

**HERTFORDSHIRE COUNTY COUNCIL**

**COMMUNITY SERVICES  
SCRUTINY COMMITTEE**

**TUESDAY 2 NOVEMBER 2004 AT 10.00A.M.**

Agenda Item No.

**1**

**CONTACT WITH THE BEREAVED**

Report of the County Secretary

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**1. Purpose of Report**

The purpose of this report is to inform members of the role of Hertfordshire Coroner Service in relation to contact with the bereaved, as requested by the Community Services Scrutiny Committee.

**2. Summary**

This report examines the evidence from the 'Families and Friends' survey, which was conducted to establish the perception of the bereaved of the service. This was instigated by the service as part of the application for ISO 9002:2000, a recognised international quality standard.

**3. Conclusions**

- 3.1 The 'Families and Friends' survey illustrated that the bereaved's perception of the coroner service is predominately very positive and there are improvements that can be identified (see section 8)
- 3.2 It is suggested that further surveys be undertaken in order to continue to consider the perception of the bereaved in the delivery of the service to HM Coroner and the people of Hertfordshire.
- 3.3 It is also planned to use the ISO 9002/2000 accreditation to externally scrutinise the service and to continue to develop the quality management systems within the service.
- 3.4 Members are invited to review and comment on these suggestions.

## 4. Background

- 4.1 The Coroner Service receives 3200 referrals of deaths every year, which is approximately one third of deaths in Hertfordshire. Approximately 400 cases proceed to a full inquest hearing.
- 4.2 Deaths are referred to HM Coroner when the deceased:
- has died a violent or an unnatural death,
  - has died a sudden death of which the cause is unknown,
  - has died in prison or in such a place or in such circumstances as to require an inquest (*Coroners Act 1988*).
- 4.3 The bereaved that come into contact with the service are often not only dealing with the death of a family member or someone close but also with very difficult circumstances of death such as suicide, homicide, fatal accidents, deaths abroad, etc.

## 5. Contact with the bereaved

- 5.1 Primary contact with the bereaved is by a Coroner's Officer. Contact is made via the telephone during the investigation stage and face-to-face for review of the inquest file and at the inquest hearings.
- 5.2.1 Typically, contact is made with a family representative at the following stages:
- 5.2.2 **At the point of referral.** Once the referral has been received, the Coroner's Officer makes contact with the family representative and explains why the death has been referred to HM Coroner. Information regarding the deceased and the death is shared. The family has the opportunity to raise any concerns surrounding the death. The procedure for the investigation is explained.
- 5.2.3 **If a post mortem examination is necessary.** The reasons for having a post mortem examination are explained. Full details of the timings and location of the examination are given. Full explanation of the procedure is offered (including offering a copy of the Department of Health booklet 'A simple guide to the post mortem examination procedure').
- 5.2.4 **On receipt of the post mortem examination results.** The Coroner's Officer explains the cause of death and necessary action. The Coroner's Officer explains if there has been any retention of organs and tissue and establishes their instructions regarding the disposal of the samples.
- 5.2.5 **At the opening of an inquest.** The Coroner's Officer explains the procedure for the release of the deceased from the mortuary and the investigation process.
- 5.2.6 **For statements.** The family may be required to submit a statement for the inquest. This is usually completed by post and allows the family time to construct the letter. It can be arranged for a Coroner's Officer to attend with the member to take a written statement.

- 5.2.7 **As the investigation progresses.** The Coroner's Officer will contact the family in order to keep them up to date as to the progress of the investigation, including Health and Safety Executive (HSE) investigations, further post mortem examination tests, police investigations, as appropriate.
- 5.2.8 **Review of inquest file.** Before an inquest families are invited to look at the inquest file. This assists the family to understand what information will be discussed during the hearing and for them to construct any questions that they wish to be considered during the hearing.
- 5.2.9 **At the closing of an inquest.** At least one Coroner's Officer is present at all inquests. A primary concern is for the family, ensuring that they are kept informed as to what will happen during the hearing.

