hoc assessments of which request for disclosure is the most important at any given time. This is usually decided by which case is progressing to inquest, or preliminary hearing, at the earliest date.

4.4 The recommendations made in this report are designed to provide a framework of legislation, prioritisation, resources, processes and procedures to enable outcomes to be delivered. If recommendations are accepted and progressed, it will be incumbent on the PSNI, in partnership with the Coroners Service to set meaningful measures and outcomes.

Appendix

Appendix 1: Terms of reference

An inspection of the arrangements in place in the PSNI to manage and disclose information in support of the Coronial process in Northern Ireland

Introduction

Legislative remit

The Justice (Northern Ireland) Act 2002 (The Act) outlines the circumstances under which inspection of organisations can be carried out by the Chief Inspector of Criminal Justice Northern Ireland. Section 46 of The Act lists the organisations which can be inspected and these include the Police Service of Northern Ireland (PSNI). Under section 47(3) of The Act, the Minister of Justice may require the Chief Inspector to carry out an inspection of an organisation specified in s.46. Additionally, under section 47(4) the Minister of Justice may require the Chief Inspector to carry out a review of any matter relating to the criminal justice system in Northern Ireland (apart from a matter relating to a court or tribunal). Section 47(6) states that the Chief Inspector may not carry out inspections or reviews of individual cases.

Background to inspection

On 4 December 2015, CJI received letters from the Minister of Justice and the chair of the Northern Ireland Policing Board (NIPB) setting out proposals to inspect the arrangements in place within the Police Service of Northern Ireland (PSNI) in support of the coroner conducting legacy inquests. The Minister of Justice invited the Chief Inspector to;

> *'…review the efficiency and effectiveness of the arrangements in place in the PSNI to manage and disclose information to support the coroner in undertaking legacy inquests'.*

These terms of reference have been developed by the Chief Inspector in direct response to the Minister of Justice's invitation.

Context

Legacy cases continue to be a contentious and intractable issue and despite numerous attempts a solution to the challenge presented by legacy cases in Northern Ireland has yet to be found. This inspection focuses on how the PSNI manages and discloses information in support of legacy inquests. Concerns raised previously included:

- delay in disclosure processes;
- issues of redaction;
- how relevant material is categorised;
- resourcing of the PSNI Legacy Support Unit (LSU)[21];
- response to requests for assistance outside of section 8[22] responsibilities; and
- the use of agency staff.

The Stormont House Agreement 2014[23] stated that;

'Recent domestic and European judgments have demonstrated that the legacy inquest process is not providing access to a sufficiently effective investigation within an acceptable timeframe'.

The Lord Chief Justice was appointed President of the Coroners Court on 1 November 2015. The Lord Chief Justice asked Lord Justice Weir to review the state of readiness of legacy inquests.

The inspection aims to complement the work of the review undertaken by Lord Justice Weir, to provide a fuller understanding of the issues involved in delivering an effective and efficient service.

Aims of the inspection

Whilst not reviewing individual legacy cases the inspection will review the effectiveness and efficiency of the arrangements to manage and disclose information to support the Coroner in undertaking legacy inquests by:

- assessing current PSNI policy, practice and procedures with regard to disclosure of information in support of the Coroner in undertaking legacy inquests;
- examining the statutory obligations of the PSNI in disclosing information in support of the Coroner;
- evaluating whether current arrangements for managing and disclosing information are effective and efficient while fulfilling statutory obligations; and
- providing comparative analysis with current, relevant best practice models.

21 LSU was established in 2009 and has primarily responsibility for all aspects of disclosure of material to HM Coroner in legacy inquests

22 Section 8 Coroners Act (NI) 1959: Whenever a dead body is found, or an unexpected or unexplained death, or a death attended by suspicious circumstances, occurs, the district inspector (now Superintendent or Chief Superintendent) within whose district the body is found, or the death occurs, shall give or cause to be given immediate notice in writing thereof to the coroner within whose district the body is found or the death occurs, together with such information also in writing as he is able to obtain concerning the finding of the body or concerning the death. In the case of McCaughey (2007) the House of Lords held that section 8 imposed a continuing obligation to make disclosure.

23 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/390672/Stormont_House_Agreement.pdf

Methodology

The following methodology is proposed.

The inspection will focus on assessing the performance of the PSNI through its LSU and the adequacy of any relevant policies, in providing support to the Coroner to undertake legacy inquests in compliance with Article 2 of the European Convention on Human Rights. Any factors found to impact upon the performance of the LSU will be examined.

Research and Review

Desktop research will be conducted into the legislation, procedures and practice with regard to disclosure of information to the Coroner. Existing arrangements in Northern Ireland will be compared with current practice in other relevant jurisdictions, including England and Wales. Information already in the public domain regarding issues of disclosure arising from previous and current cases will be examined.

Fieldwork

Fieldwork is scheduled to commence in February 2016. Details of the fieldwork will be agreed with statutory agencies appointed representatives and will include an examination of the processes applied to requests for disclosure of information by the Coroner. Requests for disclosure of information will be tracked in order to evaluate the processes currently undertaken and to identify potential improvements.

Engagement with relevant stakeholders will follow the agency fieldwork and will include meetings with representative organisations such as the Victims and Survivors Forum, the Law Society and the Bar Council. These discussions will focus on issues of commonality rather than individual cases as CJI are not empowered to inspect specific cases. CJI will also consider any relevant outcomes arising from the work of the review undertaken by Lord Justice Weir.

The inspection will also be based on the CJI Inspection Framework, as outlined below, for each inspection that it conducts. The three main elements of the inspection framework are:

- strategy and governance;
- delivery; and
- outcomes.

CJI constants throughout each inspection are equality and fairness, together with standards and best practice. The information obtained from this inspection will be presented in accordance with the CJI inspection framework.

Feedback and writing

Following completion of the fieldwork and analysis of data, a draft report will be shared with the Minister of Justice.

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