

# Death Certification and Investigation in England, Wales and Northern Ireland

The Report of a Fundamental Review 2003





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The Report of a Fundamental Review 2003

Presented to Parliament  
by the Secretary of State for the Home Department  
by Command of Her Majesty  
June 2003

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The Review of Coroner Services  
100 Pall Mall  
London SW1Y 5HP

Hilary Benn MP  
The Home Office  
Queen Anne's Gate  
London SW1H 9AT

28 April 2003

Dear Minister

We were appointed in July 2001 by your predecessor Beverley Hughes MP to review and report on death certification and the coroner services in England, Wales and Northern Ireland. Details of our terms of reference and membership are overleaf.

We have pleasure in submitting our report. The main changes proposed are summarised in chapter 3 paragraph 2. A detailed summary of our recommendations and conclusions is in chapter 21.

We have been greatly helped in this Review by full and generous contributions and advice from a large number of private individuals, professional people and voluntary and professional groups and institutions here and in other countries. They are listed in Annex B. We have a special debt to the members of our Reference Groups for England and Wales, and Northern Ireland, respectively. They are listed in Annex A.

During the last three-quarters of a century, the Government has twice commissioned reviews of these subjects, in 1936 and 1965. Very little happened in response to their reports. The services are showing the consequences of this neglect. We, and those whom we have consulted, hope that the inaction will not continue.

Yours sincerely

Elizabeth Hodder

*Elizabeth Hodder*

Deirdre McAuley

*Deirdre McAuley*

Anthony Heaton-Armstrong

*Anthony Heaton-Armstrong*

Colin Berry

*Colin Berry*

Iqbal Sacranie

Tom Luce (Chair)

*Tom Luce*

Michael Gallagher  
(Secretary)

*Michael Gallagher*

Sophy Osborn  
(Secretariat)

*Sophy Osborn*



## **TERMS OF REFERENCE**

The terms of reference in respect of England, Wales and Northern Ireland are as follows:

- To consider the most effective arrangements for identifying the deceased and for ascertaining and certifying the medical cause of death for public health and public record purposes, having regard to proposals for a system of medical examiners.
- To consider the extent to which the public interest may require deaths to be subject to further independent investigation, having regard to existing criminal and other statutory and non-statutory investigative procedures.
- To consider the qualifications and experience required, and the necessary supporting organisations and structures, for those appointed to undertake the duties for ascertaining, certifying and investigating deaths.
- To consider arrangements for the provision of post mortem services for the investigation of deaths.
- To consider the consequences of any changes arising from the above for the registration service and the role of coroners under the Treasure Act 1996, and to consider where Departmental responsibilities for the arrangements should be located, having regard both to coherence for bereavement services and effective accountability.

## **MEMBERSHIP**

Tom Luce, former Head of Social Care Policy Department of Health (Chair)

Elizabeth Hodder, Public Accountability Consultant, former Deputy Chair of the Equal Opportunities Commission

Deirdre McAuley, Solicitor

Professor Sir Colin Berry, Professor Emeritus of Pathology, Queen Mary London

Anthony Heaton-Armstrong, Barrister

Iqbal A K M Sacranie OBE, Secretary General, The Muslim Council of Britain





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## INTRODUCTION

1. The systems in England, Wales and Northern Ireland for the certification of most deaths by doctors and the investigation of others by coroners have been seriously neglected over many decades. They must undergo radical change if they are to become fit for the purposes of a modern society and capable of meeting future challenges. The need for reform is widely recognised and supported.
2. Two changes are essential. One is to restore public confidence in the protection afforded by the death certification process. The other is to improve the response of the coroner service to families.
3. The certification and coroner systems are both of considerable age. The certification process had its origins in the first half of the nineteenth century and was last significantly changed in the 1920s. The coroner system in its present form is largely a creation of the Coroners Act of 1887. The most recent statute, the Coroners Act 1988, was largely a consolidating measure.
4. There were reviews of the coroner system in 1936 and of death certification and coroner services between 1965 and 1971. Little action was taken after either review.<sup>1</sup>
5. Both systems have come under increased public scrutiny because of important failings, clearly identified by recent events :-
  - The murders of his patients committed by Harold Shipman, a doctor in general practice in Hyde, Cheshire, make it clear that current systems do not provide adequate protection against malpractice. They are the subject of a Judicial Inquiry by Dame Janet Smith, an Appeal Court Judge<sup>2</sup>, which has made a first report<sup>3</sup>. Six of the 15 deaths for which he was convicted had been certified through the cremation procedures. 166 of the 200 cases where the Inquiry gave a finding of unlawful killing had also been certified for cremation, as had 36 of the other 45 cases where there was a suspicion of Shipman being responsible for the deaths. Dame Janet Smith's Inquiry continues to investigate the roles of systems and institutions in the failure to prevent these crimes as well as those of responsible individuals.
  - Other inquiries have raised significant issues about the role and practice of coroners. These include the Allitt inquiry following the

<sup>1</sup> A summary of the recommendations of previous inquiries and reviews is at Annex D.

<sup>2</sup> The Shipman Inquiry, an Independent Public Inquiry into the issues arising from the case of Harold Fredrick Shipman, Chairman Dame Janet Smith DBE.

<sup>3</sup> The Shipman Inquiry, First Report, paragraphs 15 and 22 of Summary, July 2002.

## Introduction

conviction in 1992 of a hospital nurse, Beverley Allitt, for the murder of 4 children in her care<sup>4</sup>, the inquiries that took place following the Bowbelle/Marchioness disaster<sup>5</sup> and the Bristol Inquiry into deaths of children following paediatric surgery<sup>6</sup>. The Alder Hey Inquiry<sup>7</sup> into the inappropriate retention of tissue and organs from children who had died at the hospital also identified as a major issue the unsuitable responses to parental enquiries about what happened.

- In Northern Ireland many individuals and organisations, including Human Rights groups, have expressed serious concerns about the way in which the inquest system is working there. A review of the criminal justice system in 2000 recommended an independent review into the law and practice relating to inquests<sup>8</sup>. Some have particular concerns that in Northern Ireland inquests do not have outcomes of any value and, generally, as to how the process has handled deaths related to inter-community conflict.
6. Other important reviews have proceeded in parallel with our own, as well as the continued work of the Shipman Inquiry. The Retained Organs Commission is reviewing policies, ethics and practices concerning the retention and disposal of human tissue for health care purpose. The Department of Health and the Welsh Assembly have been reviewing the law on the retention and use of human tissue and have consulted on the scope and content of what promises to be important reforming legislation. Similar work is in progress in Northern Ireland.
  7. There has been a review of forensic pathology services – the form of pathology used especially in the investigation of possible criminal offences<sup>9</sup>. It has recommended the creation of a number of regional centres and other measures to improve consistency, quality control and facilities.
  8. There has been a Government review of the Registration Service. The White Paper “*Civil Registration: Vital Change*”<sup>10</sup> of January 2002 described its outcome. Delivery of the service will remain with local authorities, but there will be national standards and the existing national inspectorate will remain. It will become possible to apply to register births and deaths by phone and on-line as well as in person. It is also intended that the registered cause of an individual death should become private information available to families and approved users but not, as now, to

<sup>4</sup> *Inquiry into Deaths and Injuries on the Children’s Ward at Grantham and Kesteven General Hospital in 1991*; by Sir Cecil Clothier, published 1994.

<sup>5</sup> *Public Inquiry into the Identification of Victims following Major Transport Accidents*, by Lord Justice Clarke, March 2001.

<sup>6</sup> *Learning from Bristol: Report into Children’s Heart Surgery at Bristol Royal Infirmary*, by Ian Kennedy, July 2001.

<sup>7</sup> *The Royal Liverpool Children’s Inquiry*, by Michael Redfern QC November 2001.

<sup>8</sup> *Review of the Criminal Justice System in Northern Ireland*; published March 2000.

<sup>9</sup> *Review of Forensic Pathology Services*; The Home Office, March 2003.

<sup>10</sup> *Civil Registration: Vital Change. Birth, Marriage and Death Registration* (Published by HM Stationery Office January 2002, CM 5355).

any member of the public who buys a certificate. From the family's perspective this is an important gain in privacy. A review in Northern Ireland has reached similar conclusions.

9. Also of critical importance is the evolving interpretation of Human Rights law as it affects the State's obligation to investigate deaths.
10. Article 2 of the European Convention on Human Rights gives signatory states an obligation to protect the lives of their citizens:

*"Everyone's life shall be protected by law. No-one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which the penalty is provided by law. Deprivation of life shall not be regarded as inflicted in contravention of this article when it results from the use of force which is no more than absolutely necessary: (a) in the defence of any person from unlawful violence; (b) in order to effect a lawful arrest or to prevent escape of a person lawfully detained; (c) in action lawfully taken for the purposes of quelling a riot".*

11. The courts have found that in some circumstances this duty implies an obligation to investigate deaths. A number of important judgements of the European Court of Human Rights and the domestic courts have significance for the conduct of some coroners' inquests, though the inquest is not the only process through which the obligation to investigate can be met. There are a number of relevant cases which await resolution in the higher courts<sup>11</sup>.

## Review Process

12. After our appointment in July 2001 we sought the views of over 200 groups and organisations on death certification and coroner services. We arranged a series of visits by members of our Group to all the regions in England, to Wales and to Northern Ireland, and a series of meetings in London, Wales and Belfast with individuals, groups and institutions. An outline of the visits is at Annex C.
13. We have through these means been in contact with all the key professional bodies whose members work within or alongside the death certification and coroner systems. They include various medical and legal organisations and the Coroners' Society for England and Wales and its counterpart in Northern Ireland. We have met individually with more than half the 123<sup>12</sup> coroners in England and Wales, and most of the 7 coroners

<sup>11</sup> The most significant of these is *R v Coroner for West Somerset, ex parte Middleton*.

<sup>12</sup> Figures supplied by The Coroners' Society. There are 136 coroner districts (excluding the Royal Household) in England and Wales but some individual coroners are appointed to more than one district. See also the Home Office Statistical Bulletin: "Coroners", issued May 2002.

## Introduction

in Northern Ireland. We have met a wide range of doctors in hospitals, general practice and public health, coroners' officers, police, pathologists, solicitors and barristers. We have also met a variety of groups with religious affiliations.

14. Members of the Group have attended autopsies and a significant number of inquests.
15. We have seen a large number of voluntary bodies, support groups such as INQUEST, Victims Voice, RoadPeace and Support After Murder and Manslaughter, and private individuals with experience of the systems as users. We appointed a number of people and groups to form Reference Groups for England and Wales and Northern Ireland. We committed ourselves to offering the members, listed at Annex A, repeated opportunities to see us and we saw most of them at least three times during the Review.
16. Our general approach has been to listen to and dialogue with people in open discussion and receive written statements of views. We received a large response to the Consultation Paper which we issued in August 2002<sup>13</sup>. This summarised the direction of our thinking and outlined some specific proposals for possible change.
17. A list of people whom we met or who sent us written submissions is at Annex B. We are grateful to them all. We appreciate how difficult and distressing it has been for some individuals and families to recount their experiences to the Review. The written submissions and our summary notes of meetings constitute a large archive which will be placed in the Public Record Office. It will be accessible to everyone wishing to see it except where the material relates to personal cases and was provided to us in confidence.
18. We commissioned three surveys, the reports of which are available separately in the background papers: 'Volume 2':
  - Of relevant specialist literature and some professional practice issues in death certification. This was carried out by Dr Aileen Clarke and Dr Jean Graham working through the London School of Hygiene and Tropical Medicine<sup>14</sup>.
  - An Analysis of Coroners' Casework Data: Non-Inquest and Inquest Cases, by Peter Jordan, an operational research consultant.

<sup>13</sup> *Certifying and Investigating Deaths in England, Wales and Northern Ireland, An Invitation for Views*, published August 2002.

<sup>14</sup> This study is titled "Improving the Health of the Living? An Investigation into Death Certification and Coroner Services and Some Suggestions for Change".

- Public attitudes to death certification and the coroner services. This was done for us by the Omnibus Survey Team of the Office for National Statistics and their counterpart in Northern Ireland.
  - We also commissioned advice on the impact of the European Convention on Human Rights from Tim Owen QC and Danny Friedman of Matrix Chambers. This appears in Volume 2 alongside a memorandum on issues of self-incrimination in the inquest prepared under the auspices of our colleague Anthony Heaton-Armstrong.
  - Also of considerable relevance to our review is the study “Experiencing Inquests” a survey by Gwynn Davis and colleagues at Bristol University who observed 81 inquests in 9 coroner districts during 2000<sup>15</sup>.
19. On a selective basis we looked at some systems overseas and in Scotland, and some members paid brief visits to Canada, Australia, New Zealand, Edinburgh and Dublin. We have made a summary of practice in these other jurisdictions which is at Annex E. We acknowledge with gratitude the help we had from all concerned on those visits. Whilst none of the systems we examined could or should be transplanted here in their entirety, this international dimension was a valuable aid to our own thinking. It is plain that more attention has been paid to developing these systems in the New World than so far in the Old.
  20. The total cost of the Review is £1.1 million. Most of this was met by the Home Office. Costs directly associated with reviewing the coroner service in Northern Ireland were met by the Northern Ireland Court Service.
  21. We record our great debt to our small secretariat for their unfailingly imaginative and helpful work, and especially to Mike Gallagher our Secretary, and Sophy Osborn, who were both with us throughout the Review.
  22. We are also grateful to Mavis Maclean of Wolfson College and the Oxford Centre for Family Law and Policy for facilitating our residential weekends.

<sup>15</sup> *Experiencing Inquests*, Home Office Research Study 241. Home Office Research, Development and Statistics Directorate. September 2002.





## **PART 1:**

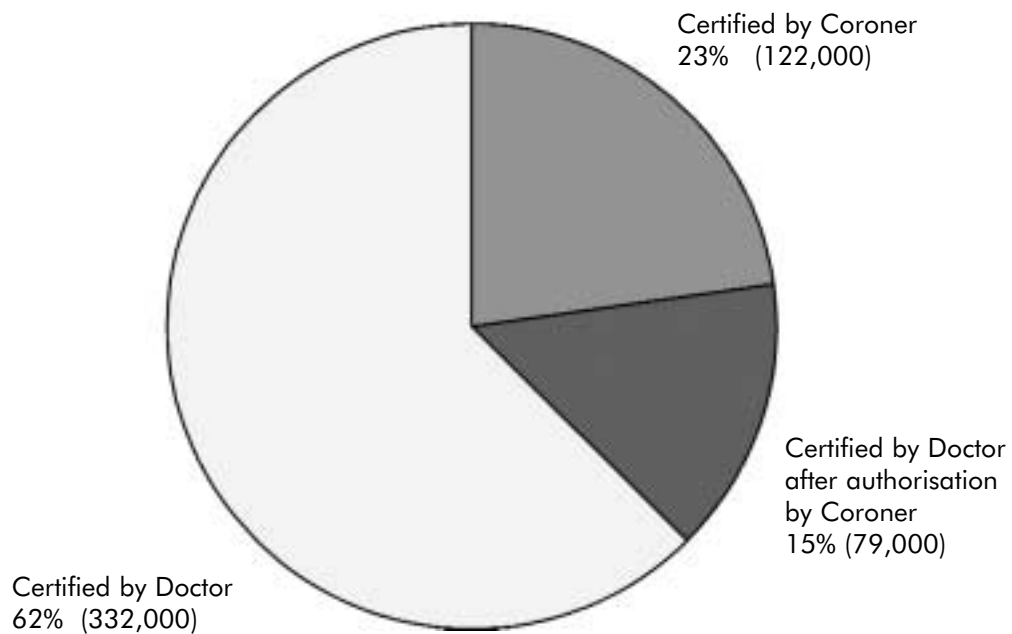
# **THE PRESENT SYSTEM AND THE NEED FOR CHANGE**

## CHAPTER 1 - THE PRESENT SYSTEM

1. When someone dies, the death is registered by the Registrar of Births, Deaths and Marriages. This registration provides a permanent record of the death and its cause. It is legally required before the body can be buried or cremated, and before the personal representative and family can settle the affairs of the person who has died. Before a death can be registered the Registrar must be provided with notification of the death and a certificate of the cause of death from a doctor or a coroner.
2. Registered deaths provide the main input to the national mortality statistics regularly published by the Office for National Statistics. These are essential for monitoring national and local health trends. The framework within which causes of death are classified and the approach adopted in the form on which doctors give the cause of death<sup>1</sup> accord with World Health Organisation guidelines.
3. For most deaths the doctor who provided care during the last illness completes a certificate of the medical cause of death. This is delivered to the local Registrar who issues an authority for the disposal of the body. If the body is to be buried there are no more formalities.
4. If there is to be a cremation, there are further requirements. A personal representative or family member completes a cremation application, the doctor who has provided the Medical Certificate of the Cause of Death completes a further certificate, and a second doctor completes another after seeing the body and talking to the first. These certificates then go to the Medical Referee at the Crematorium who checks them and gives or withholds the final approval necessary for the cremation to occur.
5. Deaths which may require further investigation are reported to the local coroner who decides whether to carry out further inquiries. Violent or unnatural deaths, deaths in prison and certain other deaths must be reported to the coroner by the registrar if no-one else has done so; so too must sudden or unexpected deaths. Many reports are also made by doctors because they do not fulfil the requirements of attendance for certifying the death. The doctor may certify the death if he has seen the patient during the 14 days before death (28 days in Northern Ireland) or if he has seen the body after death.
6. When a death is reported to a coroner, he decides whether he is satisfied as to the nature of the death on the basis of the facts already available, whether to arrange an autopsy, and/or to hold an inquest. If the coroner chooses not to continue the investigation to autopsy or inquest he informs the registrar and doctor of this and certification takes place with his concurrence.

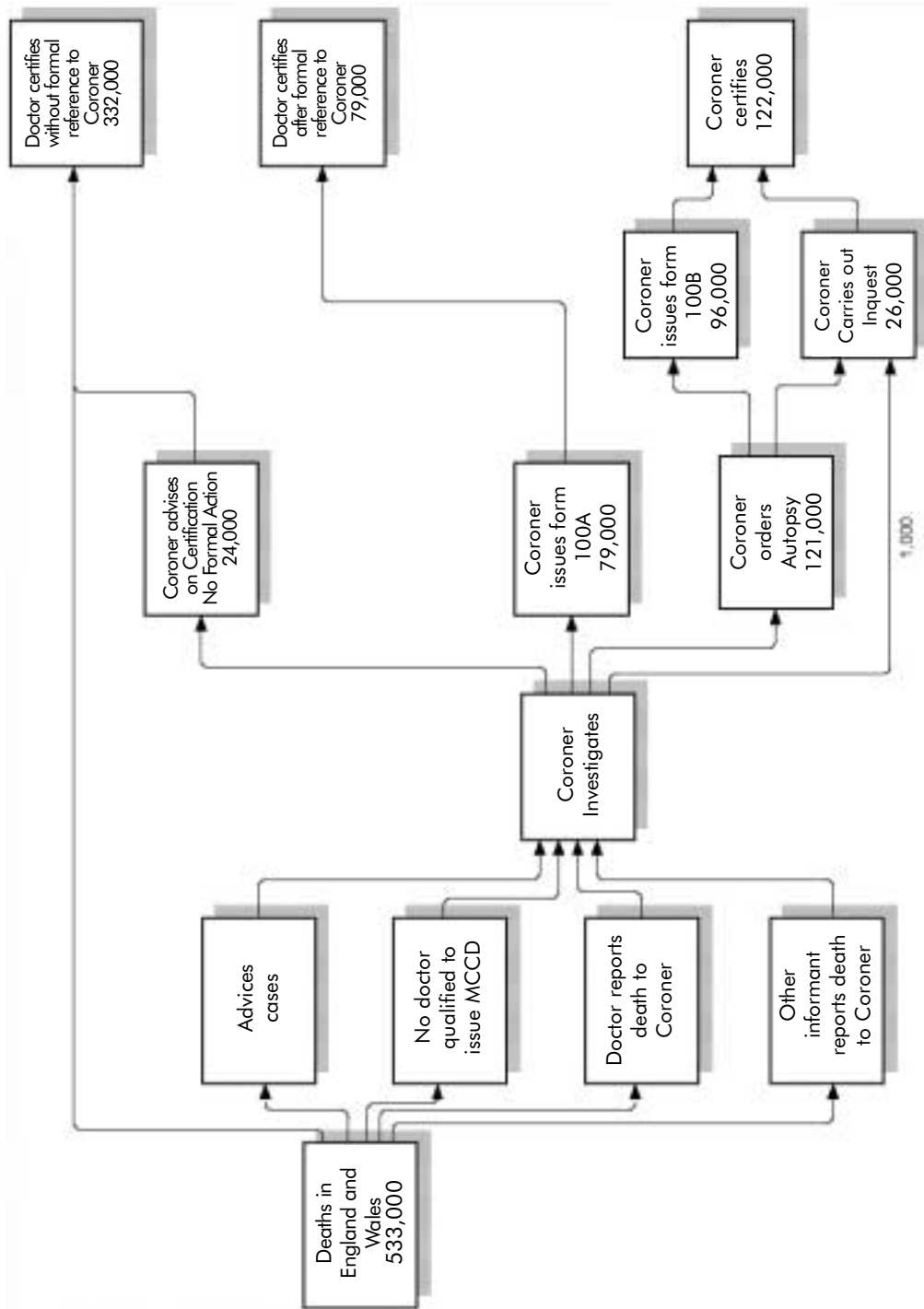
<sup>1</sup> This is called a Medical Certificate of the Cause of Death (frequently referred to as the MCCD).