## 6. Families and Friends survey

- 6.1 The service conducted a survey of families and friends over a six-month period from November 2003 until May 2004. Family representatives were asked if they were willing to complete a short questionnaire. This was requested at the time when the post mortem results were being divulged and on attendance at inquest.
- 6.2 There were 325 respondents overall which represents a sample of 10% of annual referrals. 258 were non-inquest cases and the remaining 67 were inquest cases.
- 6.3 There are two versions of the questionnaire:
- **Non-Inquest.** A questionnaire for family representatives where the referral is dealt with without an inquest (*appendix 1*).
  - **Inquest.** A questionnaire for family representatives where the referral requires an inquest (*appendix 2*).

## 7. Results

The responses to each of the survey questions are summarised below:

- 7.1 ***How soon after your bereavement did the Coroner's Officer contact you?***  
79% of respondents in inquest cases were contacted within two days.  
92% of respondents in non-inquest cases were contacted within two days.  
The respondents commented that delays experienced were due to:
- Delays in referrals to HM Coroner by GPs and Police.
  - Deaths occurring out of office hours or during the weekend.
  - Particularly in inquest cases it was noted that the liaison was carried out by Hertfordshire Constabulary Family Liaison Officers (FLO).
  - Coroner's Officers initially dealing with other members of the family.
- Further questionnaires would need to identify more clearly the cause of delays.

7.2 ***Do you feel that you were informed of the necessary action to be taken?***

99% of respondents in inquest cases felt they were fully informed. One respondent felt that they were not.

99.6% of respondents in non-inquest cases felt they were fully informed. Two respondents felt that they were not.

The respondents who did not feel informed of the necessary action reported that liaison was not directly with Coroner's Officers but via an FLO.

7.3 ***If there was a post mortem examination, how long did it take for you to be informed of the result?***

48% of respondents in inquest cases were informed within two days and 69% within four days.

85% of respondents in non-inquest cases were informed within two days and 95% within three days.

The issues identified were:

- Additional tests such as toxicology and histology are particularly necessary in inquest cases. These tests require a further period before the cause of death can be established.
- Multiple post mortem examinations are sometimes required as per the legislation in criminal cases.
- Coroner's Officer communicating with another member of the family. The make up of families is diverse. Coroner's Officers attempt to establish a family representative to communicate with and expect them to impart the information to other family members.

It should be noted that all delays were explained and there were no adverse comments recorded in response to this question.

7.4 ***Was the cause of death adequately explained to you by the Coroner's Officer?***

98% of respondents in inquest cases felt that the cause of death was fully explained and one respondent did not.

96% of respondents in non-inquest cases felt that the cause of death was fully explained and 4% did not.

The reasons given were:

- A Consultant Histopathologist gave the explanation of the cause of death.
- GP gave the explanation. Coroner's Officers are only trained to Certificate in Professional Development – Fundamental Medicine level and therefore refer the bereaved to medics for more comprehensive explanations.
- Explanation not required by the family as they have personal medical knowledge.
- FLO had insufficient knowledge to explain the medical terminology.

There were no negative comments regarding the explanations given by the Coroner's Officers.

7.5 ***Did the Coroner's Officer fully explain what was to happen next?***

98% of respondents in inquest cases felt that they received a full explanation and one respondent did not.

100% of respondents in non-inquest cases felt that they received a full explanation.

The issue raised was that the FLO conducting the liaison did not fully explain the coroner's process.

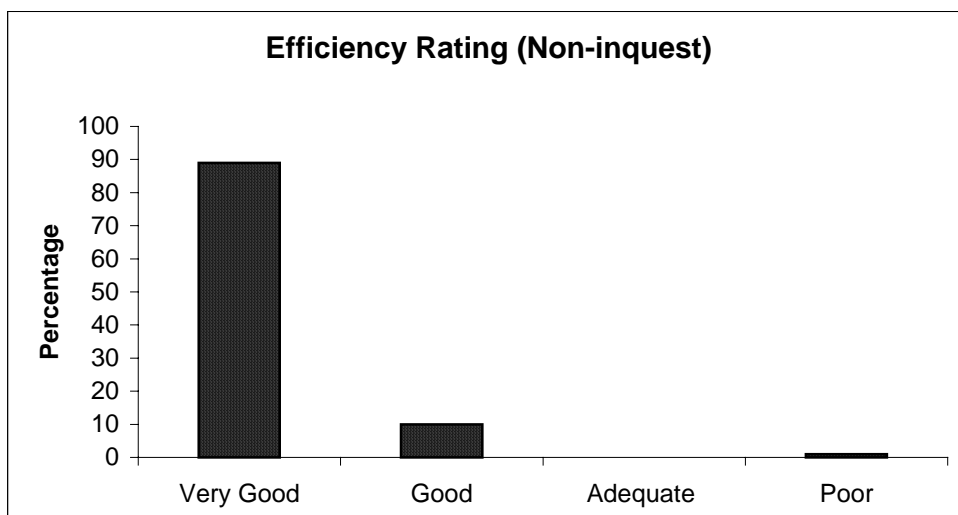
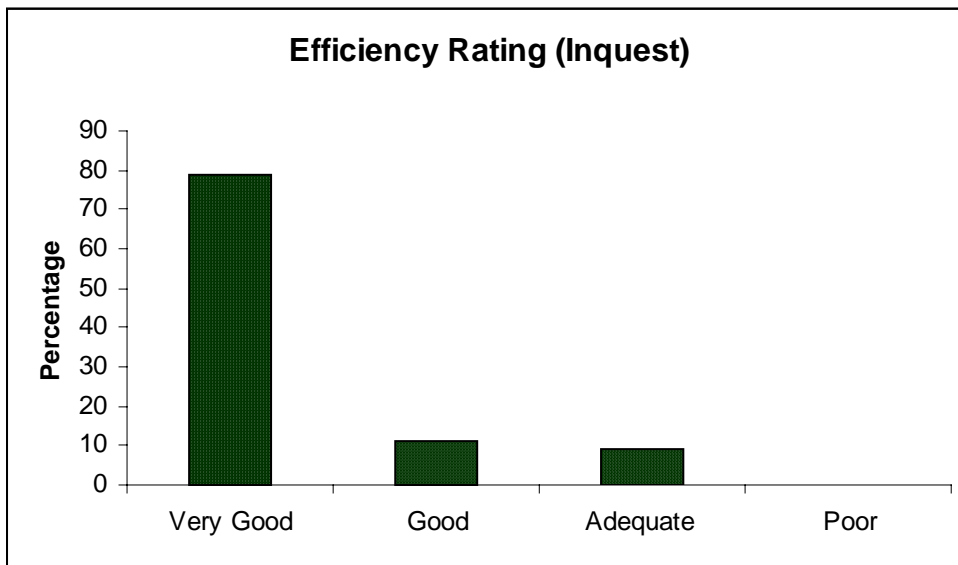
7.6 **Respondents were asked to rate the service according to:**