7. There are, thus, three categories of death:
  - those certified by a doctor;
  - those certified by a doctor with the coroner's agreement;
  - those reported to and investigated by the coroner.
8. The numbers in each category in 2001 are shown below:



9. When a death is reported to the coroner he may :
  - certify the death on the basis of the information he has or acquires;
  - certify the death after ordering an autopsy;
  - certify the death after holding an inquest.
10. A chart detailing the stages of the current reporting system and the number of cases involved at each stage for the year 2001 follows.

Figure 1: Current system of death certification and investigation



## Key Participants and Structures

11. The key participants are:

- The *relatives and friends* of the person who has died, and any professional representatives they may have
- *Local Registrars of Births, Deaths and Marriages*. They are holders of a statutory office, and are subject to guidance and direction by the Registrar General for England and Wales, a senior official and statutory office-holder in the Office for National Statistics. They are appointed and resourced by the local authority where they work. In Northern Ireland, registrars are appointed by local authorities but the cost of employing them is met from central funds. They are part of the Northern Ireland Statistical and Research Agency which is part of the Northern Ireland Department of Finance and Personnel.
- *Doctors certifying deaths* do so as a statutory duty under the Births and Deaths Registration Act (1953) and not as a condition of their employment in the NHS, since certification of death is not an NHS responsibility. The completion of death certificates is, thus, treated as an independent activity for which there is no answerability to the NHS or other employer. In these as in other matters doctors are subject to regulation of their conduct by the General Medical Council.
- *The 123 coroners in England and Wales* are appointed by local authorities. 23 are whole-time and the remainder part-time. Each coroner is required to have a deputy coroner and the majority also have an assistant deputy coroner; a few have more than one assistant deputy. These secondary appointments are made individually by coroners themselves and bring the total up to approximately 375. Coroners, who are judicial officers, must have medical or legal qualifications. Like other members of the judiciary coroners can be dismissed only by the Lord Chancellor. The 7 Northern Ireland coroners (of whom 1 is whole-time) are appointed by the Lord Chancellor, and all must be legally qualified. They have deputy coroners but no assistant deputies.
- *414 coroners' officers*<sup>2</sup> in England and Wales provide support for coroners and are employed by the police or local authorities. Many are serving or retired police officers, but people from other professional backgrounds are also employed. In Northern Ireland support for coroners is provided by serving police officers.

<sup>2</sup> Survey data from Peter Jordan.

## Chapter 1 - The Present System

- *Pathologists* performing autopsies for coroners are remunerated separately through a fee for service payment and engaged on an ad hoc basis. A large proportion of autopsies are performed in NHS mortuaries by pathologists otherwise employed by the NHS or universities. Some local authorities, mainly in cities, have mortuaries of their own. In Northern Ireland, most coroners' autopsies are performed by pathologists employed in the State Pathologist's Department which is the responsibility of the Northern Ireland Office and is located in the Royal Victoria Hospital Belfast.
  - *Funeral Directors and their staff.* They are private firms who work closely with the bereaved. Funerals are also arranged by the burial societies of synagogues and mosques in Jewish and Muslim communities. They organise funerals in accordance with the beliefs of these faiths.
  - The 220 *crematoria* in England and Wales each have a *medical referee* and one or more deputies appointed by the Home Office. In Northern Ireland there is one crematorium and the medical referee role is carried out by hospital doctors.
  - The wide range of *care and bereavement staff* who support and help families.
  - A wide range of *voluntary bodies, support groups and religious groups* who work with families and individuals who have been bereaved. Groups such as CRUSE provide a range of support to bereaved people generally. Others work especially with people who have been bereaved through particular categories of death, such as Disaster Action and RoadPeace and groups such as INQUEST and the Centre for Corporate Accountability which provide support to those who lose relatives held in prison or as a result of workplace incidents.
12. Within Government in England and Wales, the *Home Office* has a general responsibility for death certification through its responsibility for coroners, cremation and burial law. Responsibility for resourcing the coroner service lies with independent *local authorities* and in their decisions on individual cases coroners have judicial independence. The Home Office also provides some training for coroners. *The Lord Chancellor* has responsibility for coronial discipline and the Coroners Rules which, broadly, regulate the conduct of inquests and some other coronial functions. He also has a power to direct the adjournment of an inquest where a public inquiry chaired by a judge is expected to fulfil the role of the inquest. *The Attorney General* has a limited power to allow applications to be made to the High Court for new inquests and also a role in some judicial review proceedings.

13. *The Department of Health and the Welsh Assembly* are responsible for public health and health care. Government responsibility for the *Office for National Statistics* and the *Registration Service* lies with Treasury Ministers.
14. In Northern Ireland general administrative and resource provision responsibilities for the coronial service lie with the Northern Ireland Court Service. The Department for Health, Social Services and Public Safety has responsibility for public health and health care while the Northern Ireland Department of Finance and Personnel has responsibility for the Registration Service.
15. The main statutes and other regulations are:
  - The Coroners Act 1988
  - The Coroners Rules 1984
  - The Coroners Act (Northern Ireland) 1959
  - The Coroners (Practice and Procedure) Rules (Northern Ireland) 1963
  - The Births and Deaths Registration Act 1953
  - The Births and Death Regulations 1987
  - The Births and Deaths Registration (Northern Ireland) Order 1976
  - The Cremation Act 1902 & 1952 and Cremation Regulations 1930
16. There are a number of guides and reference books about the coroner system. They include:
  - a. "Jervis on the Office and Duties of Coroners" - with Forms and Precedents. Twelfth Edition (2002) Matthews, Paul. Sweet & Maxwell Limited, London.
  - b. "Levine on Coroners' Courts" (1999) Levine, Sir Montague. Sweet & Maxwell, London.
  - c. "Coroners' Courts. A guide to law and practice" (1991) Dorries, Christopher P. John Wiley & Sons, Chichester.
  - d. "Inquests; a Practitioner's Guide" (2002) Christian, Louise; Friedman, Danny; and Thomas, Leslie. Legal Action Group, London.
  - e. "Coroners' Law and Practice in Northern Ireland" (1998) Leckey, John and Greer, Desmond. SLS Legal Publications (NI).

## CHAPTER 2 - THE NEED FOR CHANGE

1. In our Consultation Paper of August 2002 we offered an analysis of the systems' defects, and a set of aims for their reform. We concluded that the death certification and coroner services were not "fit for purpose" in modern society. This conclusion and the aims we suggested for their reform were widely supported in consultation responses.
2. Some of those who commented said that whatever the systems' defects the services were better and more effective than we had recognised and that many cases were properly and sympathetically handled.
3. We agree that the people working within the systems often manage to produce better results than could reasonably be expected from the obsolete and flawed structures through which they work. It is to their credit that things are not worse. The challenge now is to provide structures which support them better and give the public services which reliably safeguard their interests. In particular there is a need to give bereaved families better support and to recognise that many will suddenly and unexpectedly experience these systems about which they have no prior knowledge. If they are not adequately informed or are treated insensitively their distress will, inevitably, be exacerbated and the mourning process made more difficult. Much of the evidence presented to us suggests that there is significant room for improvement in these respects:-

*"The bereaved are precipitated into a devastating situation and are having to deal with agencies and procedures unknown to them and from which they feel totally excluded."*<sup>1</sup>

### Critical Defects

4. We assess the critical weaknesses of the death certification and coronial processes to be:-
  - a. The systems themselves are internally fragmented and although both deal with individual deaths they are not concerned with patterns or trends.
  - b. The certification and coronial processes are separate from each other. The coroner has no information on or responsibility for deaths not reported to him. No public authority is tasked or resourced to see that the certification process is being properly carried out and that deaths which ought to be investigated by the coroner are reported for investigation. There is thus little to stop an unscrupulous doctor from "certifying his way out of trouble".

<sup>1</sup> Victims Voice – Reference group members.



- c. There is a lack of supervisory structures within the coronial service and therefore no leadership, accountability or quality assurance.
- d. There is no formal linkage to or communication with other public health services and systems locally and nationally, such as those concerned with looking at drug abuse, public health trends, the safety and effectiveness of medical practice, adverse reactions to medicines etc. There is persuasive evidence suggesting that the coroner service is not identifying some suicides, drug related deaths and deaths to which adverse reactions to prescribed drugs may have contributed.
- e. The death certification process and the inquest process are carried out in isolation from the mainstreams of medicine and justice administration and there is no cross-fertilisation or modernisation of knowledge and skills.
- f. There is a lack of clear participation rights for bereaved families, and of standards for their treatment and support. They are largely excluded from the death certification process – they do not have a right, for example, to see the medical certificate of the cause of death. They are not systematically or reliably given information and help concerning autopsy decisions, other processes and inquests. The evidence disclosure arrangements at inquests fall below modern judicial standards of openness, fairness and predictability.
- g. There has been no reliable or systematic response to minority community wishes, traditions and religious beliefs.
- h. There is a lack of appropriately placed medical skills to supervise, support and audit the death certification process, and to work within the investigation process, even though a large number of deaths reported to the coroner, or referred to the coroner's office for advice, are the result of natural disease.
- i. There is a general lack of sustained and consistent training of coroners, coroners' officers, and of other contributing professionals in the requirements of these systems and in the skills required to work with bereaved families.
- j. Most coroners are part-time and many work also as lawyers in private practice. Compared to other areas of justice and public administration, there is no full-time dedicated service leadership in most localities or nationally.
- k. There is a lack of resources at coroners' inquests to deal effectively with the most complex or contentious cases; and of any clear and reliable process for clarifying the relationship between the inquest and other formal processes for investigating deaths.

## Chapter 2 - The Need for Change

- l. There is no clear modern legal base for the conduct of most death investigations.
- m. There are no mechanisms encouraging the systems to adapt and to develop in accordance with emerging needs.
- n. There are no agreed objectives or priorities.
- o. There is a general lack of resources and support - for example to provide coroners with premises for inquests - or in some cases even a minimal amount of secretarial and administrative support.

### Scale and Suitability of Work

5. There are also some questions about activity levels and priorities in England and Wales compared to elsewhere. Overleaf is a comparison, for England and Wales, Northern Ireland, Scotland, the Republic of Ireland, Ontario, Alberta and British Columbia in Canada, and Victoria and New South Wales in Australia, and New Zealand of the proportion of deaths reported to coroners (or in Alberta the Medical Examiner), the proportion in respect of which they order autopsies, and the proportion in which there are public inquests.
6. Broadly, in England and Wales:
  - deaths are reported to coroners on a scale varying between double the rates and 50% higher than the rates of other jurisdictions;
  - the autopsy rate is between double and triple the autopsy rate in other jurisdictions;
  - the rates for public inquests are much higher than in most of the other jurisdictions.

## Investigation, Autopsy and Inquest Rates expressed as % of Total Deaths

Jurisdiction	Total Number of Deaths Per Year	% of Total Deaths Referred to , Coroner, ME Procurator Fiscal	% of Total Deaths Autopsied	% of Total Deaths Given Public Inquests
England & Wales <sup>2</sup>	532,500	37.8%	22.8%	4.8%
Scotland <sup>3</sup>	57,400	23.7%	12.2%	0.11%
Northern Ireland <sup>4</sup>	14,500	24%	8.8%	1.3%
Republic of Ireland <sup>5</sup>	29,812	26.5%	9.4%	4.9%
Alberta, Canada	17,000	25%	7%	0.12%
British Columbia, Canada	25,000	28%	10%	0.06% <sup>6</sup>
Ontario, Canada	Approx. 70,000	27%	11%	0.1%
Victoria, Australia	32,000	13%	9.7%	0.8%
New South Wales, Australia	Approx. 46,000	14%	10.3%	0.35%
New Zealand	28,000	14%	9.8%	4%

Source: Remainder figures obtained from personal communications with jurisdictions.

7. The figures do not of themselves show that the rates of these activities are necessarily too high in England and Wales or those elsewhere too low. However they prompt questions about the focus and priorities in our own arrangements. These higher activity levels have costs, and they impose delays and other disadvantages on families. They need to be justified by evidence of benefit. There is neither such evidence nor any satisfactory mechanisms for discovering what it might be. This may, partly, be because the fragmented systems through which the service is provided make it impossible to assess the value of its activities. It may also be that the activity rates are too high.
8. The work commissioned for our review from Clarke and Gladwin has drawn attention to increases in the number and proportion of deaths reported to coroners where no further action is taken by the coroner, and

<sup>2</sup> Deaths Reported to Coroners, England and Wales 2001, Richard Allen, Home Office.

<sup>3</sup> Figures for 2001 supplied by the General Registry Office (Scotland).

<sup>4</sup> Figures supplied by the Northern Ireland Court Service and the General Registry Office (Northern Ireland).

<sup>5</sup> Figures for 2001 supplied by the General Registry Office (Ireland) and the Department of Justice, Equality and Law Reform (Ireland).

<sup>6</sup> British Columbia Coroners' Service Annual Report 2000.

## Chapter 2 - The Need for Change

an increase in the number of inquests with verdicts of natural causes. They comment:

*“All these trends suggest that the resources of coroners are being stretched by, and the primary purpose of the coronial system is being subverted by, an increase in referrals for reasons other than that an unnatural or accidental cause of death is suspected. These trends are not only unsustainable with current resourcing patterns, but are undesirable”.*<sup>7</sup>

9. Also relevant is the way in which over the years the coroner’s powers have developed and been expressed in the law. The powers are focused on the activities of holding inquests and ordering autopsies. There is no general power or duty to hold an investigation into the causes and circumstances of a death and to deliver an outcome to that investigation. Although there are rules relating to the holding and conduct of inquests (the Coroners Rules which are made under the statutes governing the service in England and Wales and Northern Ireland respectively) the legal framework within which the majority of cases are handled is much less clear. It gives families very few defined rights of access to the processes or outcomes of investigations in cases where there is no inquest. Such investigations constitute the majority of cases handled by the coroner service.
10. We think it likely that the relatively high reporting, autopsy and inquest rates in England and Wales reflect:
  - the inherited legislative framework which emphasises these activities and processes rather than outcomes;
  - custom and practice with little or no national analytical capacity or guidance and scrutiny powers;
  - the absence in most coroners’ offices of medical skills to deal confidently with deaths from natural disease.
11. Though we are not suggesting quantified targets, we anticipate that the changes we are recommending will cause all the key activity rates in England and Wales, for deaths reported to the coroner, for autopsies, and for public inquests, to move closer to those in the other countries; and that in consequence deaths which really need investigation by the coroner will be more suitably and thoroughly investigated than many now are.

<sup>7</sup> Clarke and Gladwin, op cit, page 6.

## CHAPTER 3 - THE NEW APPROACH

1. The main purposes of the changes we recommend are to deal with defects we have identified – to create a service that has consistent and known national standards, that safeguards the public but makes good service to bereaved families a major priority, that is equipped with modern duties and powers, proper professional leadership, and the range of legal, medical and investigative and human skills necessary for these purposes.
2. There are six areas of major change involved in our recommendations. Their detail is set out in later Chapters.

### **THE SIX MAJOR CHANGES involve the introduction of:**

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

The death investigation service – the coroner service – should become a service of predominantly full-time legally qualified professionals appointed, trained and supported to modern judicial and public service standards. It should provide consistent and reliable services to safeguard the public. To achieve this:

- the service should be reformed into two national jurisdictions, one for England and Wales, and one for Northern Ireland;
- the Lord Chancellor should become responsible for appointing and supporting the service as he is for other justice services;
- a statutory Coronial Council should oversee the working of the death certification and coroner services to ensure that they work properly together and have consistent standards;
- there should be a small inspectorate to monitor coroner service standards;
- each national coroner jurisdiction should be headed by a Chief Coroner;
- there should be a Rules Committee in each national jurisdiction to promote consistency of practice in the holding of inquests and to allow practice to respond to emerging and changing needs;
- the present 136 coroner districts in England and Wales should be replaced by around 60 coroner areas broadly linked with police

authorities to give the service the mass necessary for a proper professional base and full time leadership;

- there should be structured and mandatory training for all key personnel;
- there should be a new statutory basis for the service defining its role and giving it powers as a general death investigation service. There is a need to replace the patchwork of powers it has inherited from the distant past.

2. **Consistency of service to families** to be underpinned by a Family Charter having legal effect and including:

- measurement and audit of times for the completion of investigations and inquests;
- a statement of families' rights to specified information;
- a right to formal review of decisions to order an autopsy (or not to do so), and of certain other administrative decisions by coroners;
- fuller and more reliable links with providers of bereavement services;
- a mechanism for making complaints.

3. **A service that deals effectively with legal and health issues, works effectively across the full range of public health and public safety, and supports and audits the death certification process.** To achieve this, each coroner area should have, in addition to a legally qualified coroner, a doctor acting as Statutory Medical Assessor to:

- oversee and support the certification of individual deaths by clinical doctors in the area;
- support the coroner in death investigations and supervise the generality of cases involving death from natural disease;
- create appropriate and effective links between the coroner's office and public health and other public safety networks.

This will bring an important new dimension of medical expertise into the coroner service, without placing unrealistic demands on scarce medical manpower.

4. **In death certification, a common process to replace the "three-tier" cremation process with a "two-tier" certification system applying to all deaths equally whether the body is buried or cremated.** The responsibility for doing this will lie with doctors providing health care to

patients in the community and in hospital. The first certifier should usually be the doctor looking after the person who has died. The second should be from a panel chosen and supported by the Statutory Medical Assessor based in the coroner's office:

- families will have a defined right to pursue any anxieties about a death with the second certifier or the coroner's office;
- there will be some changes to the detailed rules which will allow the certification process to work faster and more smoothly.

5. **More informative and accessible outcomes to coroners' death investigations:**

- more detail and transparency in those relating to the large majority of cases which are not subject to a public inquest;
- the retention of the public inquest in cases where deaths occur in situations of restraint or special vulnerability, where there is a need for the judicial examination of evidence, or there is otherwise a public interest in a judicial examination;
- more privacy in certain other public inquest cases;
- more flexibility over the scope of the inquest;
- more authoritative handling of exceptionally complex inquests through the selective involvement of the permanent and higher judiciary in the conduct of inquests;
- fuller conclusions from inquests with a stronger bias towards narrative and preventive findings, and less inappropriate imputation of liability through short-form "verdicts";
- in Northern Ireland, more consistency, predictability and clarity in the use of inquests;
- fairer and more consistent rules on disclosure of evidence in inquests.

6. **A proper recognition of the work of coroners' officers:**

- in the new statute for the service;
- through the provision of training;
- through a widening of the skills base to encompass the new role and structure of the service in the handling of deaths from natural disease; some health care skills to supplement the essential investigative and family liaison skills already represented;

- some specialisation, for example in the deaths of children, self-inflicted deaths, and in workplace deaths;
- in Northern Ireland, the creation of a coroners' officer service from scratch.

3. Along with these changes of structure, the services need statements of their **functional objectives** and their **service values**. We suggest that they should be the following:

### **Functional Objectives**

#### **Death Verification and Certification**

1. *to confirm formally that death has occurred;*
2. *to certify to the best of the certifier's knowledge and belief that the death has occurred from natural disease and that there are no suspicious or other circumstances requiring investigation;*
3. *to give medical causes of the death which to the best of the certifier's knowledge and belief explain the death, are suitable for inclusion in the permanent record of the death, and enable the family to understand why it occurred;*
4. *to provide information on the cause of death for inclusion in the national mortality statistics which, along with other sources of information on the causes of death and disease, contribute to the maintenance and improvement of public health and safety;*

#### **Death Investigation through the Coroner Service**

5. *to satisfy the public that there is an independent and professional process for scrutinising deaths of uncertain cause or circumstances, and for investigating all deaths of people detained by the state or dying at the hands of state agents, or otherwise in situations of special vulnerability or where special vigilance is required;*
6. *to help families understand the causes and circumstances of the death of the family member in cases of significant uncertainty which cannot be resolved through other processes;*
7. *to contribute along with other public services and agencies to the avoidance of preventable deaths.*



### **Death Certification and Coroner Services: Service Values**

*These services should, for the differing circumstances of England, Wales and Northern Ireland, efficiently and promptly certify and where necessary investigate deaths so as to:*

- 1. meet public safety, public health, public confidence and human rights requirements for the protection of life throughout all sections of the community without discrimination or favour, with full independence and proper accountability;*
- 2. ensure that information on preventable deaths is made fully available and has proper influence;*
- 3. so far as is consistent with 1 and 2 respect individual, community and family wishes, feelings and expectations, including community and family preferences, traditions and religious requirements relating to mourning and the disposal of the dead; and respect family and individual privacy;*
- 4. allow participation by families and bereaved people in the processes of certifying and where necessary investigating deaths, treating them sensitively and with dignity, helping them find further help where this is necessary, and meeting their concerns and uncertainties as promptly and effectively as possible;*
- 5. provide a seamless service when certifying or investigating deaths with a single point of access for families, thus avoiding unnecessary confusion and distress.*

*The services should:*

- 6. be suitably staffed to deal with medical and legal and judicial responsibilities by people who are properly and consistently trained for their specific tasks;*
- 7. work to known and auditable standards;*
- 8. contain processes encouraging change and adaptation to future challenges.*

- 4. The service values are based on proposals in our consultation paper of August 2002. They reflect some changes suggested by respondents – notably the addition of a seamless rather than fragmented service for bereaved families, and the need to apply the principles relating to public health and safety without discrimination throughout the whole community.*
- 5. The new structures we recommend to end the fragmentation and inconsistency of the services are radical departures from the past. So, too,*

is the introduction of service standards and the means to monitor and deliver them. Nevertheless, our recommendations retain some key features of the present arrangements.

### **The Role of Patients' Medical Carers in Verifying and Certifying their Deaths**

6. Our recommendations involve the retention of the role of doctors looking after hospital and family practice patients in the certification of the majority of deaths. Other models are possible. An alternative would be to centralise the responsibility for certifying all deaths in the coroner's office. The certification of deaths would then be effected completely independently of the doctors who provide medical care. This might reduce the risks of unsafe or abusive certification. But it would mean taking out of the hands of the doctors who look after patients the responsibility for providing them with what we believe to be an important final service.
7. The failures of the present process to protect patients mean that systems improvement are necessary, and that henceforth all concerned – relatives, doctors, other health care staff, the police and coroners and their staffs – should show more wariness. But it is possible to carry mistrust too far. We think it important that doctors providing health care to patients should, individually and collectively, have the major responsibility for a prompt, fair and accurate certification of their deaths. The new support and safeguards we recommend will reduce the risks of malpractice but not at the cost of removing responsibility from those with whom it most sensibly lies.
8. We are proposing also that other health care personnel with suitable qualifications should verify that a death has occurred. We also suggest, in Chapter 6, that some nurses might be more actively involved in the certification of deaths.

### **Coronial and Alternative Systems for Investigating Deaths**

9. Our recommendations build on the inheritance of the coroner service for dealing with deaths of uncertain cause or circumstances. We have looked at alternative models, and at the development of the coroner tradition in Commonwealth countries.
10. We have brought together in Annex E some material on death investigation methods in Scotland and other European countries, the Medical Examiner systems used in many parts of North America, and the coroner service developments in Canada, Ireland, and Australia and New Zealand.

11. The Scottish and continental European practice is to use the generic criminal and judicial investigation process – the Procurator Fiscal in Scotland and the *procureur* in France, for example, for initial investigation; Sheriff Courts and a *Juge d’Instruction* then conduct further investigation if it is necessary.
12. That approach cannot be replicated in England, Wales and Northern Ireland because the institutions on which they are based do not exist. We have no service responsible for both prosecution and investigation (as the *Procurator Fiscal* is in Scotland and the *Procureur* in France). Nor do we have any equivalent of the French *Juge d’Instruction* who at judicial level oversees these processes.
13. The police and the Crown Prosecution Service have their own challenges and priorities. Even if suitable structures existed it would not be sensible to transfer to those services the responsibility for general death investigation. Much senior police opinion is against even the present level of police responsibility for supporting the coroner service through the provision of coroners’ officers.
14. Medical Examiner systems, as in North America, are led by pathologists, most of whom specialise in forensic work. The recent Home Office Review of Forensic Pathology Services estimates that there are 32 forensic pathologists practising in England and Wales<sup>1</sup>. It is already difficult to cover essential forensic work with this small workforce. It would not be sensible or foreseeably practicable to extend their role into the wider area of general death investigation. There is also a shortage of specialist histopathologists and about 10% of NHS consultant posts are unfilled.
15. More positively, the Omnibus Survey<sup>2</sup> work on public attitudes to coroners suggests that there is a reasonable understanding of their role, and a fair degree of respect for the concept of an independent judicial style of death investigation, even though there is not, generally, much detailed knowledge of where coroners work or exactly what they do.
16. Most of the overseas coroner systems that we have examined have been radically developed from their original base. We were particularly impressed by the professionalism and quality control we saw in Ontario, Canada and Victoria, Australia. We were also struck by the prompt and professional way in which a wide range of deaths are investigated and reported on, without routine resort to public inquests. We are proposing an improvement in the accessibility and quality of investigation and reporting in cases which do not involve inquests. Whilst we are also proposing a more flexible and sparing use of public inquests, the openness of the remaining parts of the coroner system will be enhanced.

<sup>1</sup> Review of Forensic Pathology Services; The Home Office, March 2003.

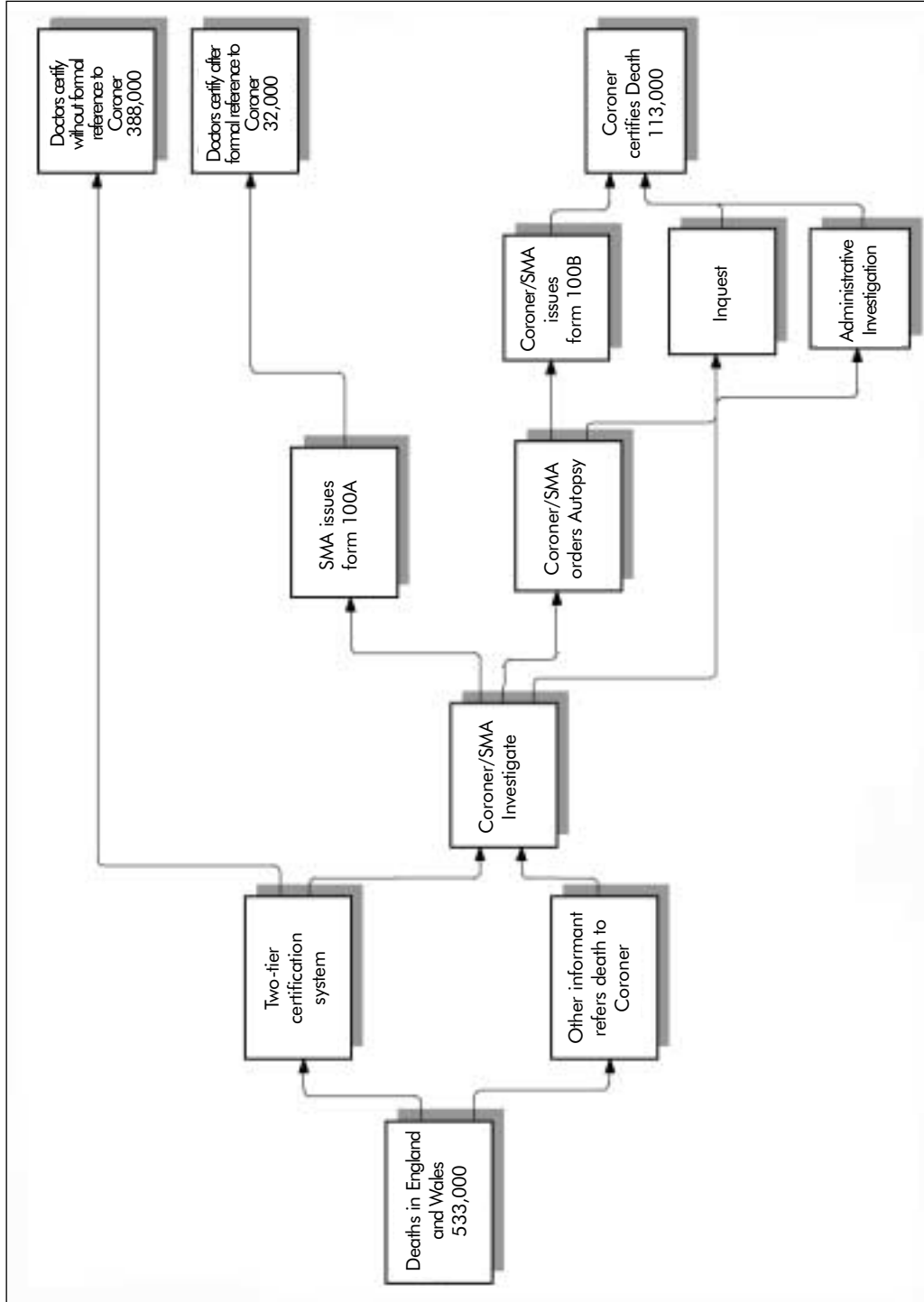
<sup>2</sup> Public Attitudes to Death Certification and the Coroner Services, ONS Omnibus Survey 2002.

### Chapter 3 - The New Approach

17. In the more detailed chapters which follow there are references to certain crucial structure changes we recommend which are relevant to some of the particular issues and problems we have examined. These are, in particular:
- the *Coronial Council*. This would be an independent statutory body, appointed by the Government, to oversee the public interest and family service aspects of death certification and the coroner services, to ensure common standards and adaptability to change, and to monitor the performance of the services and the standards of service given to families. Its membership would include people with insight into the experiences of bereaved families, and certain key independent public office-holders such as the Chief Medical Officer, the Registrar General, and the senior judicial figure in the coroner jurisdiction. Details of the Council's suggested functions and role are in Chapter 14, paragraphs 24 to 37;
  - the *Statutory Medical Assessor*. This would be a doctor working alongside each coroner. He would be responsible for auditing the death certification done by doctors in his area, dealing himself with many of the natural cause deaths reported to the coroner, helping the coroner in the medical aspects of wider circumstantial investigations, and acting as a bridge between the coroner service and the worlds of public health, healthcare, and public safety. More details of the role are in Chapters 5, 6 and 15;
  - the *second certifying doctor*. This would be the second of the two doctors certifying deaths not reported to the coroner. He would confirm that the certification was in order, be available for consultation with the family if they wished, and give authority for the burial or cremation of the body. Details of the role are in Chapter 6, paragraphs 27-34.
18. We recommend in several instances that the Coronial Council should issue *statutory guidance* made under the new Parliamentary legislation that will be necessary to bring the Council formally into being and give effect to the other major structural changes which we recommend. By *statutory guidance* we mean that the main legislation should explicitly give the Council powers to issue such guidance, and that the guidance issued under such powers should have legal force. It would not wholly remove the discretion from individual coroners in their handling of individual cases. It would, however, mean that any departure from the guidance could be legally challenged and that in the face of such a challenge the onus would be on the coroner to justify what he had done.
19. There is an overview of the new service structure we recommend in paragraphs 89-99 of Chapter 15.

20. Opposite, Figure 2 and 3 respectively, are flow charts summarising the new processes we recommend for handling cases. Figure 2 summarises the processes for all cases, and is comparable with Figure 1 in Chapter 1. Figure 3 covers the death certification process.

**Figure 2: Proposed future system of death certification and investigation**

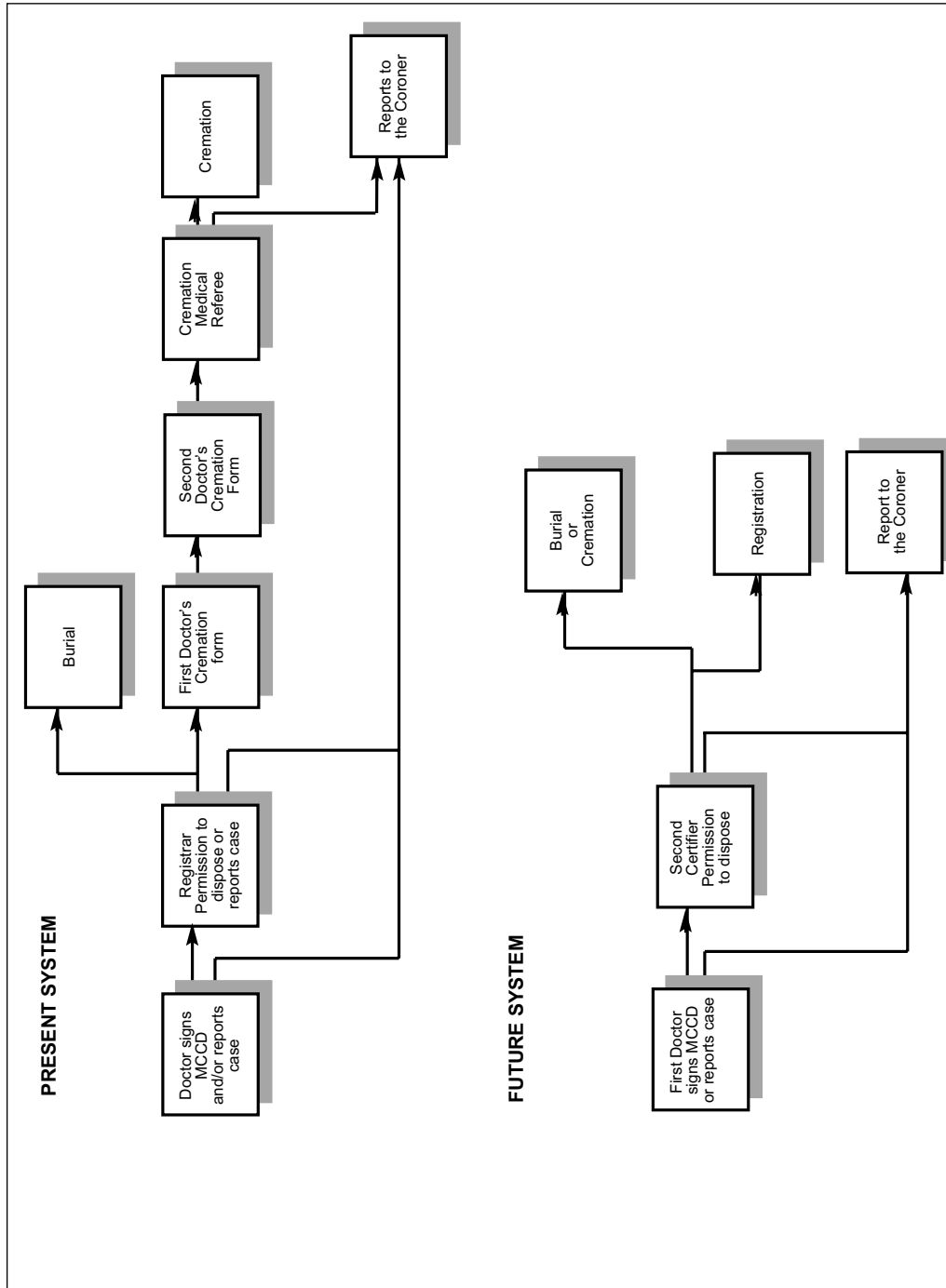


This figure illustrates the processes that we have in mind for the new system of certification and investigation.

The final column contains broad illustrative projections of the overall numbers expected to be dealt with by certificants and coroners. They assume that the new two-tier system will lead to a reduction in deaths referred to coroners of 56,000 cases.

We have not included the projections of the flows of cases through the processes in the new system.

**Figure 3: Current and future systems of death certification**



## CHAPTER 4 - REPORTING DEATHS TO THE CORONER

**In this chapter we examine the mechanisms for determining which deaths are reported to coroners, and the process of making such reports.**

1. Most systems for regulating deaths make a distinction between those caused by natural disease or the effects of old age, and those which occur in circumstances needing further and special investigation. The deaths needing further investigation usually include deaths in uncertain or suspect circumstances and those which occur in situations where special vigilance is required or public safety or health interests are identified.
2. The legal provisions governing the process for selecting and defining deaths which should be reported to coroners in England and Wales and in Northern Ireland are unclear and unsatisfactory.
3. There is a common law duty to report a death to the coroner in circumstances where an inquest might be required. It is traced by most commentators to a case three centuries old<sup>1</sup>. It applies to everyone, not just professional people involved in one capacity or another in dealing with deaths.
4. The Coroners Act 1988 requires coroners to hold inquests into violent or unnatural deaths, sudden deaths of which the cause is unknown and into deaths in prison. The Act does not however deal with the obligation to report such deaths. The reporting process, as legally defined, derives from Registration legislation which prevents a registrar from registering a death which has been reported to the coroner and, through regulations, defines certain deaths which the registrar should report.
5. Regulation 41 of the Births and Death Regulations 1987 requires a registrar to report a death to the coroner *"if the death is one:*
  - a. *in respect of which the deceased was not attended during his last illness by a registered medical practitioner; or*
  - b. *in respect of which the registrar:*
    - i. *has been unable to obtain a duly completed certificate of cause of death; or*
    - ii. *has received such a certificate with respect to which it appears to him, from the particulars contained in the certificate or otherwise*

<sup>1</sup> *R v Clerk* (1702). The lack of clarity as to who should supply what information to the coroner was recently commented upon by the Divisional Court in *R v Wiltshire Coroner, ex parte Clegg* (1996) 161 JP 521.



*that the deceased was not seen by the certifying medical practitioner either after death or within 14 days before death; or*

- c. *the cause of which appears to be unknown; or*
  - d. *which the registrar has reason to believe to have been unnatural or to have been caused by violence or neglect or by abortion or to have been attended by suspicious circumstances; or*
  - e. *which appears to the registrar to have occurred during an operation or before recovery from the effect of an anaesthetic; or*
  - f. *which appears to the registrar from the contents of any medical certificate of cause of death to have been due to industrial disease or industrial poisoning”.*
6. There are no other statutory legal provisions which require any other person to report a death to the coroner. The registrar is thus the only person on whom there is a statutory duty to report a death to the coroner.
  7. In practice most deaths are reported to the coroner by doctors or the police and the proportion of deaths reported by registrars is only 3.4% of the total. The police and doctors know which deaths would be reported by the registrar, and normally report such cases directly themselves, before the registration process starts. This avoids the delay which would be involved if the death were reported to the coroner only at the registration stage.
  8. It would be more logical if statute defined clearly and comprehensively the types of death which should be reported and who should report them to coroners. These lists might better be prepared by those responsible for the operation of the death investigation process, i.e. the coroner service, than by the registration service. The definition of their terms would be a suitable function for the statutory Coronial Council to perform.
  9. It would be desirable if parallel statutory guidance explained which people or institutions were normally expected to report deaths to the coroner.
  10. These might sensibly include the police, doctors, other regulated health care personnel, care inspectorate personnel, fire service personnel, and funeral service staff. The general expectation should however be that where a person who has died was receiving medical care before the death the doctor providing such care should in suitable cases report the death to the coroner. Similarly, where there is an unexplained or traumatic death to which the police are called, it should be the police who report to the coroner. It will be confusing to all if there are no clear ground-rules to that effect. The other groups' duty to report would be rarely exercised in practice.

11. There is also a need to make the reporting system more accessible to families, members of the dead person's circle of friends and "whistle-blowers" who might want to share anxieties about a death. Generally people in these categories should be encouraged to take up anxieties or uncertainties about a death with the second certifier in the two-tier death certification structure that we recommend, but if they have significant unresolved anxieties after doing so the second certifier should report the case to the coroner. Exceptionally, the coroners' office itself should be open to approach from families and others concerned about a death which, hitherto, had not been formally reported by other people or agencies.
12. **We recommend that:**
  - a. **the identification of the categories of death which should be reported to the coroner should cease to be legally centred on the registration process. The Coronial Council should issue statutory guidance on the types of death which should be reported to coroners and by whom, and should keep that guidance under review;**
  - b. **the doctor providing care during the final illness, or the police who attend the scene of a traumatic or sudden death, should normally report deaths to the coroner, but the range of people with a power to do so if necessary should include other professional health care personnel, and members of the care inspectorates, fire service personnel and funeral staffs;**
  - c. **families with anxieties about a death should be encouraged to pursue matters with the second certifying doctor. If they are left with significant unresolved anxieties the second certifier should report the death to the coroner. Families and others who have continuing concerns should be able to report a death directly to the coroners' office.**
13. Because the reporting process is assumed in law to be in the hands of the registrar, there is no obligation on the doctors or police who in practice report the large majority of deaths to inform the family that they have done so. Clearly, there will be some circumstances where that is not possible, particularly where the identity of the person who has died or the details of their family are unknown. But otherwise the reporting doctor or police should be under an obligation to take all reasonable steps promptly to inform the family that the death is being reported.
14. **We recommend that a doctor or member of the police reporting a death to the coroner should be obliged to take all reasonable steps promptly to inform the family that the death has been reported.**

15. In Chapter 12 we recommend that the coroners' office should, on receipt of a report of a death, immediately contact the deceased's person's family to give them information about the processes which may follow the report.