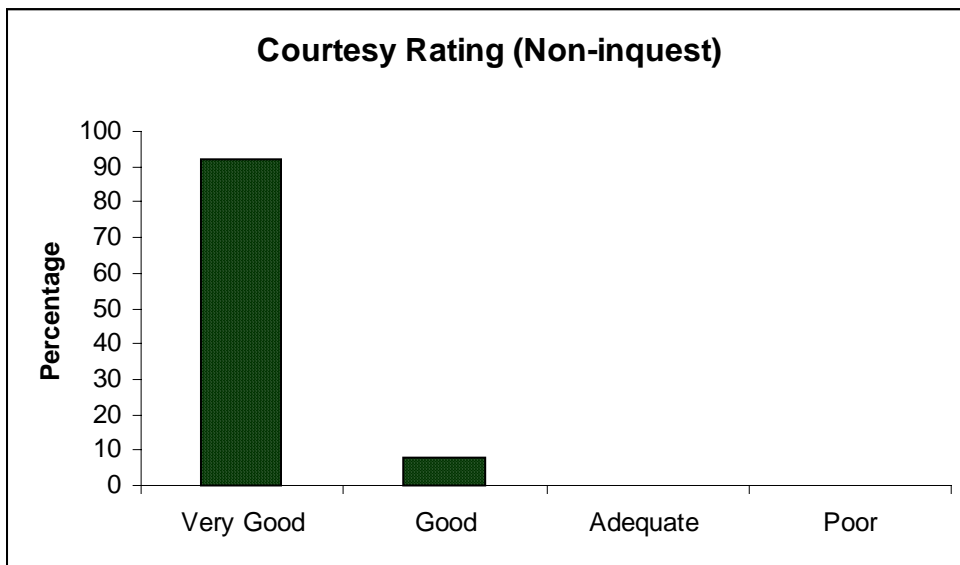
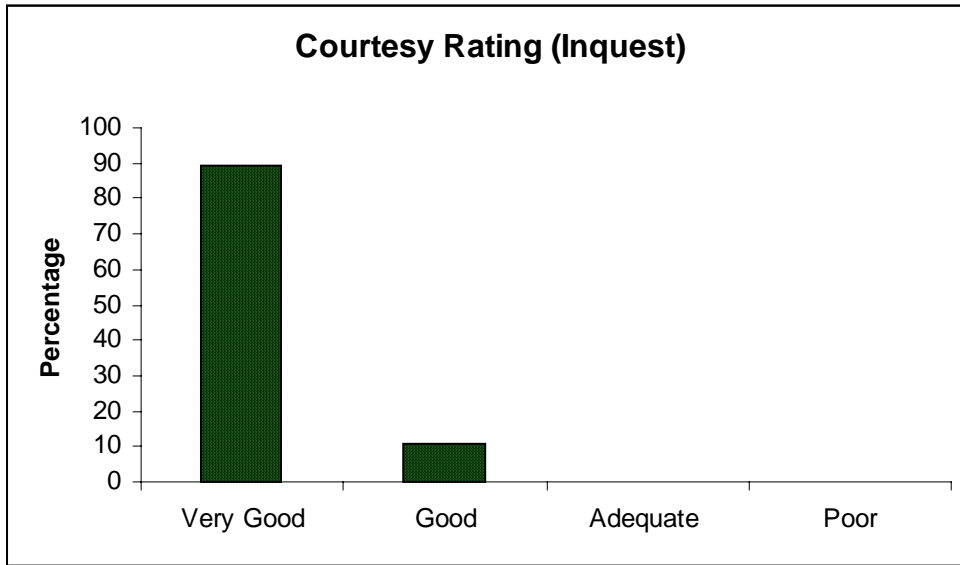
- Efficiency
- Courtesy
- Sensitivity

The results are summarised in the table below:

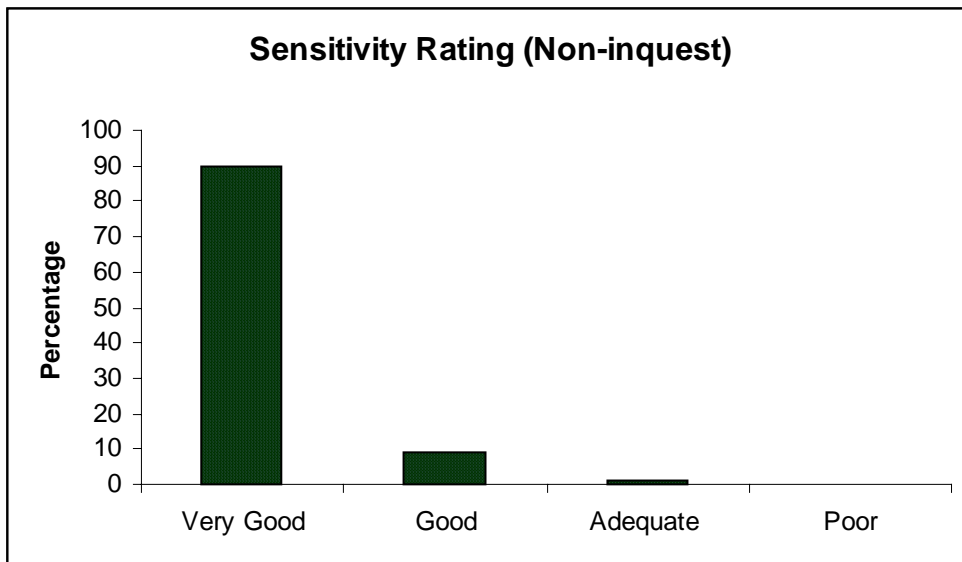
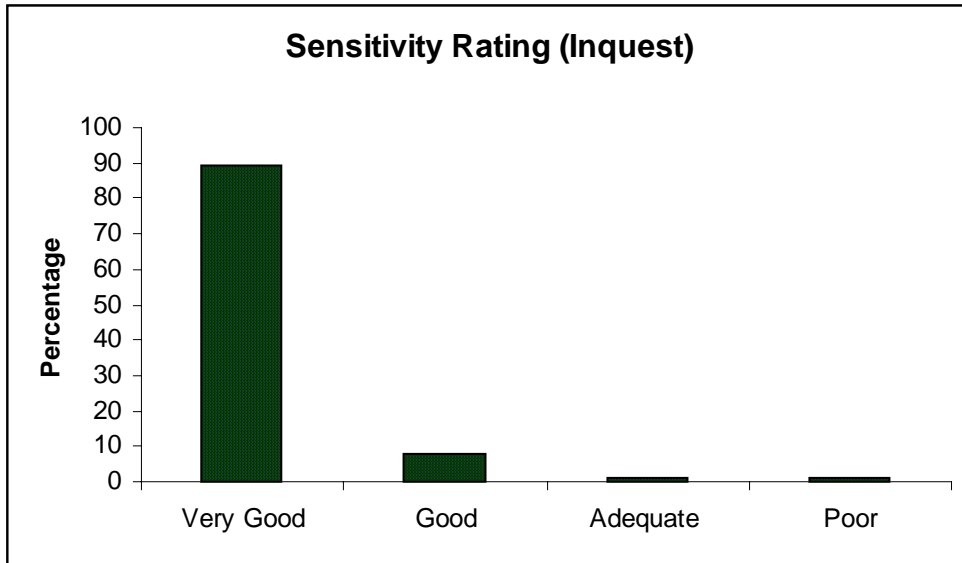
	Efficiency	%	Courtesy	%	Sensitivity	%	
Very Good	53	<b>79</b>	58	<b>89</b>	58	<b>89</b>	Inquest
Good	8	<b>11</b>	7	<b>11</b>	5	<b>8</b>	
Adequate	5	<b>9</b>	0	<b>0</b>	1	<b>1</b>	
Poor	0	<b>0</b>	0	<b>0</b>	1	<b>1</b>	
Very Good	226	<b>89</b>	227	<b>92</b>	224	<b>90</b>	Non Inquest
Good	25	<b>10</b>	19	<b>8</b>	23	<b>9</b>	
Adequate	0	<b>0</b>	1	<b>0</b>	2	<b>1</b>	
Poor	4	<b>1</b>	0	<b>0</b>	1	<b>0</b>	

7.6.1 The perception of the bereaved regarding the efficiency of the service is positive. Only one respondent of the 325 respondents rated efficiency as poor.





7.6.2 The perception of the bereaved with regard courtesy is 100% good or very good.



7.6.3 The rating for sensitivity is for inquest cases 98% good or very good and 99% good or very good for non-inquest cases. This equates to 2 respondents out of 325 recording sensitivity as poor.