### **Deaths which should be Reported to the Coroner**

16. There is a range of material which explains which deaths should be reported to the coroner. The Home Office issues a leaflet, and for people needing to know the details and background there are good accounts in a number of specialist books<sup>2</sup>.
17. It would, however, be generally helpful if the official list of deaths which should be reported were in plain and easily comprehensible language.
18. Our suggested list follows. It expands somewhat the range of child deaths that should be reported by including any death of a privately fostered child, any death of a child being looked after by or on behalf of a local authority or on the "At risk" register, and any death of a child in a family where there has been a looked after child or a child on the "At risk" register.

<sup>2</sup> For example, *Coroner's Courts: A Guide to Law and Practice*, by Chris Dorries, John Wiley and Sons, 1991, Chapter 3.

## **DEATHS WHICH SHOULD ALWAYS BE REPORTED TO CORONERS**

Any violent or traumatic death, including all traffic deaths, workplace deaths, deaths apparently from self-harm, from injury, fire or drowning or other unnatural cause in the home or in any other place, or as a result of the operations of the law and order services.

Any death of a person detained in a prison or in military detention, in police custody, in a special hospital or under statutory mental health powers, or of a person resident in a bail or asylum hostel.

Any death from a range of communicable diseases defined from time to time by the Coronial Council as needing investigation by the coroner.

Any death in which occupational disease may have played a part.

Any death in which lack of care, defective treatment, or adverse reaction to prescribed medicine may have played a part, or unexpected deaths during or after medical or surgical treatment.

Any death which occurs, from any cause, of a woman who is either pregnant, or within a year of delivery, termination of pregnancy, ectopic pregnancy or miscarriage.

Any death of a child looked after by or on behalf of a social services authority, or on the "At risk" register, or in a family in which another child is or has been looked after or on the "At risk" register; or of a child being privately fostered.

Any death in which the use of addictive drugs may have played a part.

Any other death which a doctor may not certify as being from natural disease or old age.

Any death which is the subject of significant unresolved concern or suspicion as to its cause or circumstances on the part of any family member, or any member of the public, any health care, funeral services or other professional with knowledge of the death.

Any death in respect of which the Registrar has significant continuing uncertainties.

19. This list extends the categories of deaths which should be reported to include deaths which are the subject of any unresolved concern on the part of the family or others, including members of the healthcare and funeral services professions.
20. It also assumes that the statutory Coronial Council should be able to give guidance on the range of communicable disease deaths that should be reported to coroners. There is uncertainty about this, and no clear mechanism for ensuring a consistent approach amongst doctors and coroners. The Office for National Statistics has told us that:

*“A lack of definition has led to a divergence in coronial practice on certification and inquests into deaths from AIDS, and CJD related to BSE for example. No Government Department has accepted responsibility for addressing this<sup>3</sup>”*
21. The list should determine standard national practice and requirements for reporting throughout both national jurisdictions. This is without prejudice to our recommendation in Chapter 7 that area coroners should have powers exceptionally or temporarily to require other categories of death to be reported.
22. **We recommend that the statutory definitions of deaths which should always be reported should be in clear and easily comprehensible language, and should lead to consistency of the basic reporting standards and requirements in each national jurisdiction. The reporting criteria we suggest expand somewhat on the current range of child deaths which should be reported, give families and members of the healthcare professions a role of last resort in reporting deaths to the coroner, and envisage a role for the statutory Coronial Council in determining the range of communicable disease deaths that should be reported.**

### Process for Reporting Deaths to the Coroner

23. The Births and Deaths Registration Act 1953 requires doctors to issue a medical certificate of the cause of death even when the death is being referred to the coroner. The Office for National Statistics consider that this requirement causes confusion. The Brodrick Report<sup>4</sup> recommended its removal as have various other committees and bodies since.

<sup>3</sup> Memorandum of 9 January 2003 to the Review.

<sup>4</sup> The Report of the Committee on Death Certification and Coroners (Published by HM Stationery Office November 1971, CM 4810).

24. Nevertheless the requirement remains in place. **We recommend that it should be repealed and that, as the Office for National Statistics proposes, where a doctor is reporting a death to the coroner there should instead be a report in standard form detailing the reasons for the referral, giving a brief medical history, a tentative diagnosis if there is one, and details of any relevant investigations which have been completed or whose results are still awaited.**
25. The Office for National Statistics has also drawn attention to a problem that they have in obtaining timely information from coroners in cases where an inquest is to be held. They say that they receive no information from coroners until inquest procedures are all complete. Such delays, which can be up to a year or more, make it difficult for the ONS to provide fully up-to-date and timely mortality data and mortality patterns. They have in mind, for example, cases of possible suicide where careful monitoring of trends is important and late information can make it difficult to discern them. They propose that coroners should as soon as possible provide some factual information to them on such deaths and their circumstances so that they can make a provisional entry in their figures.
26. **We recommend that, in categories of deaths to be defined in detail by the ONS, coroners should as soon as possible after the death inform ONS of its circumstances, but in terms which do not prejudice the inquest outcome. After the inquest they should send the inquest findings to the ONS in the normal way.**

## **PART 2**

# **DEATH CERTIFICATION**

## CHAPTER 5 - DEATH CERTIFICATION SUPPORT AND SUPERVISION

**In this chapter we recommend new structures for supporting and supervising death certification.**

### Introduction

1. Nearly two-thirds of all deaths are registered after being certified by general practitioners or hospital doctors. The death certification process serves several purposes:
  - it is an essential preliminary to registration of a death, and therefore to the burial or cremation, the funeral and the mourning of the person who has died;
  - it is a safeguard against the disposal of bodies without professional scrutiny of the need for further investigation;
  - it is the main source of the national mortality statistics which are important for public health and health care.
2. There is clear evidence that the process is not performing the first two of these functions satisfactorily and that there is need for improvement in the way it contributes to the third function.
3. As a preliminary to registration and the disposal and funeral arrangements the process is apt to be subject to delays and difficulties, partly attributable to changes in general practice which have created difficulty in the prompt certification of deaths occurring at home during the night or at weekends. In particular there has been increasing use of emergency or locum doctors with no previous contacts with the patient or access to medical records. Delays or uncertainties in having a death confirmed and certified are extremely unwelcome to families.
4. The Shipman case has shown that the process is not an effective safeguard.
5. There is a substantial research literature showing that a significant proportion of certificates are wrongly completed in various ways and that the quality of the national mortality data suffers accordingly. Clarke and Gladwin in their report for the Review say:

*“Our research has suggested that the process of death certification even for the most routine of cases remains outdated, complex, not well understood by those who use it and open to abuse by those with a criminal intent. Perhaps because of this basic lack of understanding,*



*doctors do not necessarily produce an accurate death certificate. The lack of accuracy has been indicated by research using a number of different methods in a variety of settings and in a number of different countries.....*

*“The literature on the quality of death certification does not sufficiently distinguish between two aspects. One is the poor completion of certificates which may occur for a number of reasons, e.g. lack of awareness of the reasons for the different sections of the certificate or illogical sequencing. The second has been identified by pathologists comparing post-mortem findings with information written on death certificates. Substantial discrepancies and levels of error have been identified. The cause of error may be a more serious one i.e. inadequate diagnosis of the cause of the patient’s last illness or underlying cause of death....”<sup>1</sup>*

6. The legislation under which certification is done is in many respects obsolete and unhelpful. The structures through which it is undertaken give the doctors doing it inadequate support and help, and the public little assurance that it is being done to proper professional standards.
7. In our consultation paper of August 2002 we outlined an assessment on these lines. It was strongly supported by all respondents, not least those from the medical profession.

## Legislation

8. The Office for National Statistics has said that the legislation governing death certification – the Registration of Births and Deaths Act 1953 for England and Wales – is inflexible in that unlike otherwise comparable legislation in Scotland and in Northern Ireland it allows no scope for piloting or experimentation with changes, for example, electronic certification, nor for differences of approach to certification in different settings.<sup>2</sup>
9. Changing the death certification system in any significant way cannot safely or sensibly be done without trial and piloting. A legislative framework which does not allow for adaptation, piloting and justified variety of approach is clearly defective. We recommend that the legislation governing death certification in England and Wales should be amended to allow for adaptation of the certification system, for the piloting of change, and for differences of approach in different settings where this would be desirable. There is the same need for legislative change in Northern Ireland.

<sup>1</sup> Clarke and Gladwin, op cit, paragraphs 5.2.1 and 5.2.4.

<sup>2</sup> Memorandum to the Review from the Chief Medical Statistician, ONS, 25 November 2002.

## **Support, Audit and Supervision; A New Post of Statutory Medical Assessor**

10. Doctors are given little help in death certification. They may receive some training in medical school or in their first year of hospital training, and some coroners give talks in local hospitals and to local medical groups. The General Medical Council has issued some guidance on it, and the books of blank death certificates that the registration service provides contain guidance on the process.
11. For many doctors in clinical practice certifying death is relatively rare – on average general practitioners will certify deaths three or four times a year.
12. Death certification is not part of doctors' contractual National Health Service responsibilities. It is not therefore subject to monitoring in hospitals by Trusts or Universities or in general practice by the primary care trusts. Nor is it within the clinical governance arrangements for hospitals.
13. Coroners have no formal responsibility for death certification nor any responsibility in respect of deaths not reported to them. They operate a largely informal advice service to doctors on whether and if so how they should certify individual deaths. This advisory service is performed in England and Wales, often over the telephone, largely by coroners' officers who have experience and investigative skills but for the most part no health care or medical training.
14. The Registration Service is legally responsible for registering deaths and for reporting deaths needing further investigation to the coroner. However it has no management or supervisory powers over the certification process and, as we have seen in Chapter 4, its role in reporting deaths to coroners has now for the most part been superseded by direct reports from doctors and the police. The Registration Service is more the client of the death certification process than its master.
15. There is no public service or authority or other institution tasked and resourced to see that the death certification process is being properly done and to take steps to ensure that it is. In particular there is no reliable mechanism to check that deaths which should be investigated by the coroner are reported to him.
16. There is no reason to doubt that the large majority of doctors carry out death certification with integrity, but major structural reform is clearly necessary.
17. Structural change should achieve three objectives:
  - to provide in each area an expert medical focus for continuing education and support of doctors and other healthcare personnel involved in death certification and the verification of death

- to audit the performance of death certification in the area with particular reference to observance of the criteria for reporting deaths to the coroner, and to the quality and suitability of cause of death data
  - to establish a link between the presently separate worlds of death certification and the investigation of deaths by the coroner
18. To achieve these objectives we envisage the creation of a new post in the coroner's office to work alongside the coroner. It should be filled by a doctor. The functions of the post should be set out in legislation, to make clear its independence of any health service provider or professional grouping, and its answerability under the law. We give it the title of Statutory Medical Assessor.
19. The responsibilities of the post should include the support and training responsibilities already referred to. The audit responsibilities should involve conducting or supervising periodic audits of the death certificates completed by all the doctors in general practice and hospitals in the area. The audits would cover broadly trends in the rates and given causes and circumstances of death in the cases certified by each doctor and in each practice and hospital or other facility. The purpose would be to identify as quickly as possible any apparently unusual trend or pattern for such further scrutiny as might be necessary.
20. Most such audit could be done using the certificates lodged with Registrars. The statistical framework would need careful working out and the detailed analysis would probably best be done by the Office for National Statistics centrally. Clarke and Gladwin report some doubt whether a robust and sufficiently sensitive statistical framework could be devised which would provide early enough warning of serious malpractice<sup>3</sup> However there is significant work in hand on the issue in this country and elsewhere<sup>4</sup>.
21. We outlined a proposal on these lines for a new post with responsibility to support and audit death certification in our Consultation Paper of August 2002<sup>5</sup>. Nearly all respondents supported the idea of creating such a post and broadly the functions envisaged for it. Some medical interests expressed concern about the medical manpower implications of staffing this new function satisfactorily when the National Health Service is expanding. We address that more fully in Chapter 15.

<sup>3</sup> Clarke and Gladwin, *op.cit.* 4.10.10 to 4.10.13.

<sup>4</sup> The Department of Health has informed us that it has in hand work on the assessment of death rates in general practices. It is currently carrying out a scoping study to look at linking mortality data with NHS data, and plans to pilot this in the Autumn 2003. We were also told of work in hand between the Ontario Coroner Service and STATISTICS CANADA to identify unusual patterns in doctors' death certifications.

<sup>5</sup> The post was then described as "Medical Auditor". The idea found more favour than that title which was generally disliked by medical respondents. One suggested alternative was "Medical Examiner", but this is the title used in North America to denote a forensic pathology-led death investigation service. To use it in England and Wales and Northern Ireland for a very different function would cause confusion.

22. **We recommend that to provide support for doctors in death certification, to audit the death certification process and create links between death certification and the death investigations performed through the coroner service, there should be a new post of Statutory Medical Assessor created in each coroner area, to be filled by doctors working alongside the coroner.**
23. We envisage further functions for these posts, in the selection and support of the second tier of doctors in the new death certification process described in the next chapter, and in support of the coroner's investigative work and the choice, interpretation and use of scientific, pathology and other investigative tests for the coroner as explained in chapters 10 and 13.

### Death certification in Medical Education and Training

24. The Office for National Statistics has raised issues about the place of death certification in undergraduate and postgraduate medical education. They say that "Training of medical students and doctors on death certification and related issues is accorded low priority by medical schools and postgraduate centres"<sup>6</sup>.
25. They suggest that: "*The importance of accurate death certification and the knowledge and skills required for it should be taught as part of a wider course covering approaches to death, dying, palliative care and bereavement. In addition to this focus on patient and family care, death certification should also be covered in the pathology and public health curricula*".
26. They point to a lack of uniformity in the coverage of these matters in undergraduate and postgraduate education. They acknowledge that initial training needs to be followed up by in-service training, and suggest an imaginative scheme linked to electronic death certification which we endorse.
27. The work of the Statutory Medical Assessor will be an important part of the in-service training which they advocate.
28. It is important that the subject is given proper coverage in all undergraduate and all relevant postgraduate medical education. **We recommend that the General Medical Council and the Royal Colleges should acknowledge the importance of death certification in the initial training and continuing professional education of medical students and doctors.**

<sup>6</sup> Memorandum of 25 November 2002, op cit.

## CHAPTER 6 - VERIFYING AND CERTIFYING DEATHS

**In this chapter we describe the new systems we recommend for confirming that a death has occurred, for certifying deaths not reported to the coroner, and for obtaining authority to bury or cremate the body.**

### Introduction

1. After a death has occurred there are currently four processes which a family may need to go through before the body can be buried or cremated and a start can be made on the settlement of the estate:
  - verification that a death has occurred;
  - certification of its cause by a doctor who provided care in the final illness (unless the death is reported to the coroner);
  - registration of the death by taking the certificate of the cause of death to the local registrar's office;
  - authorisation of the disposal of the body by the registrar at the same time as the death is registered. When that authorisation is received the family member or personal representative takes the authorisation form to the funeral director who can then make the disposal arrangements.
2. If the body is to be cremated there are four additional steps that need to be taken. After the registration of the death the family member or personal representative needs additionally to:
  - make an application for the body to be cremated;
  - obtain a cremation certificate from the doctor who has completed the medical certificate of the cause of death;
  - obtain another certificate from another doctor endorsing the cremation certificate. This doctor is required by the regulations to view the body and to contact the certifying doctor before completing his certificate;
  - obtain the authorisation of the crematorium referee.
3. The family or personal representative may not be fully aware of all these steps because in practice funeral directors often attend to all the extra cremation steps after the relative or personal representative has completed the application for a cremation.

## Chapter 6 - Verifying and Certifying Deaths

4. The certificatory processes needed for a burial have no cost to the family, but the extra steps needed for cremation cost in all about £100 – i.e. £45.50 to each of the doctors completing the cremation certificates, and £5.50 to the crematorium referee. These charges are often met by the funeral director and recovered from the family as part of the professional funeral expenses. Not all families will be aware of them.
5. Some 70% of deaths in England and in Wales lead to cremations, though members of some religions – notably Jews and Muslims – do not practise cremation and bury the body in the earth.
6. For largely cultural reasons in Northern Ireland the cremation rate is considerably lower – at 17%.
7. In England and Wales the cremation rate rose gradually from a low base in the early part of the twentieth century and has been steady at roughly its present rate for the last decade or so. In Northern Ireland the cremation rate has been rising slowly, and continues to rise at about 1 percentage point a year.
8. In our consultation paper of August 2002 we:
  - pointed out that the process of verifying death is not in itself a statutory process separate from or separately identified within the certification process and suggested that it should be defined as a process in its own right which might be performed by suitably trained personnel not necessarily doctors;
  - drew attention to structural weaknesses in the cremation certification process undermining its value as a safeguard and suggested that it might be discontinued in favour of a common certification process for burial and cremation;
  - invited views on whether such a common process should involve certification by one or alternatively two doctors, and whether either should necessarily view the body (and if so which one of the two);
  - drew attention to a difference between Northern Ireland and England and Wales in the period prior to the death within which a certifying doctor must have attended the patient (unless he views the body after death) – in England and Wales this is 14 days, in Northern Ireland 28 days.
9. We also:
  - drew attention to the fact that the bereaved family is given no participatory status in the certification process. They have no right to see the doctor's certificate of the medical cause of death, which when the process follows the pattern strictly required by the law, is delivered

to the registrar by the doctor or if given by the doctor to the family may be in a sealed envelope;

- acknowledged the importance of prompt process to families, especially in Northern Ireland where the tradition is for burial within three days of death, and in the Muslim and Jewish communities who prefer to inter within a day or so of the death.

### Verification of Death

10. There was general support amongst those respondents who commented on the matter for a clear and specific process to verify that a death has occurred, and for this verification to be performable by suitably trained personnel who need not be doctors.
11. The point is of particular importance in some situations, for example:
  - when someone is taken very ill at home, the ambulance or a paramedic is summoned and death occurs before they arrive or while they are there;
  - where someone dies in a public place, for example in a traffic fatality or from a heart attack, the scene is attended by an ambulance crew;
  - undertakers will not normally move a body from a scene of death until there has been independent professional confirmation that death has occurred and that the removal is in order. If a doctor has been at the scene he can provide this service but there may be a considerable wait before a doctor can come. If the body cannot be moved before he does so, the family in a home death may be left for a considerable time alone with the body. If the scene is a public place, the ambulance and the police may have to wait for the arrival of a doctor when they could be attending other urgent duties. As well as causing distress to families, these delays can involve considerable inconvenience to members of the public, e.g. where, in a death on a railway, trains are held up until a doctor arrives at the scene to confirm that death has occurred.
12. In some localities there are protocols agreed between the police, the ambulance service and local funeral directors which enable specific and suitably trained groups of personnel to certify that death has occurred so that the undertaker can remove the body without delay. The personnel are usually qualified ambulance staff and paramedics. We saw such a protocol, for example, in Nottingham. But there are places where they do not exist and the problems which result are therefore unresolved.

13. **We recommend that:**
- a. **all deaths should be subject to professional verification that the life has ended. This verification should be made after the body has been viewed;**
  - b. **verifying that a death has occurred should be statutorily defined as a step distinct from certifying the cause of death;**
  - c. **verification of death may be performed by a doctor (whether or not the doctor who also certifies the cause of death), or by other suitably qualified personnel;**
  - d. **there should be, in England and Wales and Northern Ireland respectively, national protocols agreed with representatives of the police, the medical and other healthcare professions and the funeral services industry, governing the circumstances in which verification should occur, the information that should be recorded, the groups of personnel able to perform the function and the training they should have.**
14. We suggest that the groups should include doctors, registered nurses, qualified ambulance personnel and paramedics. We attach at Annex A to this chapter a draft verification form as a starting point for the detailed work necessary to carry forward this recommendation. We address some issues about verification specific to care homes in Chapter 11.

### **Certification**

15. Virtually no consultation respondent argued in favour of retaining the separate and additional process for certifying cremations. Cremation interests themselves have long argued for a common process governing all disposals whether by burial or cremation. All those who commented accepted that the process in which a second certifying doctor may be chosen by the first certifying doctor from any doctor of his acquaintance lacks independence and cannot be regarded as a proper safeguard, and that the crematorium referees often receive the papers at too late a stage for any intervention to be practicable. Since by that stage the death will have been registered and the family will already have authority to dispose of the body, there is nothing in the process itself to prevent a family refused cremation approval by a crematorium referee from having the body buried, or even approaching another crematorium.
16. The separate and additional cremation certification system dates from a time when cremation was relatively new as a process and no doubt reflected concern that the incineration of bodies might remove evidence of foul play because exhumation of a body for further forensic examination – which still remains possible after it has been buried -



would not be possible after a cremation. Further and special checks were seen therefore as an essential safeguard.

17. The Shipman experience combines with the structural weaknesses of the cremation certification system to mean that it cannot sensibly or safely be retained.
18. There are however significant issues about the character and purpose of any certification system which would deal equally with all deaths whether the route of disposal is burial or cremation, and there are features of the cremation system which should not be lightly jettisoned.
19. Firstly, the cremation application that has to be made by a family member or personal representative gives the family some status in the certification process which the ordinary certification does not give them. It also requires some information about the circumstances of the death which is not required for the Medical Certificate of the Cause of Death, including a statement that to the applicant's knowledge there are no grounds for suspecting "violence, poison, privation or neglect", and the location of death and the type of location (for example nursing home).
20. Secondly we were informed in several of the hospitals which we visited in the regions that they use the second certification required under the cremation scheme as a means of doing broad informal checks on the standards of death certification in the hospital. Many such second certifications are done by doctors in the pathology department who are a source of expertise and advice to the hospital as a whole on death certification issues.
21. We must also report that though the weaknesses of the cremation certification arrangements were widely acknowledged in the responses to our consultation paper, virtually no respondents thought it would be satisfactory to rely simply on a single medical opinion as to the cause of death and the suitability of allowing the disposal of the body without further investigation or inquiry. All private individuals and voluntary groups thought that this would be unacceptable. This was also reflected in comments we received from police and prosecuting interests, and from many medical responses, individual and collective.
22. It may be that some of these responses underestimate the reliability and integrity of doctors in their certification work. However, we said in the introduction to our Report that we see a restoration of public confidence in the death certification process as one of the two essential objectives of reform. Our judgment has to be that this objective will not be achieved unless there is a system which brings two expert professional opinions to bear on each death before it is accepted that the body may be buried or cremated without further investigation or inquiry.

23. This conclusion holds good, in our opinion, even if, as we recommend in Chapter 5, all certifications are subject to general periodic audit by the Statutory Medical Assessor working with the coroner. This audit and the Statutory Medical Assessor's support function to all doctors who certify deaths would be of value. It would improve the quality of certification generally in terms of the accuracy of the disease information given in certificates and encourage more attention and wariness being brought to the certification process. But - particularly in view of the likely difficulty of developing methods of statistical analysis which would quickly show up suspect patterns of certification – it would not be a substitute for a second and independent professional opinion in each case.
24. Also of relevance is the intention, described in the Government's White Paper on the reform of Civil Registration, that the registration of deaths should become possible electronically by e-mail or fax. This "remote" registration would be an alternative to visiting the Registrar. The personal visit to the Registrar, in the privacy of his or her office, is an opportunity for the family member to participate in the process following the death. It is also an opportunity for the family informant to express any doubts about the death, and for the registrar to explore any questions with the informant that the material may prompt. This may not be a major safeguard but its loss is not irrelevant to the design of a new certification system.
25. For these reasons, **we recommend that:**
  - a. **the existing cremation certification process should not be continued;**
  - b. **there should be a common certification process for all deaths not reported to the coroner, whether the body is to be buried or cremated;**
  - c. **that process should in each case bring two professional opinions to bear before disposal of the body is authorised.**

### **Form of Two-Tier Certification Process**

26. We address in paragraphs 61–69 below whether both these professional opinions need to be given by doctors. We conclude that in the longer term there would be scope for enabling some nurses – particularly nurses who achieve the newly introduced 'nurse consultant' status – to have a role in death certification but that for the time being the professional scrutiny of deaths not reported to coroners should at both levels be undertaken by doctors.

27. The first certificant would in principle be the doctor who had looked after the patient during the final illness whether in hospital or in general practice though we have some relaxations of the present arrangements to suggest in general practice – see paragraphs 54-55 below.
28. In our consultation paper we suggested that instead of allowing the first certifier, or the funeral director, to make his own choice of second certifier from any doctor of his acquaintance, second certifications should be done only by members of a panel of doctors in each locality chosen and supported by the Statutory Medical Assessor. They would be predominantly doctors in clinical practice who would perform the certification role part-time in addition to their normal patient care.
29. This concept attracted considerable support from those who commented. They recognised that it would enhance the independence of second certifiers, and help to build up standards in and a greater sense of collective responsibility for death certification.
30. We shall come to some specific recommendations about how the system would work in the certification of hospital deaths but **we recommend that for the second certification of deaths in the community:**
  - a. **the Statutory Medical Assessor in each coroner area should appoint a panel of doctors to provide all second certifications;**
  - b. **they should be experienced clinical doctors, chosen for their skills and professional independence. They could still be in clinical practice or recently retired from it;**
  - c. **they should be given some initial training, and some continuing training periodically after appointment;**
  - d. **they should concern themselves both with the safety of the certification process – i.e. the safeguarding against certifying deaths which should be investigated by the coroner or the police – and with the accuracy and suitability of the disease data given in the certificate;**
  - e. **they should invariably speak to the first certifier, and see some of the clinical case notes, including the note of the last occasion the first certifier treated the patient, any recent hospital discharge note or other note authenticating the diagnosis relevant to the death, and the list of medicines prescribed for the patient in the period preceding death;**
  - f. **they should be available to talk to or see members of the immediate family if that were to be requested.**

## Chapter 6 - Verifying and Certifying Deaths

31. Second certifiers would not perform this function for their own patients or for patients from the general practice in which they worked. Subject to that, it would be for the first certifier to choose a second certifier from the panel and to arrange for the passing of papers to him, by secure and tamper-proof e-mail if and where this was available and by fax or direct delivery in other cases. It would be necessary for the mechanics of choice to be effected on a rota basis; this would avoid the first certifier routinely choosing the same second certifier and the development, thus, of arrangements which could be said to be unhealthily “cosy”.
32. There are clearly issues about the availability of second certifiers in sufficient numbers and with the accessibility needed to ensure that the process is promptly conducted.
33. So far as we can judge the existing cremation process which involves a second doctor in each case performing some of the functions we foresee for the second certifier here operates without too much difficulty in terms of the availability of doctors. They are paid fees for the work and it would be necessary for the doctors engaged as second certifiers in the new system to be engaged on terms which would result in the delivery of a satisfactory level of service to the public.
34. Work done by Peter Jordan suggests that in England and Wales the overall amount of medical time spent on cremation certification is roughly the equivalent of 99 whole time doctors. His broad assessment of the overall amount of medical time required in the second certification of deaths is the equivalent of 105 whole time doctors. The increase in the overall medical time involved is therefore around 5 per cent.
35. Second certifiers, whether in the community or in hospitals – see paragraphs 47–53 below – would be both experienced representatives of local clinicians, and in effect representatives of the regulatory and quality control functions performed from the coroner’s office by the Statutory Medical Assessor. In respect of their certification function they could be regarded as out-posted representatives of the Statutory Medical Assessor. There is, therefore, a fine line between the concept of second certification as we have developed it and giving the coroner’s office a surveillance function in relation to all deaths, including those not initially judged to have any characteristics requiring special investigation.
36. Those deaths that clearly do need reporting to the coroner for any of the reasons given in Chapter 4 should be reported at the earliest possible stage – that is normally by the first certifying doctor or sometimes by the police who attended the scene. Second certifiers would be able to report a case to the coroner if they judged it to need further investigation but we would expect such cases to be rare and that the reporting of most deaths to the coroner would be done by first certifiers directly.

37. The most likely circumstance in which a second certifier would report a death to the coroner which the first certifier had been prepared to certify would be when a family had exercised its right to talk to the second certifier and still had significant unresolved doubts or anxieties about the death.
38. To enable the family to benefit from that right it would of course be necessary for first certifiers, or their practice staff, to inform the family of the name and contact details of the second certifier.

### Viewing the Body

39. It has been remarked as a defect in the existing certification arrangements that the UK is one of the few countries in the developed world where there is no requirement for a dead body to be viewed by a doctor before its burial is authorised.<sup>1</sup> This is so because where there is to be a burial the certifying doctor does not have to view the body after death if he has seen the patient within 14 days of the death.
40. Most of the interests who commented on this point in our consultation said that they thought that one or another of the doctors in a two-tier certification process should view the body after death.
41. The British Medical Association said that the obligations of the second certifier might include reviewing the patient's medical notes, talking to the first certificant and examining the body.
42. However, they go on to say:

*"To be of any value, examination of the body needs to be carried out by a doctor with appropriate training in forensic medicine, and the knowledge and skills required are not amongst those that doctors would routinely be expected to have....a perfunctory examination by the second certificant is therefore also of no real value and, if an examination is to be legally required, it is essential that this is done thoroughly...The examination should also be performed in an appropriate environment, preferably a mortuary, and should be properly documented. In practice, these arguments will need to be balanced against the financial implications and a more realistic solution might be to require an examination in certain specified*

<sup>1</sup> S. Leadbeatter and B. Knight *Anomalies and Ambiguities in the Disposal of the Dead*, article in the Journal of the Royal College of Physicians of London 1986 and in several articles since; Peter Franklin *A Review of the Law of England and Wales Relating to Death*, research thesis 1993; it also seems to have featured significantly in the concerns put to the Brodrick Committee by the BMA (section 5 of the Brodrick Report).

*circumstances (which might for example include an expression of concern by the first or second certificant, another health professional, or a relative)”<sup>2</sup>*

43. Peter Jordan has estimated for us that the costs of requiring doctors to view in mortuaries all bodies of people who die outside hospital would lie between £10 million and £15 million a year for England and Wales.<sup>3</sup>
44. Such extra costs would be equal to 14% to 21% of the present £71.4 million direct cost of the coroner service in England and Wales. If extra money on this scale were to become available to improve the certification and investigation systems it would not be sensible to spend it in this way, even if the real resources of forensic skill were available to spend it on. We have in any case already recommended that all deaths should be verified after inspection of the body at the scene of death by a suitably qualified and trained healthcare professional.
45. We therefore agree with the approach outlined by the BMA. **We recommend that there should be no general requirement that all bodies should necessarily be viewed by the certifying doctor before certification. Bodies should be viewed by a professional with the necessary specialist forensic skills at the discretion of either certifier or the coroner, in cases where the process would clarify an uncertainty or anxiety, including any uncertainty or anxiety raised by a family member.**
46. In practice it is likely that such cases would be reported by the second certifier to the coroner.

### **Certifying Deaths in Hospital**

47. In principle the two-tier certification process should be the same whether the death has occurred in hospital or in the community. The first certifier should have looked after the patient during the last illness, and the doctors able to perform the second certifications should be selected and accredited by the Statutory Medical Assessor.
48. We have said that for community deaths a doctor should not second-certify any death of a patient in the care of the practice in which he himself works. There is an issue whether the same principle should extend to the second certification of deaths in hospital – i.e. whether all second certifications of hospital deaths should be performed by doctors not engaged in any form of clinical practice in that hospital.

<sup>2</sup> BMA submission to the Review of 27 November 2002.

<sup>3</sup> The lower estimate assumes that since most mortuary costs are met by the coroner service the significant extra utilisation of mortuaries that would be necessary if bodies were to be viewed on this scale would reduce unit mortuary costs to the coroner service.

49. There is an argument of principle in favour of requiring second certification to be wholly independent of the hospital in which the death occurs. On the other hand, as with the issue of viewing the body, there are issues of scale and cost – not so much in money terms but in the use of the real resources of medical skill, and the time of family members wishing to see a second certifier and perhaps needing to travel to a different town or locality if second certification by a doctor from the same hospital were not permitted.
50. Some 285,000 deaths a year in England and Wales are certified in hospitals without reference to coroners so the practical consequences for relatives and doctors alike are of major importance.
51. General and acute hospitals are much more diversified organisations than general practices. They contain a number of specialisations and often a large number of consultants, working in separate departments or “firms”.
52. The most practical approach to the issue, in our view, is for the system to require that no hospital death should be second-certified by any doctor from the same department or “firm” as provides the first certifier, and that the Statutory Medical Assessor should in respect of each hospital not only “credential” the doctors who may perform second certification, but also approve the hospital’s policy concerning its patterns of referral for second certification to its own doctors to ensure that all second certification would be done with proper independence.
53. **We recommend that for deaths in hospital there should be in principle the same two-tier certification process in which the Statutory Medical Assessor would appoint and support doctors to perform second certification. He should also approve the hospital’s policy for ensuring that in referring deaths for second certification by approved doctors engaged in clinical practice in the same hospital a satisfactory degree of independence of first certifiers would be achieved.**

### **Authorising Disposal of the Body**

54. We have a change to recommend in the arrangements for authorising the burial or cremation of the body. At present this authorisation is given when the death is registered – that is to say after the doctor has certified the death. That is a sensible provision while it is possible for a single doctor to certify a death. It would plainly be unwise for the doctor who has looked after a patient up to the time of death also to certify the death as requiring no further investigation and then in addition without any independent check whatsoever to authorise the burial of the body.

55. The introduction of a certification process requiring an independent medical check on the judgement of the first certifier, validated by some clinical documentation, alters the position in two ways. Firstly, there will be an independent medical check whereas under the present arrangements there is none in burial cases. Secondly, there will be a further stage in the process of obtaining authorisation of a burial unless there is some compensating change in the system. This could cause delay unwelcome to families especially in Northern Ireland where the tradition is for prompt burial. The prospect of such delay would also be objectionable to members of the Jewish and Muslim communities since it would threaten their custom of burial on the day of death if possible.
56. **We recommend that authorisation to dispose of the body should be given by the second certifier at the time he completes the second certification, and should not wait on the process of registering the death.**
57. This would keep the number of stages through which the family need to go before the burial at the same as it is now, that is two.
58. It would remain important to ensure that the death was reliably and quickly registered. The family would have an incentive to complete the process properly in most cases because without the registration certificate they will be unable to process administration of the estate. It might however be necessary to introduce a specific statutory duty on the next of kin or personal representative to register the death within a defined period of its certification, and to monitor its implementation through the funeral service industry and the certification process.

### **Professional Status of Medical Certifiers**

59. We consider that the existing requirement for a certifying doctor to be fully registered as a medical practitioner should be maintained. For second certification in the community we have already said that the second certifiers to be selected by the Statutory Medical Assessor should be experienced clinicians. Second certification in hospital should represent the considered judgement of a mature and fully qualified hospital specialist. We consider that second certifiers in hospital should therefore be of consultant status.
60. **We recommend that all certification should be done by fully registered doctors, and that second certifiers in hospital should be of consultant status.**



### **Certification by Medical Practice**

61. At present the patients of NHS general practitioners are registered with an individual named general practitioner even though most family doctors work in partnership and patients often see other members of the practice than the doctor with whom they are registered. The Health Departments have been negotiating new contractual arrangements for general practice under which the patient's registration would be with the practice rather than an individual doctor within it.
62. When that change occurs it would be sensible if any doctor in the practice with access to the patient's records who is willing and available to certify a death should be able to act as first certifier if the practice member who last or regularly looked after the patient is not available.

### **Maximum Interval between Death and Last Attendance**

63. In England and Wales doctors may certify a death if they have seen the patient within the previous 14 days, or alternatively if they view the body after death. In Northern Ireland the rule is similar except that the maximum interval allowed between the death and the previous attendance is 28 days not 14 days.
64. The longer Northern Ireland interval may be related to the Northern Ireland custom of prompt burial and may also reflect the rural character of much of Northern Ireland. It is not however clear that the maximum intervals in either jurisdiction, or the difference between them, have any precise rationale.
65. We are recommending a new certification structure in which every death not reported to the coroner should be certified by two doctors, of whom the second would be from a panel appointed for the purpose, and that the second certification should be supported by material from the patient's record. We are also recommending a new process for auditing and supporting all certifications.
66. In this new context we think it sensible to bring the maximum interval between the death and the last visit by the certifying doctor, or his practice partner, into line as between Northern Ireland and England and Wales by suggesting that the Northern Ireland interval of 28 days should be adopted also in England and Wales.
67. We can see no reason why the shorter interval should be regarded as increasing the safeguards against abusive or deliberately criminal conduct. The other changes in process and structure which we recommend should make it harder for incompetent or abusive certification to go for long unchecked. The promptness of the certification process is important to families. Lengthening the maximum interval would

reduce the number of cases in which reporting the death to the coroner was necessary, and perhaps also the number of deaths which lead to an autopsy.

68. **We recommend that:**

- a. **any doctor in a general practice looking after a patient if available and willing to certify the patient's death should be able to act as first certifier;**
- b. **the maximum interval between the death and the preceding visit or attendance by the certifying doctor or his practice partner should be 28 days.**

69. It should be noted that this recommendation is in terms of doctors being able to act as first certifiers. The obligation on them would be to consider whether to certify a death. It would remain a matter for their professional judgement whether in a particular case they decide to do so.

### **Possible Role of Nurses in Death Certification**

70. We have recommended that nurses, qualified ambulance personnel and paramedics, as well as doctors, should be able to verify that a death has occurred. We have suggested that the staffing of coroners' offices would benefit from more people with healthcare and in particular nursing backgrounds.

71. There is also an issue as to whether nurses should have a role to play in certifying the cause of death and that the disposal of the body may proceed without further investigation.

72. We raised this in our consultation paper. The Royal College of Nursing gave the prospect a cautious welcome:

*"The RCN membership believes that where death is expected (...regardless of setting) registered nurses should have the authority to complete certification of death paperwork. Training and protocols for death certification need to be in place so that professions other than medicine can assume this responsibility. Where the death is not expected, there is a clear mandate from the RCN that it would be inappropriate for nurses to be involved in certifying death."*<sup>4</sup>

73. The Department of Health also expressed support in principle.

<sup>4</sup> Royal College of Nursing, response to the Review of Coroners Consultation Paper, 22 November 2002.

74. In the context of a two-tier death certification process the issue needs careful consideration. The essence of the judgement to be made is whether a death is an expected consequence of a diagnosed disease, and whether there is anything about its timing or other circumstances which justifies further investigation. Questions of diagnosis, causality and prognosis would generally be regarded as being mainly for doctors though nurses would often be well placed to assess the condition and circumstances of individual patients.
75. We would certainly expect that the second certifier should contact and consult nursing and other health care staff in any case where there were uncertainties which they might be able to help resolve, including any such issues that had been raised by the family or others. There might also be a role as first certifiers for the new nurse consultants once that status has been fully established and has significant membership. In the meantime, and particularly in the initial period of the new certification system, it would probably be sensible for doctors to remain the certifiers.

### Role of the Family in Certification

76. We envisage that the family should participate in the certification process in two ways. Firstly, the next of kin, main family representative, or personal representative should provide the personal details of the person who has died, including the full name, including all the given names, date of birth, and normal address. They should, then, have an opportunity to check that the personal information given on the certificate has been correctly transcribed. Secondly the main family representative, next of kin or personal representative should by right be informed of the cause of death that the first certifier gives, and should have a right to talk to the second certifier if they wished to do so.
77. **We recommend that the family representative should provide or confirm full personal details of the person who has died, should have a right to be informed of the cause of death given by the first certifier, and a right to talk to the second certifier.**

### Forms and Records

78. We do not propose change in the structure of the main cause of death entries to the Medical Certificate of the Cause of Death, nor any change in the admissibility of "old age" as a cause of death in suitable cases.
79. Clarke and Gladwin raise issues about the handling of old peoples' deaths in certificates and in particular whether the *admissibility of "old age" may* have implications beyond the role of the health services, e.g. *human rights and equity issues. Further investigations into the likelihood of excess deaths amongst the elderly due to negligence or criminal activity*

*with this cause of death, the attitude of certifiers, whether excessive resources are spent in identifying causes of death which are natural and the extra value that can be accrued if no deaths were certified as caused by "old age" would be useful".*<sup>5</sup>

80. There may well be value in such further work. The average age of death continues to rise and more people are likely to die with the multiple pathologies associated with very long life. Structured research into these issues, involving the normal processes of ethical clearance and consent, would seem better than random attempts to use the death investigation processes and coroners' powers to go into the causes of individual deaths where there are no grounds to suspect foul play or neglect.
81. Several of the recommendations we have made – the audit of death certification by the Statutory Medical Assessor, the introduction of second certification and the use of clinical records to validate certifications – should reduce the risk of abusive or incompetent certification. In Chapter 11 we also make recommendations related to the handling of deaths in care homes.
82. With the abolition of the separate cremation certification process there will be a need to bring within the common two-tier process for all deaths that we propose the circumstantial information on the death that is at present required in the cremation forms but not for the Medical Certificate of the Cause of Death.
83. We have not gone into any detail on the composition and content of the forms that will be required for the new process. However, we offer at Annex B to this chapter the first outline of a possible form to cover both stages of the certification process. It is designed to improve the range of the material that would be available in certification, and subsequently in certification audit, without adding excessively to the time required for its completion.
84. Any change in the death certification process will require the most careful detailed design and development work, followed by careful piloting. **We recommend that this work should be undertaken as a high priority and that it should be linked to the programmes of work already in hand or planned for electronic registration of deaths, and the introduction of electronically transmissible health records.**
85. Clarke and Gladwin's work also raises a number of other substantial issues which need further examination. These include whether there should be a further cause entry in the death certificate to improve the reporting of relevant underlying conditions such as diabetes, and whether ethnicity and social class data should be included in certification material to improve the database for targeting health promotion campaigns.

<sup>5</sup> Clarke and Gladwin op cit, 4.2.6.