7.7 The questionnaire included an opportunity for respondents to make comments and suggestions. These are combined with the responses to the questions and detailed with the proposed actions below:

**8. Responding to the results.**

8.1 The quantitative results detailed above and the comments and suggestions received identified some areas for improvement:

**8.1.1. Delays in referrals of deaths to HM Coroner.** The survey illustrated that efficiency is viewed to be predominately very good or good. However a very small sample of responses commented that delays would be reduced if GPs,

Police Officers and FLO's at the scene had greater understanding of the coroner's system.

Improved information regarding the process of referral to HM Coroner would reduce delays at the referral stage and improve the information imparted to the bereaved. An information leaflet for all General Practitioners in Hertfordshire has been developed and distributed via the Practitioner Services Unit. The leaflet details the process and contact details for the service. The Coroner Service has input into the training of probationer police officers and this is being developed to include a session at the Coroner's Court. Particular focus will be upon referring deaths to HM Coroner. Reference information will be included in the constabulary's Patrol Handbook, which is carried by all Police Officers.

- 8.1.2. **Out of hour's availability.** The survey responses did not specifically identify an expectation for there to be out of hours availability of Coroner's Officers. The potential delays in dealing with deaths that occur out of hours and at weekends should be considered.

The Coroner Service operates within normal office hours with the exception of HM Coroner who is available seven days a week as per the Coroners Act 1988. This could result in delays in contact with the bereaved. In this context it is important to consider the availability of other integral services in the process. Whilst there would be opportunity to expedite the initial contact with the bereaved in some cases, there would be limited benefit in expediting the process as mortuary services and Registration services operate a similar working pattern.

- 8.1.3. **Liaison with the bereaved.** Two respondents noted that there was some issues with communication when primary liaison was carried out by Family Liaison Officers (FLO).

Hertfordshire Constabulary assigns Family Liaison Officers to deaths including road traffic collisions, accidents, suspected homicides and sudden deaths of infants. They undertake the primary liaison with families. The Coroner's Officer communicates with the FLO as to the progress of the coroner's investigation. The survey responses indicated that direct communication with the family by the Coroner's Officer would improve the explanation of the coroner's investigation and judicial process. Coroner's Officers will conduct direct communication with the bereaved in these cases whilst ensuring that the FLO is fully informed. The Coroner Service is currently having input into the training of FLO's with regards the Coroner system.

- 8.1.4. **Identification of the next of kin.** A respondent noted that communication had been primarily with the next of kin and not with the respondent.

Modern families can have a diverse make up, including ex-partners and same sex relationships. This can present Coroner's Officers with difficulties in establishing a sole contact within the family. Initially the Coroner's Officer establishes the next of kin and/or executor, however the survey illustrates that it is imperative that communication with those who consider themselves closest to the deceased is also established.

- 8.1.5. **Support in dealing with the press.** A respondent identified the presence of the press following the death and at the inquest as an issue.

The Coroner Service has established an agreement with Corporate Communications for a designated Press Officer. This has enabled the service to offer support to families in dealing with the press and expert assistance in writing press releases.

- 8.1.6. **Telephone contact with the service.** A respondent noted that contact from the Coroner's Officer should not be too early in the day. Another respondent suggested that a telephone queuing system would improve contact with the Coroner's Officers during busy periods.

There are currently eight phone lines available for contact with Coroner's Officers and an answer phone system for out of hour's messages. Alternative queuing and answering services are to be explored.

- 8.1.7. **Advising the bereaved of support organisations.** A respondent suggested that the Coroner Service could advise the bereaved as to where further emotional support could be accessed.

The Coroner Service has established contact with many voluntary support groups who offer support to the bereaved in Hertfordshire. Leaflets and contact details are now available at the court. Cruse Bereavement Care offices are now located within the courthouse.

## 9. The Future

The Coroner Service will conduct further surveys of the bereaved annually as part of the established quality management system.

## 10. Access to Services Implications

There are no specific access to services implications.