86. **We recommend that the priority at this point lies in the design, piloting and introduction of the new common two-tier certification process, and in introducing an audit and support process around it, and in making the other systems changes, including the introduction of the Statutory Medical Assessor to improve the flow of information back into the public health and healthcare systems.**
87. **The other fundamental issues should be considered under the auspices of the Coronial Council which we recommend to supervise the development of the death certification and coroner systems.**

### Location of Records

88. The introduction of a common certification system and the discontinuation of the separate cremation system provide an opportunity to remove an anomaly under which cremation certificates are separate from the death certificates and remain the property of crematoria. There is therefore no single place, locally or nationally, which holds all the regulatory documentation concerning a death and the authorisation to dispose of the body. This is clearly a handicap to any audit of how the process is working. **We recommend that copies of all the new certification material should be sent to and retained by the area coroner's office so that the Statutory Medical Assessor can perform the audit function on the basis of full information.**

### Charges for Certification

89. If as we recommend the cremation certification system is discontinued and a common two-tier certification system applying equally to all deaths is introduced there will be an issue about costs and how they should be met. The cremation certification system is self-financed from fees payable to doctors by families amounting to about £100 in each case.
90. Historically, no doubt, this arrangement was seen as reasonable when the cremation certification was associated with a process chosen by families as the means of disposal in what was originally – as in Northern Ireland it remains – a minority of deaths.
91. The introduction of a common two-tier certification system to cover all deaths could not sensibly be financed through charges to families, in our view. The certification process is an essential preliminary to authorisation to dispose of the body and to the registration of the death. In its White Paper on the reform Civil Registration the Government said that death registration should remain free to the user.

92. **We recommend that the costs of the new certification system should be met from the funds of the new death certification and coroner service that we recommend. This would lead to a saving to families choosing cremation of £100.** The implications for service funding are examined in Chapter 19

**ANNEX A TO CHAPTER 6 - SUGGESTED FORM FOR  
VERIFICATION OF THE FACT OF DEATH (SEE PARAGRAPHS  
10 - 14)**

<b>CERTIFICATE OF THE FACT OF DEATH</b>			
Name of Deceased:			
Family Name:		Date of Birth:	
Forename(s):		Sex:	
Usual Address:			
Number	Street	Town/City	Postcode
Name and Address of General Practitioner:			
NHS No:		NI. No. (for deaths in care homes)	
Address and contact details of next of kin or responsible person:			
Number	Street	Town/City	Postcode
Telephone Numbers			
<b>CERTIFICATION</b>			
Name of Certificant:			
Position and occupation (tick one):			
<ul style="list-style-type: none"> <li>- Medical Practitioner</li> <li>- Nurse</li> <li>- Paramedic</li> <li>- Other qualified person (define)</li> </ul>			
Persons present at death (occupation/position):			
1.			
2.			
3.			
4.			
Time death certified (24hr):		<b>Signs noted:</b> Absent heart sound/pulses Y/N Tracking in retinal vessels Y/N Evidence of decomposition Y/N	
Place of Death:			
Is there obvious injury? Y/N      If "Yes", have the police been informed of the death? Y/N			
Has the Coroner been notified? Y/N			
<b>Who identified the body to the certificant?</b>			
Date and time of arrival of signatory at site of death:			
Date:		Time:	
I certify the fact of death and authorise the removal of the body from the place of death:			
Signed:		Date:	Time:

**ANNEX B TO CHAPTER 6 - SUGGESTED FORM TO PROVIDE THE MEDICAL CERTIFICATE OF THE CAUSE OF DEATH**

<b>MEDICAL CERTIFICATE OF CAUSE OF DEATH</b>	
<b>IDENTITY</b>	
Identity of deceased: Address:  GP:	Identity of first certifier of cause of death:  GMC Registration number:
<b>PLACE, DATE and TIME</b>	
Place, date and time of death: (if known, or give approximate location where necessary)	Place, date and time of verification of fact of death:
<b>LEVEL OF INVESTIGATION</b>	
In my opinion, no further investigation is necessary to ascertain the cause of death:    Yes/No	
This death is from natural disease and/or old age:    Yes/No	
<b>CAUSE OF DEATH</b>	
Conditions causing death (see over):  I (a) IMMEDIATE CAUSE OF DEATH ..... Disease or condition leading immediately to death (may include 'old age')  I (b) INTERVENING CAUSE OF DEATH ..... Underlying condition leading to I (a)  I (c) UNDERLYING CAUSE OF DEATH ..... Underlying condition leading to I (b)  II Other significant conditions contributing to death but not related to immediate cause specified in I (a) above: .....	Approximate interval between onset and death
<b>CONTRIBUTING FACTORS</b>	
To the best of your knowledge and belief are there any drugs, medical substances, or treatment, which may have contributed to the death?  .....	
<b>DECLARATION</b>	
<b>First Certificant:</b> When did you/your practise/a doctor in your department in the hospital last see this person? .....  I hereby certify that the contents of this form are true and accurate to the best of my knowledge and belief. Signed: .....	
Second Certificant: Address:  GMC Registration number:  I hereby certify that the contents of this form are true and accurate to the best of my knowledge and belief. Signed .....	What discussion did you have with the first certificant? .....  What information was made available to you by the first certificant? .....  Have you had any approach by any member of the family or any question by any other person about the manner in which the death has been certified? .....  Are there any other aspects which justify further investigation    Yes/No
Family Representative:  Address:	



**Completion of Cause of Death**

- Line (a) is for the immediate cause of death.
- If there is only one step in the chain of events, an entry at line (a) is sufficient.
- If there is more than one step, the condition that gave rise to the immediate cause of death should be entered in line (b). If this in turn was resulted from a further condition, report that condition on line (c).
- The underlying cause of death should be entered on the lowest used line in Part I, i.e. line I(c) in this example.
- The mode of dying (e.g. cardiac arrest and respiratory arrest) should NOT be used.
- If an organ system failure such as congestive heart failure, hepatic failure, is listed as a cause of death, always report the underlying etiology (e.g. I(a). Congestive heart failure and I(b). Ischaemic cardiomyopathy).
- The best estimate of the interval between the onset of each condition and death should be entered. It helps the certifying doctor to establish the chain of events that lead to death, and is also useful subsequently in choosing the appropriate code for the underlying cause of death.



## **PART 3:**

# **DEATH INVESTIGATION**

## CHAPTER 7 - GENERAL DEATH INVESTIGATION ISSUES

**This part of the report deals with the arrangements for investigating deaths which should be reported to coroners. This chapter examines the skills and powers needed in the Coroner's office, the objectives we recommend for the coronial death investigation service, the purpose and scope of death investigations, families' rights of access to investigations, the criteria for holding public inquests, and for making public the outcomes of investigations where there is no inquest. The following chapters cover the outcomes and scope of inquests, the handling of inquests, and the relationship between inquests and other investigations.**

### Introduction

1. Currently, over 200,000 deaths in England and Wales – about two deaths in every five – are formally reported to coroners for assessment before authority is given to bury or cremate the body. Of these, the large majority are dealt with “administratively” – i.e. without a public inquest. Inquests are held in some 26,000 cases, about 13% of the cases reported.
2. Where there is no inquest, the coroner or his office notify the Registrar of the cause of death either after contacting the doctors who looked after the person who has died or others who can cast light on the cause and circumstances of death, or after an autopsy has taken place.
3. Where there is no inquest but an autopsy is performed, the family have a right to see the autopsy report, and to be represented at the autopsy by a doctor. They do not otherwise have any rights of access to the investigation process or its outcome; though in practice their inquiries may be responded to informally.
4. Currently, inquests are normally held in England and Wales where a body is within a coroner's local jurisdiction and there is reasonable cause to suspect that there has been a violent or unnatural death, or that the person has died a sudden death of which the cause is unknown, or has died in prison or from certain notifiable diseases. Deaths in police custody or while compulsorily detained under mental health legislation also usually result in inquests. In Northern Ireland the coroner has discretion whether to hold an inquest unless the death occurs in prison or certain other limited circumstances. The inquest rate there is markedly lower than in England and Wales.
5. The inquest is a public court proceeding, but is inquisitorial rather than adversarial – there are no contending parties and its primary purpose is to find facts rather than to attribute blame or liability. At the inquest representatives of the family and other interests with standing may, at the

coroner's discretion, ask questions of witnesses.

6. The recorded outcome of inquests in England and Wales, known as 'The Inquisition', usually includes a summary conclusion or "verdict" - "natural causes", "accidental death", "suicide", or "unlawful killing" for example.
7. There are widespread criticisms of what is seen as the disparity of practice between coroners in the conduct of inquests and more generally in the way in which they do their work. This is perhaps the most frequent comment that we have heard from families and by organisations such as Railway Safety who work nationally and therefore experience the different handling procedures followed by different coroners.
8. There are also concerns about the scale on which public inquests are held and the lack, in comparison, of transparency and accessibility to the family of the way in which the coronial system deals with non-inquest cases which form the great majority of reported cases. Other issues which give rise to concern are the relationship between the inquest and other investigative processes, the suitability of "verdicts" commonly returned in inquests, and the adequacy of the inquest in its present form to deal with exceptionally complex or contentious cases, including some cases which engage Article 2 of the European Convention on Human Rights.
9. We also consider that there is a lack of suitable medical skills represented within the coroner system to deal with the many cases that are referred because of uncertainty over which natural disease caused a death rather than any uncertainty or anxiety over its circumstances. This gives rise to the anomaly that when a doctor is unsure how to certify a particular death he first turns for advice to, typically, a non-medically qualified coroners' officer.
10. Finally, there are some general defects in the legal powers under which the system works.

### **Improving the Medical Skills Available in the Investigation of Deaths**

11. Though some coroners in England and Wales are doctors, most are lawyers. A very small proportion are doubly qualified. In Northern Ireland the statute permits only lawyers to become coroners. Most coroners' officers are serving or retired police officers and have investigative skills relating to criminally suspicious, as opposed to health related, circumstances.
12. Of the more than 200,000 deaths formally reported to coroners in England and Wales, about 32% concern those from natural disease which are reported by doctors because they do not fulfil the attendance requirements for certifying a death or because they are not sure which

natural disease the person died from. In a further 24,000 deaths doctors seek advice from the coroner's office as to whether and if so how they should certify the death. This is often provided on an informal basis by coroners' officers who are not medically qualified, often in circumstances which do not lead to any auditable record being created.

13. In about 50% of deaths reported to coroners the relevant decisions or advice given to doctors involve essentially medical judgements about the cause of death and how these should be expressed in writing.
14. We consider that the service needs to be provided with its own dedicated medical expertise to supplement the judicial and legal skills of the coroner in order to handle this essentially medical caseload properly. It is important that the doctors providing this service should be and should be seen to be independent of those in clinical practice in hospitals and general practice. To this end they need to be able to exercise a distinct and independent professional function of their own.
15. We consider that each of the new coroner jurisdictions that we recommend should have one such doctor in-house working alongside the coroner, supervising the handling of the essentially medical case-load. We see this as a role for the Statutory Medical Assessor the creation of which we have already recommended to supervise the death certification process. The involvement of the Statutory Medical Assessor might avoid the need for those autopsies which are ordered only because the coroner or his staff are insufficiently confident or medically knowledgeable.
16. **We recommend that alongside each coroner in the sixty or so new coroner jurisdictions there should be a doctor acting as Statutory Medical Assessor. This would improve the handling of the essentially medical case-load reaching the coroner's office. The Statutory Medical Assessor would also help the coroner in the handling of cases needing circumstantial investigation of medical issues and improve the choice and suitability of pathology and other medical/scientific investigations. The Statutory Medical Assessor's functions should include the supervision and audit of the death certification process and liaison with public health and other healthcare networks on the work of the coroner's office.**

### **Qualifications and Experience Needed for Coroner Appointments**

17. The creation of the new Statutory Medical Assessor posts to strengthen the medical skills available within the coroner service means that there will be an increased emphasis on the investigative and judicial work in the role of coroners themselves.

18. The essence of their work will be the assessment of evidence and the conduct of judicial investigations and inquests in cases where the issues are circumstantial rather than medical (or, if they are medical, give rise to uncertainty or contention over treatment and the exact cause of death).
19. We consider that to equip the system to handle such issues, coroners and their deputies should in future have legal qualifications and experience as barristers and solicitors, and that a medical qualification and experience of practice alone should not in future be accepted in coroner appointments.
20. **We recommend that, when the new structure is introduced, a legal qualification and experience of practice as a barrister or solicitor should be required for coroners and deputy coroners in England and Wales (as is already the case in Northern Ireland).**
21. This recommendation is subject to the proposal – in paragraph 19 of Chapter 16, which deals generally with appointments in the new structure – that existing medically qualified coroners, deputy coroners and assistant deputy coroners<sup>1</sup> – should be able to apply for posts in the new structure by virtue of their experience.
22. We suggest that the minimum experience needed as a solicitor or a barrister should continue to be 5 years' practice.

### **Disparity of Coroners' Practices and Defects in their Powers**

23. The phrase we have heard more than any other during the Review is "the coroner is a law unto himself". Virtually every interest has complained of inconsistency and unpredictability between coroners in the handling of inquests and other procedures. Many of those who have experienced the system, whether families, lawyers and doctors who work alongside it, the police or voluntary bodies with concerns over the handling of deaths with a mental health element, child deaths or deaths in prison, have all made the same point.
24. One set of comments can stand for them all :-

*"Having experienced inquests in a number of geographical areas, we have seen first-hand that there is at present a wide divergence in the practice of inquests....The disparity between coroners... ..makes preparation for inquests difficult. ..Some coroners willingly allow advance disclosure of documentation if they are requested. This is a tremendous help to preparation. Other coroners flatly refuse to*

<sup>1</sup> However, we are not recommending that there should continue to be assistant deputy coroners in the new structure.

*disclose any documentation prior to the inquest. The use of juries is inconsistent. In similar circumstances one coroner may sit with a jury, whilst another feels it is not necessary. Some coroners invite an address from legal representatives at the end of the inquest, whilst other coroners refuse to hear any closing comment. Some coroners allow a significant degree of latitude during an inquest, whilst others will not allow for any degree of divergence from the bald facts. Some coroners display incredible sensitivity during the inquest process, whilst others can be extremely inconsiderate. Inconsistency is a criticism that is levelled at all courts, and parity is difficult to achieve..... given the nature of inquests, however, it should be easier to invoke some uniformity into the system".<sup>2</sup>*

25. It is obviously desirable that there should be more uniformity of process and approach. The issues cannot sensibly be regarded as being about apparently idiosyncratic behaviour by individuals. They are at heart structural – involving the lack of any consistent training and appointment processes, the loose and inconsistent procedural framework, the absence of any dedicated higher court structure of the kind which in other areas of justice provides accountability and a means of rectifying mistakes, the emphasis on process rather than a more general investigative function in the legislation and rules, and the absence of clear objectives.

## Objectives

26. **We recommend that the objectives of the coronial death investigation service should be reflected in the relevant legislation and that these should be:**
- a. **to satisfy the public that there is an independent and professional process for scrutinising deaths of uncertain cause or circumstances, for scrutinising all deaths of people detained by the state or dying at the hands of state agents, or otherwise in situations of special vulnerability or where special vigilance is required;**
  - b. **to help families understand the causes and circumstances of the death of the family member where these cannot be resolved through other processes;**
  - c. **to contribute along with other public services and agencies to the avoidance of preventable deaths.**

<sup>2</sup> Carol Brooks-Johnson, of Pannone and Partners, Solicitors, submission to the Review, 19 November 2002.



## **A New Framework for the Service**

27. Elsewhere in our report we make recommendations for solutions to the structural shortfalls that give rise to these inconsistencies and for the policies and approaches that should lie behind a new coronial service. They include the following:
- the coronial jurisdiction should be re-formed on modern judicial lines, as a national jurisdiction, small in size but comparable to other jurisdictions in having a Chief Coroner from the higher judiciary and in being built around full-time local appointments (chapter 15);
  - the creation of a standing Rules Committee. Its role will be to formulate new and more detailed rules for the conduct of inquests, and to provide a permanent mechanism whereby the system can develop in accordance with new and developing needs (chapter 9);
  - the creation of a Coronial Council to oversee the links between the coroner system and the range of public interests and agencies that its work should serve, and to provide a mechanism whereby the investigation and certification systems can adapt to new challenges (chapter 14);
  - the creation of a small inspectorate and of compulsory initial and continuing training for coroners and other key personnel (chapter 14);
  - a national organisation and top structure to give leadership (chapter 15).
28. These changes would provide the main structures through which the death investigation service would be helped to act with reasonable consistency.

## **Powers of the Coroner**

29. The statutory powers and duties of the coroner need clarifying and modernising:
- The Coroners Act 1988 specifies certain powers and processes that the coroner may use, notably holding inquests and ordering autopsies. These powers stem originally from the days when all cases reported to coroners were the subject of public inquests. Subsequently, provision was made for a post mortem examination to be held in lieu of an inquest. The precise nature of this post mortem examination and its extent were never defined by law,

although in practice it has come to mean the general autopsy such as is carried out now. This “process-orientated” legislation needs to be replaced with powers and duties orientated instead towards objectives and outcomes.

- There are some defects in coroners’ powers to acquire the evidence and material they need to conduct effective investigations.
- Their powers are largely reactive. They have no defined powers or responsibilities in relation to deaths that give rise to suspicion or concern but which have not been reported to them.

30. **We recommend coroners should be given explicit powers to:**

- investigate and find the causes and circumstances of any death reported to them by examining records (including medical records), arranging for scientific and medical or other investigations, gathering evidence or holding public inquests;
- determine the scope and scale of the investigation necessary to find the cause and circumstances of the death (subject to what is said below about cases in which a public inquest would be necessary);
- obtain any document, statement, report or other material needed for such investigations from any source, subject only to any public interest immunity exclusions that might be claimed in individual cases; and enter any premises for purposes relevant to the proper investigation of a death;
- investigate any death on their own initiative, whether or not it had been reported;
- investigate any group of deaths which have already been certified if, in retrospect, there are grounds to think there might have been common factors not previously identified and which require collective analysis;
- require for any specified time that all deaths occurring in particular facilities or locations should be reported to him, even if they would not normally fall within reportable categories.

31. **Secondly**, the coroner, the Statutory Medical Assessor and their staffs should be under duties to:

- comply with statutory guidance and Codes of Practice including

those covering relations with bereaved families;

- supply findings or outcomes of death investigations in whatever form or forms should be prescribed;
- work with the police force(s) in the same jurisdictional area, and with other agencies working in related fields, notably the National Care Standards Commission<sup>3</sup> and local child protection agencies in respect of the protection of vulnerable people including children, the frail elderly, and people with learning disabilities or mental health problems;
- conduct investigations in accordance with any statutory guidance issued by the Coronial Council;
- comply with practice directions or guidance issued by the head of the jurisdiction.

### Forms of Investigation

32. It is a serious defect of the present system that the only investigative process which is transparent is the public inquest. In cases which are settled by coroners without an autopsy the family and others with an interest may be informed of the report of the death to the coroner and the reason for it, but they have no right of access to the person making the report or responding to it, to the relevant documentation or to the forms on which the findings are reported to the Registrar. In cases where there is an autopsy the family have a right to be represented by a doctor when it is carried out and to see the pathologist's report. Although, in practice, their inquiries may often be reasonably well dealt with the procedure lacks defined transparency and accessibility.
33. These defects in the processes used in 87% of the cases reported to coroners may explain why some families feel that to get any 'real' or useful information there needs to be an inquest even if this involves delay and publicity.
34. We have been impressed by the way in which the large majority of investigations are recorded in Ontario, Canada and Victoria, Australia. Their standard forms set out succinctly the detail of the person who has died, the circumstances in which the body was found and the death referred for investigation, the medical or other information available, any relevant aspects of the individual's history, and the results of any scientific

<sup>3</sup> Although there is no direct equivalent of the National Care Standards Commission in Northern Ireland or Wales similar functions are carried out by the Northern Ireland Social Services Inspectorate and the Northern Ireland Social Care Council and by the Care Standards Inspectorate for Wales and the Social Services Inspectorate for Wales.

tests or medical examinations carried out. The report concludes with a summary of the cause and circumstances of death. The examples we saw were, in the shortest cases, roughly a page and a half of A4 and in a typed or printed format, signed by the investigator and were in language comprehensible to lay people. They are routinely sent, or at least accessible, to the family.

35. **We recommend** some significant changes in the handling of cases which are investigated by the coroner but which do not result in a public inquest:
- families should, by right, be able meet the person conducting the investigation – the coroner, or the Statutory Medical Assessor, or a member of their investigating staff;
  - families should have a right to a copy of the investigation report, and of any reports on which it has relied, unless, exceptionally, giving them any of this material would prejudice any criminal or other proceedings;
  - the report should broadly reflect the style and content of the Ontario and Victoria reports and should include a statement of the medical cause or causes of death in the same format as they would appear in the certificate which is sent to the Registrar;
  - it should be typed or printed, and signed by the investigator.

### Purposes and Scope of Death Investigations

36. We have said in paragraph 20 what we think should be the overall objectives for the death investigation process. In regard to individual deaths its purpose should , so far as is practicable, be to:
- a. find the cause and describe the circumstances of the death;
  - b. find whether it might have been prevented.
37. **We recommend** that the investigation should seek to establish as many of the following as are necessary in the circumstances:
- a. the identity of the person who has died;
  - b. the time and place of death;
  - c. the medical cause of death;
  - d. the immediate circumstances in which the death was discovered,

including location, position of the body, by whom and when it was discovered;

- e. events immediately leading up to the death, in particular the movements and activities of the dead person, and the movements or roles of others where these might be relevant to the death whether because of the possible involvement in the death of one or more third parties or because of their responsibility for ensuring so far as possible the safety of the dead person;
- f. identify any aspects of the dead person's circumstances, situation or history possibly relevant to the death, including medical history, and/or lifestyle or behaviour;
- g. identify any management or regulatory systems relevant to the protection of the dead person or others facing comparable risks, and information on how these bore or failed to bear on preventing the death;
- h. identify the role or roles of any emergency services that were or might have been summoned to the death.

### **The Choice between an Administrative Investigation and an Inquest**

- 38. In recommending that new criteria should be used when a decision is made whether or not to hold an inquest we do not propose any form of rationing or any target for the numbers of inquests. The criteria should be flexibly applied. A system which continued to have the inquest as the only form of death investigation that is accessible to the family would continue to frustrate many of those involved. There needs to be a general death investigation function which is independent, objective and accessible to families and an inquest system that is designed and resourced to deliver what can be achieved through no other means.
- 39. The public inquiry into individual deaths is a unique and valuable part of the inheritance of the coroner system because it provides a process through which the public can be assured that suspect deaths, or those of uncertain cause, will be independently and publicly investigated through a judicial process. It is not generally a feature of many other systems but it is one which should be preserved in suitable cases in our own.
- 40. However, there are grounds for considering whether the present scale of public inquests and the purposes for which the process is used might benefit from some reduction and change. Thus:
  - if standards of transparency and accessibility are applied to the

treatment of all the cases that are reported to the coroner it should cease to be correct that the inquest is the only process through which a family can “find out what happened”;

- the Commonwealth countries which inherited the coroner system as part of the English Common Law tradition have generally preserved it but reformed it to use the public judicial inquest largely to illuminate major issues of public policy and not as a routine investigation procedure;
  - because the public inquest often involves the attendance of witnesses it can take a considerable time to arrange and the delay can cause distress to bereaved families;
  - a significant proportion of inquests are of very short duration (30% last less than 15 minutes) and do not involve oral evidence or oral evidence which is usefully tested through cross-examination or challenge by the coroner. It must be doubted whether anything significant can be discovered or settled in so perfunctory a process where there is no need to resolve contentious evidence.
41. In most of the other jurisdictions where the public inquest exists as an option, it is used for two purposes – to examine the deaths of people in situations of special vulnerability (notably those in detention or those who die as a result of law and order operations), and as a public service and public policy audit tool. Where this is the approach, particular deaths are chosen for inquest partly because they are thought to symbolise some particular defect in public service provision or safeguards. Whilst substantial inquests are held into such cases, the overall number of inquests tend to be comparatively limited, often involving multiple recommendations.
  42. We agree that the inquest is an essential safeguard for people who die when in the care of the state or in other situations of special vulnerability. We also suggest, in Chapters 8 and 9, ways of making the inquest a more effective process in situations of great complexity or contentiousness.
  43. However we do not consider that it would be right to restrict inquests solely to situations where there are or may be major public policy issues at stake. The inquest has a potentially important role in improving safeguards and reducing the risks to life. But it also has a role in enabling the family and the public to find out “what happened” where there are significant uncertainties and conflicts of evidence which need a judicial process to resolve.
  44. It is likely that some of the reported disappointment concerning inquests stems from them being routinely held where sensible criteria for holding them are not met. The family is forced to wait, often for a considerable period, and then to undergo a public process which does not significantly

add to their knowledge of the causes and circumstances of their relative's death.

45. It is sometimes said that the inquest is a process which helps families towards "closure" or "moving on". In cases where there is a significant uncertainty and conflict of evidence about the causes and circumstances of a death it may be of some help to families. But where those conditions do not exist there is no reason to think that a formal public inquest has advantages over a less public and formal but still objective and professional determination of the key facts after an investigation by the Coroner or Statutory Medical Assessor which gives the family access to the evidence, and the investigation and its outcome.

46. The submission from the source cited at paragraph 24 above continues:

*"The public's expectations of inquests are rarely met. In our experience, families find the procedure an anti-climax. Very often, the inquest is a hurdle to be crossed before life can resume any sense of normality, but they are left feeling empty by the process. Any reform of the system needs to look at ensuring that the bereaved don't feel more aggrieved at the end of the process than at the beginning."*<sup>4</sup>

47. The Bristol study "Experiencing Inquests", in what strikes us as a very balanced assessment, said that some families felt excluded from the inquest because of its formality or because of language difficulties, some were intimidated by the presence of the press and that many outcomes appeared to be pre-determined. Yet, they concluded,

*"most families derived some benefit from the inquest. For some it helped to answer their questions, and many felt that the inquest acted as a memorial to the deceased"*.<sup>5</sup>

48. Since in the present arrangements, as we have already said, the inquest is the only reasonably clear and accessible process the coroner services offers families it is not surprising that it should attract the full range of their aspirations for the death investigation process and that it should be found wanting in some of them.

49. The Bristol team argued that there should be a redefinition of the circumstances in which public inquests are used. We agree, and **recommend the criteria** below.

<sup>4</sup> Carol Brooks-Johnson, Pannone and Partners. It should, however, be noted that Ms Brooks-Johnson does not argue for a reduction in the number of public inquests.

<sup>5</sup> Experiencing Inquests by Gwynn Davis and others, the quotation is from that part of the executive summary which deals with relatives' experience of the coroner service but the whole of Chapter 5 is also relevant.

**Circumstances in which Public Judicial Inquests should be held**

- 1. any death of a person held in prison, police custody, or a bail or asylum hostel, or of a person compulsorily detained under mental health legislation, unless the Statutory Medical Assessor certifies that the death was beyond reasonable doubt caused by natural disease**
- 2. any traumatic death occurring apparently or possibly as a consequence of police or other law and order operations**
- 3. any traumatic work-place death in which industrial process or activity is implicated**
- 4. any traumatic deaths occurring in public or commercial transport vehicles or vessels, or in public service or commercial aircraft**
- 5. any death of a child which the coroner or Statutory Medical Assessor after consulting relevant child protection interests is unable to certify as being beyond reasonable doubt from natural disease without neglect or ill-treatment**
- 6. any death from self-harm which the coroner is unable to certify beyond reasonable doubt as not involving lack of care or the active involvement of any third party in procuring the death or which does not involve a pattern of similar circumstances requiring public scrutiny**
- 7. any category of death reported for investigation where there is sufficient uncertainty or conflict of evidence over the cause or circumstances of the death to justify the use of a forensic judicial process**
- 8. where there is the likelihood that a public judicial inquest will uncover important systems defects or general risks not already known about**
- 9. any other death in which the coroner after consulting with others, including the family, considers that there is a public interest which is best served by holding a public inquest**



50. What we are proposing would have a number of effects. Firstly, the investigation of the large majority of deaths reported to coroners would be effected through a process much more accessible to families and giving a fuller and more informative report on the conclusions.
51. Secondly, some of the 26,000 deaths that are now investigated through public inquests would be handled through the new investigating process where interested parties could be proactively involved. The investigation would not be conducted in a public court.
52. The criteria we suggest would mean that all deaths of prisoners and of people detained under mental health legislation would always have a public inquest unless it was clear beyond reasonable doubt that the death was from natural disease. Deaths at the hands of the law and order services would always have a public inquest. So, too would traumatic work-place deaths. There would be public inquests on the deaths of children unless it was clear beyond reasonable doubt that the death was from natural disease, and there would be public inquests into deaths occurring in public transport crashes or in the sinking or collision of commercial vessels.
53. This list should not be regarded as definitive or restrictive and should be subject to review by the Coronial Council. There will be occasions when an inquest into a death outside the list is justified. The evidence about the cause or circumstances may be such as to need forensic and judicial examination through a court hearing. There may be occasions when the process would meet the public interest of preventing future deaths, the circumstances of which are not met by the criteria set out above.
54. The coroner would thus have discretion to hold an inquest whenever he thought the public interest would be served by doing so. This discretion might be used where there was a need to allay suspicion or where a death was prompting local or national controversy in circumstances where a non-inquest investigation would not provide an adequate resolution.
55. Families wishing for a public open inquest for a death not in one of the mandatory categories would be able to appeal against the decision not to hold a public inquest on the grounds that an inquest was essential to safeguard the public interest or public safety, or to adjudicate on conflicting evidence.
56. Under these arrangements deaths by suicide would not automatically qualify for a public inquest, unless there were grounds to examine whether there had been any third party involvement in the death, when it had occurred in prison, when the person who died was detained under mental health legislation, or where the circumstances which may have led to the death are reflective of a pattern of similar circumstances (such as allegations of coercive domestic pressure) which might benefit from public

examination and, possibly, recommendations for future preventative strategies.

57. Nearly two-thirds of the people polled in the Omnibus England and Wales Survey said they were against routine public inquests on suicides. There was a comparable result in the survey of attitudes in Northern Ireland, where suicides are not routinely given public inquests.
58. Road traffic deaths would not automatically result in public inquests. On this issue, the views of groups active in the support of people who have been bereaved through traffic deaths have, as expressed to us, been in favour of maintaining the public inquest for all such deaths. We acknowledge their views. In discussion they have said they would like to know more about the alternative methods of investigation that would be available so that they can come to a considered view. The earlier paragraphs of this chapter answer that query<sup>6</sup>.
59. Similarly, deaths from asbestosis and other occupational diseases would all be the subject of a proper and family-accessible investigation. There would, however, be a public inquest only when there was a conflict or uncertainty of evidence which justified a judicial examination. We distinguish this category of deaths from traumatic work place deaths which we consider should be in the category of mandatory inquests. This is because the occupational diseases involved are usually of long-standing, the public policy of how to deal with them is settled, and they relate to industrial practices which have long since been outlawed.

### **Public Accessibility of Investigation Outcomes**

60. We conclude this chapter by considering what should be the policy for making public, or alternatively keeping private, the outcomes of cases investigated by Statutory Medical Assessors and Coroners and their staffs, but not given a public inquest.
61. As explained in the introduction in the White Paper of January 2002 on the reform of the Registration Service<sup>7</sup> the Government announced an intention to preserve as private information accessible only to the family and bona fide researchers certain details comprised within the registration of deaths, including the medical cause of death, that are now accessible to the general public on payment of a fee.

<sup>6</sup> See also paragraph 37 of Chapter 10.

<sup>7</sup> *Civil Registration White Paper: Vital Change. Birth, Marriage and Death Registration* (Published by HM Stationery Office January 2002).

62. We **recommend** that cases reported to the coroner's office which are found to be from natural disease should in this respect be treated as though they had been certified by the general practitioner or hospital doctor in the normal way. In these cases, therefore, the medical cause of death would not be accessible to the general public.
63. However, in cases reported to the coroner for circumstantial investigation which result in an administrative investigation but not an inquest, the outcome would be made publicly available, mostly on application but some proactively as the coroner sees fit, even though the investigation had not been held in public. The coroner would, however, have a discretion to expurgate the private information, e.g. a suicide note, from the record of outcome, and describe the outcome in summary terms.

### Summary

64. **We recommend:**
- a. **the creation of a Statutory Medical Assessor to work alongside the Coroner in all the new Coroner areas (paragraphs 11-16)**
  - b. **the new powers and duties for coroners and coroners' officers (paragraphs 29 and 31)**
  - c. **that there should be more transparent and accessible arrangements for the investigation of deaths (paragraph 32-37)**
  - d. **that the practical purpose and scope of death investigations should be as in paragraphs 36 and 37**
  - e. **that the criteria for holding inquests should be as in paragraph 49**
  - f. **that the public accessibility of investigation outcomes should be as in paragraphs 60 - 63**

## CHAPTER 8 - INQUESTS: THEIR OUTCOMES AND SCOPE

**We have some major changes to recommend in the outcomes of inquests – the way the findings of the inquest are expressed, and the ways in which the preventive role of the coroner system can be made more effective. This chapter also examines the scope of the inquest and the methods to be used for defining and determining it.**

### Outcomes

1. The outcomes of an inquest are currently:
  - An *inquisition* which gives the name of the person who has died, the injury or disease causing the death, the time, place and circumstances at or in which the injury was sustained, the conclusion of the coroner or jury as to the cause and circumstances of death, and the registration particulars.
  - A short-form *verdict* intended to summarise the nature or cause of the death. This is part of the inquisition, which is otherwise factual.
  - Any *report, recommendation* or public comment the coroner may make to reduce the risk of similar deaths in future.
2. Inquests are conducted under the Coroner's Rules 1984 in England and Wales, and in Northern Ireland under the Coroners (Practice and Procedure) Rules (NI) 1963 as amended. In Northern Ireland there is no provision for short-form verdicts.
3. Generally the factual and narrative parts of the outcome are brief, and much interest has come to focus on the short-form verdict, notably through media reports.
4. The status of these "verdicts" is ambiguous. A selection of possible verdicts is suggested in the form officially provided to coroners for recording the outcome of inquests but it is not compulsory to have such "verdicts" or illegal to use any other form of short summary outcome.<sup>1</sup>
5. The purpose of having these "verdicts" in standard form is said to be to standardize conclusions over the whole country and to make statistics based on annual returns of coroners' inquests more reliable.

<sup>1</sup> Coroners Rules 1984, Schedule 4, Form 22. According to Jervis on Coroners (12th Edition, p.307) the verdict consists in the whole of the facts found and the short form statement at its conclusion. The Coroners Rules say "it is suggested that one of the following forms be adopted" and there follows the list- natural causes, the industrial disease of . . ., as a result of an accident / misadventure etc. These forms are, therefore, not compulsory.

6. The verdicts currently recommended are:
  - natural causes
  - industrial disease
  - dependence on drugs/non-dependent abuse of drugs
  - suicide
  - attempted/self-induced abortion
  - accident/misadventure
  - disaster which has been the subject of a public inquiry
  - lawful killing
  - unlawful killing
  - open verdict
  - stillbirth
  - want of attention at birth
  - sentence of death<sup>2</sup>

### Addition of comments on “neglect”

7. There is also provision for coroners or juries to add to conclusions of natural causes, suicide, industrial disease, the drugs verdicts and want of attention at birth a rider that the death was “aggravated or contributed to by neglect or self-neglect”. The test laid down by the courts for the neglect riders has traditionally been high, implying a gross failure to provide basic attention to someone in a dependent position. Some more recent cases have shaded the provision a little further towards the less demanding test for civil negligence, although the distinction between neglect and negligence is still emphasised<sup>3</sup>.

### The problems with “Verdicts”

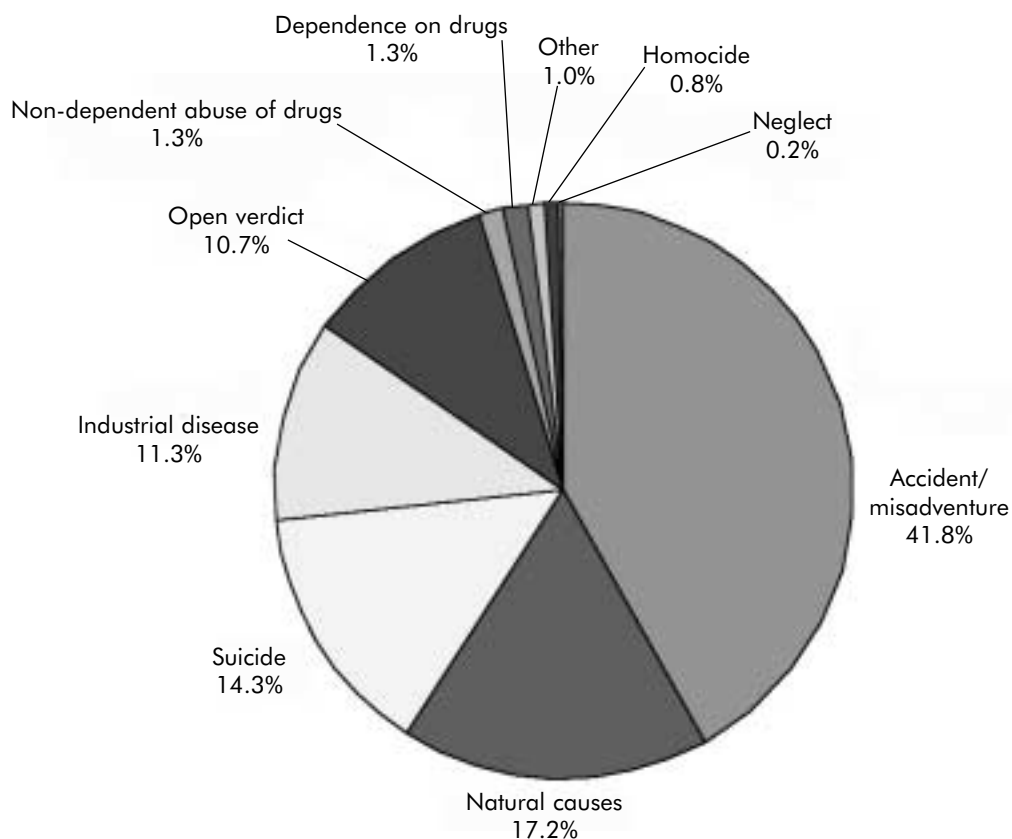
8. The verdict list is a mixture of classifications of *types* of death by cause or circumstance and explicit or implied *judgments about the legality or preventability* of the death or the legality of the actions that caused it. The natural causes, drug categories, industrial disease, abortion and stillbirth labels are examples of the first, and the lawful/unlawful killing verdicts the clearest examples of the second.
9. However in the context of the inquest the accident/misadventure label is also problematic. This is partly because different coroners disagree on the relative meanings of the two terms – some do not use “misadventure” while others use it to describe the fatal outcome of an activity which has some definite risk.

<sup>2</sup> This remains on the list although it could only apply to someone on whom a sentence was lawfully carried out abroad and the body returned to England for the burial.

<sup>3</sup> There is a detailed discussion of this in Jervis on Coroners’, 12th Edition, paragraphs 13-38 to 13-52.

10. More fundamentally, many families of people who meet traumatic deaths in the workplace or through road or other transport crashes, or public service vessel collisions or sinkings find it objectionable to have them classified as “accidents”. They feel strongly that such deaths are usually avoidable and that it is unacceptable for the coroner system to appear to shrug them off as implicitly inevitable mishaps. The value of the category as a statistical classification must be small, since it covers such diverse events as falling off ladders, being the victim of a medical mishap, or perhaps unintentionally carrying a potentially suicidal activity too far. In fact 42% of inquest deaths are found to be “accidental” or “misadventure” since the label is applied to nearly all road and transport deaths, and workplace deaths, as well as to some suicides and drug-related deaths.

### Inquest cases analysed by verdict



Source: *Deaths Reported to Coroners in England and Wales 2001*, Home Office Statistical Bulletin 3/02.

Six verdicts, 'Accident', 'Natural Causes', 'Suicide', 'Industrial disease', 'Misadventure', and 'Open verdict', account for 95% of all conclusions.

11. "Unlawful/Lawful killing" is equally problematic as an inquest outcome. It is the business of the criminal justice system to determine what is murder or manslaughter. The processes of criminal investigation and trial are more suited to that purpose than any process achievable in the coroner's court. The coroner's court does not have the same rules of evidence or provide the protections against wrongful incrimination required *inter alia* by the European Convention on Human Rights.
12. The retention of "accidental death" and of "unlawful/lawful killing" in the range of officially encouraged inquest outcomes is a source of misunderstanding and conflict for families attending inquests.
13. To a family which feels, rightly or wrongly, that a relative's death was caused by a serious and culpable failure on the part of an employer in the health and safety protection field, or of the police in a police shooting death, for example, the inquest system seems to offer a choice between a bland finding of "accidental death" and a severe but in their opinion more meaningful finding of "unlawful killing". If the coroner, mindful of the care shown in the civil and criminal justice systems to protect all parties from casual incrimination or imputations of liability, steers the proceedings away from "unlawful killing", the family is likely to feel that the system has offered them a glimpse of a meaningful outcome but then made it virtually unattainable. This is to design conflict and disappointment into the system.
14. Historically the coroner's inquest into a death of uncertain or suspect cause was an important mechanism for determining whether the death was criminal or not. The coroner had the power to commit named suspects for criminal trial, and in order to do that needed to decide whether a death was natural, accidental or unlawful. The Criminal Law Act 1977 made the necessary amendments to the law that ended the criminal jurisdiction of the coroner to commit an individual for trial in the criminal courts but the vocabulary associated with the old function has lingered on.

### **Results of consultation on these issues**

15. In our consultation paper of August 2002 we addressed these issues and asked for views on a range of options which were to:
  - increase the analytical and narrative content of inquest outcomes, and dispense with all or most short-form verdicts
  - put the emphasis mainly on analytical and narrative outcomes, but give the coroner a discretion to add such further comment as the facts found justify and would be helpful in the public interest or to interested participants

## Chapter 8 - Inquests: Their Outcomes and Scope

- go further and extend the inquest court's jurisdiction in suitable cases to settling related civil liability questions
  - continue broadly with the present arrangements but with a modernised verdict structure, removing the outcomes that effectively attribute liability or are otherwise unsuitable
16. Virtually no-one who responded supported the idea of extending the coroner's role into civil liability questions.
  17. Most respondents supported having fuller narrative and analytical outcomes. Some respondents argued for the retention of short-form verdicts. Their main reason was that such outcomes give the family and others a concrete and clearly comprehensible result. Those particularly concerned, in Northern Ireland or more widely, with deaths in prison or at the hands of the law and order services, argued for the retention of the "unlawful killing" verdict. Their main concern is that successful prosecutions for murder or manslaughter in such cases are rare. Without a criminal trial and without a coroner's inquest verdict they fear that there would be no regular process for determining whether the actions of a state agent in taking someone's life were justified.
  18. In response to our consultation paper the families and support groups concerned about the handling of traffic and workplace deaths re-emphasised their objection to the "accident" and "misadventure" categories. Some gave support to retaining "unlawful killing", mainly on the grounds that prosecutions for manslaughter – whether corporate or personal – in these fields are rarer than they think desirable, and in the traffic death field that prosecutions for causing death by dangerous driving or manslaughter are also less frequently brought or persisted with than they would like to see.
  19. A number of commentators, including some coroners, pointed out that the verdict system as it now is makes it very hard for the inquest to deal fairly with situations where there has been some problem of approach or mishap in the run-up to the death but it falls short of "unlawful killing" or the test for neglect.
  20. Another important consultation input was from the Office of National Statistics who said that if the outcomes of inquests are wholly narrative and analytical they would expect difficulty in deciding how deaths should be classified in the mortality statistics. Similar concerns were expressed by researchers and others with interests in the fields of suicide, workplace and traffic deaths.
  21. We consider that the essential role and function of the coroner's inquest should be to find the facts about the cause and circumstances of deaths in cases where there is a clear need to use a judicial process for that purpose.



22. There is an inevitable potential for conflict with other judicial processes which deal with criminal and civil liability. The relationship between an inquisitorial process to find the facts and adversarial process to attribute fault is bound at times to be uncomfortable.
23. The sensible course is not to make the fact-finding process and outcomes more like the criminal and civil liability processes but to put a greater emphasis on what the coroner's inquest can achieve but the other processes cannot.
24. This means:
  - a. putting more emphasis on the narrative and fact-finding role of the inquest, and on its analysis of whether there were failures in the circumstances leading to the death which had they not existed might have prevented it;
  - b. ceasing to encourage the use of outcome labels which, positively or by implication, determine civil or criminal liability or its absence;
  - c. developing short descriptions which enable deaths to be accurately placed in the mortality statistics, and which communicate simply the circumstances of the death, but remain so far as possible free of determinations of liability.
25. **We recommend that:**
  - a. **the outcome of the inquest should be primarily a factual account of the cause and circumstances of the death, an analysis of whether there were systemic failings which had they not existed might have prevented it, and of how the activities of individuals bore on the death. The analysis should in suitable cases examine whether there was a real and immediate risk to life and whether the authorities took, or failed to take, reasonable steps to prevent it;**
  - b. **the narrative and analytical account of the cause and circumstances of death should be succinct and include a distillation of the evidence in no greater detail than is necessary to provide a reasoned judgement and resolve significant points of contention or uncertainty;**
  - c. **the analysis should include the regulatory or safety regimes designed to protect people from risk in the circumstances of the death, and whether or not they were properly observed or were, so far as the evidence shows, adequate;**

- d. **since researchers and statisticians have a legitimate and important interest in inquest outcomes, there should continue to be some classification of each inquested death, but it should be in terms of *type* and not in terms implying criminal or other liability or its absence. Existing short- form verdicts should no longer be used.**
26. To illustrate what we mean by the recommendation about the type of death we offer the following list of possible categories of death:
- natural disease;
  - industrial disease;
  - traumatic workplace death;
  - traumatic road death as passenger/pedestrian/driver;
  - traumatic death following railway/aircraft/vessel crash, collision or sinking;
  - traumatic death at the hand of one or more other people;
  - death from a deliberate act of self-harm or injury;
  - stillbirth;<sup>4</sup>
  - death during attempted/self-induced abortion;
  - deaths where the underlying cause is poisoning, drug abuse or drug dependence and where any of the substances listed under the Misuse of Drugs Act 1971, as amended, were involved;<sup>5</sup>
  - death as a consequence of an adverse reaction to prescribed medication; or to which medical or surgical treatment may have contributed;
  - traumatic death in the home by/electrocution/following a fall/other event;
  - unascertained.

We emphasise that these are not intended to be short-form verdicts under another guise and that the list is not exhaustive. If cases arise which none of these descriptions fit they should be given a short description which suits their circumstances.

### **The unresolved homicide investigation**

27. We comment in Chapter 10 on the relationship between the inquest and other investigations, and in Chapter 11 on issues of suicide and self-harm. In the chapter after that we deal with the relationship between the inquest and other investigations. But there is one other circumstance that

<sup>4</sup> Strictly speaking a stillborn child is not regarded as being able to be the subject of an inquest – and therefore of an outcome – since there was no independent life and no subsequent death. A coroner is not under the present statute obliged to supply any certificate after his investigation if he determines that the “death” was a stillbirth. Albeit correct in law, many coroners regard it as desirable nevertheless to complete an appropriate certificate and send it to the Registrar. We recommend that this should become standard practice and we understand that the Registration Service is already introducing a certificate which will allow parents to register a stillbirth in an appropriate way.

<sup>5</sup> Definition offered by the Home Office who are currently reviewing with the Department of Health the best way of obtaining and using information from coroners’ inquests on drug-related deaths.

we wish to deal with here. It arises when it is suspected that someone might have been murdered. There is then a police investigation which does not lead to a prosecution or there is a prosecution and it fails leaving a significant uncertainty about what type of death it was – for example whether the person who died may have died by falling and injuring himself, or through injury caused by another person.

28. It is the legitimate function of an inquest in such circumstances to find out what caused the death and what type of death it was. For the medical cause, and the circumstances of the death, the inquest would make a narrative finding. For the type of death, it should say what it was according to the circumstances. Where the evidence supports a classification of “death by the actions of one or more other people” the inquest court should use a classification on those lines.
29. There may also be cases where the criminal prosecution process resolves the issue of culpability for the death but does not resolve the systemic failure issues that might have contributed to the death. In these cases a coroner’s inquest may still be necessary.

### **Evidential Standards**

30. Present practice is that most short form inquest “verdicts” should be established to the civil standard of proof – the “balance of probabilities” test. But for verdicts of “suicide” and “unlawful killing” it is the higher criminal standard of proof “beyond reasonable doubt” which is applied. The justification for this appears to lie in the need for outcomes which determine, or appear to determine, legal liability (albeit not that of a named individual) to be reached on the basis of standards which are properly applicable in the appropriate civil or criminal court. It is not feasible, however, for such standards to be systematically applied in an inquisitorial process whose role is to determine what may be a set of complex and interrelated facts.
31. In these circumstances, the narrative and analytical outcomes we recommend should include language reflective of the coroner’s (or the jury’s) broad analysis of how, and how far, the evidence given to and tested in the inquest supports the court’s findings of fact, its judgements (if any) on the preventability of the death and on the role of the regulatory and safeguarding systems in the death. The outcomes should indicate to what evidential standard the court considers the findings to be established. Where the evidence points to a probability, or a possibility – for example over the preventability of a death – the finding should make clear the degree of certainty or uncertainty which the evidence justifies. Where the evidence suggests that the prospect of preventing the death was small, or that there was in the circumstances little or no such prospect, the inquest determination should reflect such a finding.

## Rule 42 and the Implication of Liability

32. It is not the function of a coroner's inquest, or of any coroner's investigation, to determine criminal or civil liability, since this function belongs only to courts dedicated to those purposes. It is, however, inevitable that an inquest will sometimes receive evidence of actions by individuals or corporate bodies which appear to raise issues of civil or criminal liability or might be thought, possibly, to do so.
33. It is as important that the inquest should not be deterred from conducting and reporting on a complete investigation of the causes and circumstances of a death as it is that it should keep away from functions which lie properly with other courts. We have therefore examined carefully the terms in which the present Coroners Rules deal with liability issues.
34. Rule 42 of the England and Wales Rules states:
- "No verdict shall be framed in such a way as to appear to determine any question of:*
- (a) criminal liability on the part of a named person or*  
*(b) civil liability".*
35. "Verdict" is not defined, but is normally thought to include the whole reported outcome of the inquest, including any narrative statement of the circumstances of death, and the "conclusion", that is the short-form verdict such as accidental death. Currently, therefore, coroners need to take care to avoid using language in both the narrative and conclusion elements of the outcome, and in the two taken together, which might infringe Rule 42.
36. There are grounds to think that the terms of Rule 42, and in particular the phrase *"framed in such a way **as to appear to** determine any question of...liability"* may inhibit coroners from giving a full and relevant narrative of the events and the roles of individuals and any responsibility they may have had for the death.
37. We are recommending a new approach to inquest outcomes - much fuller narrative and analytical reports, the withdrawal of short-form verdicts such as "accidental death" and "unlawful killing" and their replacement with a description of the death by factual type - for example "traumatic workplace death" or "death at the hands of another".
38. It will be of key importance that in providing the new analytical outcomes coroners should not be prevented from giving an appropriately full and properly evidence-based account of how the death occurred and of what, if anything, might have prevented it. If, for example, they find that a reason offered in evidence for an action relevant to the death - for example a claim of self-defence in a shooting case - does not stand up

in the face of the evidence overall, they should be able to say so in their narrative and analytical outcome and should not be deterred from doing so by the possibility that some might see in their finding an implication of fault or liability. If, conversely, the judgement is that the reasons for the action in question appear sound the finding should make that clear.

39. The critical point is not what people might or might not read into an inquest outcome but what in a functional sense the outcome does and does not determine. What it determines is the cause and circumstances of the death. It does not determine any matter of civil or criminal liability. It would be better and clearer if the statute governing the conduct of inquests simply said so and avoided unnecessary elaboration.
40. **We recommend that in place of the present Rule 42 of the England and Wales Coroners' Rules, the statute governing coroners' inquests should simply state that their outcomes do not determine civil or criminal liability, and that the same approach should be adopted in Northern Ireland.**

### Coroners Recommendations

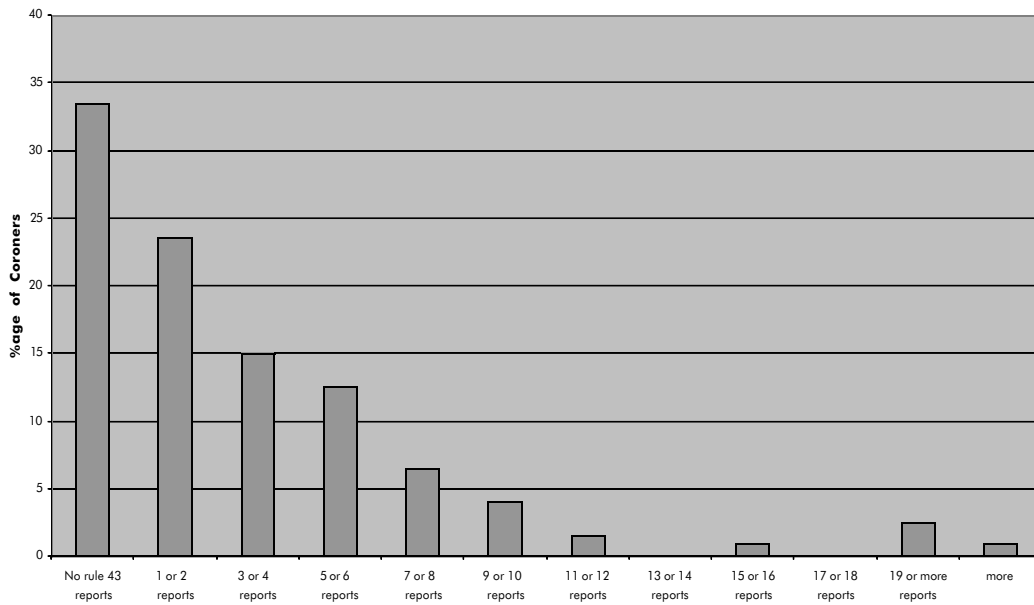
41. Rule 43 of the England and Wales Coroners' Rules states:

*"A Coroner who believes that action should be taken to prevent the recurrence of fatalities similar to that in respect of which the inquest is being held may announce at the inquest that he is reporting the matter in writing to the person or authority who may have power to take such action and he may report the matter accordingly."*

There is a similar provision in Rule 23 of the Northern Ireland Rules.

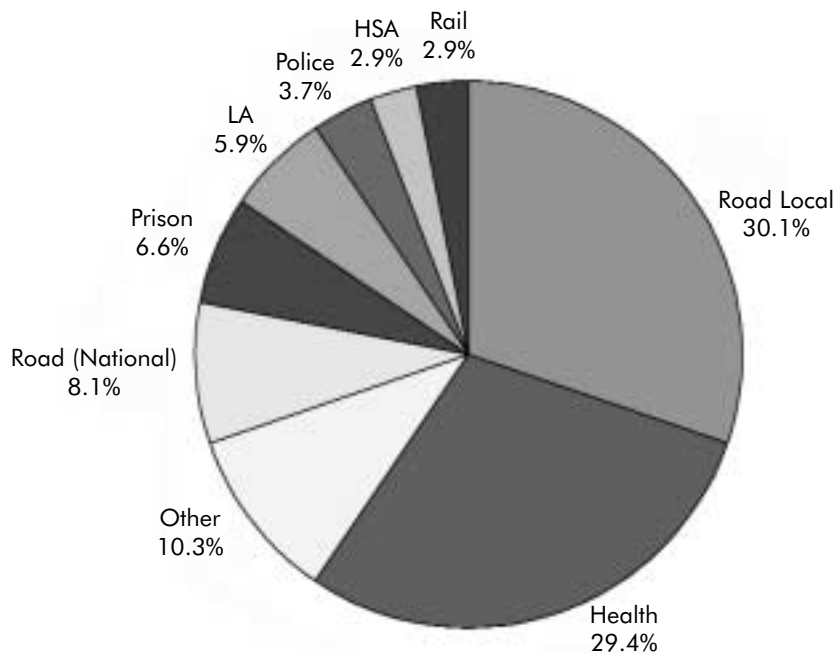
42. We commissioned Peter Jordan to look at how this Rule is used. He found that on average such recommendations are made following just less than one inquest in 50. The recommendation rate per inquest is roughly the same as between full-time and part-time coroners but amongst coroners overall there are marked discrepancies – about a third of the coroners in his sample made no recommendations at all during the previous year, one had made 60, nearly a quarter had made one or two, another quarter had made between three and six, and the remainder had made more.
43. The main agencies to which the recommendations were addressed were local road and health bodies. According to the coroners who had made the recommendations, almost half the recommendations had led within a year to some remedial action. In a quarter of cases the results were unknown or still under review. In the remaining quarter the recommendation had been rejected or the coroner felt that the response was inadequate.

**Rule 43: Frequency of use by Coroners**



In Northern Ireland the average number of reports issued was 2.2 per coroner but, as in England and Wales, this conceals wide variation between coroners. Three had issued none; one had issued one report and two had issued six reports.

**Rule 43 cases by targeted agency**



44. Peter Jordan's work makes clear that there is a significant disparity of practice between coroners over whether and when they make recommendations to reduce future risks. Some coroners have told us that they sometimes rely on press reports of inquests to convey such messages to public authorities. That strikes us as too optimistic an approach. We have a number of recommendations designed to improve the consistency and effectiveness of this important aspect of the coroner service. They cover the responsibility for considering and where justified acting on coroners' recommendations which should lie clearly with the recipient body. The responsibility for seeing that they do so should lie with their audit, regulatory or inspecting bodies. It should not lie with the coroner service though coroners have an interest in knowing, and should be told, what the response to their recommendations has been. They should in their turn keep the family informed of the responses they receive.
45. Recommendations should be made in suitable cases where the death has been investigated but there has been no public inquest, though it is likely that most recommendations will emanate from inquests.
46. **We recommend that:**
- a. **coroners should send promptly to any public or other body a clear and succinct account of any inquest or investigation finding relevant to the body's services, activities or products and to the safety of its users, customers or staff;**
  - b. **the intention to make such a report and its broad content, should be announced as part of the inquest outcome. Where such reports follow an investigation not an inquest the coroner shall make a brief public announcement about the general circumstance of the report but not disclose details of individuals;**
  - c. **copies of recommendations should be sent to any statutory regulatory service which regulates the activities of the recipient body, and to any inspectorate which inspects its work. Where there is no regulator or inspectorate, the report should be sent to the body's auditor;**
  - d. **copies should also be sent to any other corporate body or institution which has influence over the area of activity concerned such as training or education bodies and trades unions;**
  - e. **the responsibility for acting on, or deciding not to act on, such reports lies with the recipient bodies. The main responsibility for pursuing matters with the recipient body should lie with the regulator, inspectorate or auditor, but the coroner should be informed within six months of the recipient's decision on the**

**report or as soon as possible thereafter if the decision has not by then been made. Coroners should keep families informed of such responses;**

- f. the regulatory bodies or inspectorates should in their own annual or periodic reports describe any coroners' recommendations or findings of significance and say whether they are satisfied with the responses that have ensued.**
47. In formulating findings or recommendations about systems failures or weaknesses coroners should bear in mind the limitations of an evidence base that any one death or group of deaths is likely to present. In cases where the issues are narrowly concentrated on local conditions – such as local road design and traffic management arrangements – and the coroner has had knowledge of other deaths in the same circumstances it may be reasonable to make confident and specific recommendations to improve safety. The same may be true with regard to particular institutions – hospitals, prisons, and care homes, are examples, and also with regard to the emergency services.
48. In other cases it is realistic to acknowledge that the regulatory or other public health or safety system concerned covers a much wider range of situations than can sensibly be covered in any one inquest or inquiry. The coroner's role in such cases is to inform the relevant authorities of the circumstances of the death and of any evidence provided by the inquest or investigation of defects in the safety policy or its delivery or enforcement. It would not be sensible for the inquest or inquiry to widen the scope of its investigation so as to cover more aspects of the public safety or regulatory framework than are directly relevant to the case or cases it is concerned with.
49. It is then for the authority concerned on its own accountability to review the significance of the case, and make and as necessary justify its own assessment of whether or not the case substantiates a need for improvements in safety policy, what those might be, and whether they are justified in terms of effectiveness, cost, priorities, and their wider regulatory impact. Regulatory bodies and inspectorates and auditors should follow up these cases as well as those in which a definite recommendation is made.

### **Sending Material to Law Enforcement Agencies**

50. In a case where an inquest, or an investigation, is held and evidence is tendered which in the coroner's judgement discloses matters relevant or potentially relevant to the police, the Health and Safety Executive, the Crown Prosecution Service or any other law enforcement agency, the coroner should at the conclusion of the inquest send his findings on the



causes and circumstances of the death, along with any relevant supporting evidence, to the agency or agencies concerned.

51. He should, in the case of an inquest, announce his intention to do so at the end of the inquest findings. He should not express any opinion on any question concerning the lawfulness of any act or the legal liability of any person or body.
52. It is likely that this circumstance will arise rarely in any case where there is the prospect of a homicide charge, a charge of causing death by dangerous driving or charges of infanticide or assisting suicide as set out in the current Rules 26 and 28. This is because in such cases it is likely that the inquest would have been adjourned, either following a request from the police or Crown Prosecution Service, or by the coroner himself.

### Scope of the Inquest

53. The scope of the inquest has traditionally been narrowly set, concentrating on the immediate rather than the underlying cause, and the phrase “how the deceased came by his death” has not generally been held to include wider concepts of causation. In recent years the higher courts have tended to widen somewhat the scope of the examination to allow for relevant systemic issues to be considered<sup>6</sup> At present there are also unresolved issues about how far the inquest procedure in its present form may in some types of case comply with the obligation on the State to investigate deaths implied in Article 2 of the European Convention on Human Rights<sup>7</sup>, though the coroner’s inquest is not the only process through which that obligation can be met<sup>8</sup>.
54. It is clear that there is some discrepancy between coroners in their approach to issues of scope, and that very tight definitions of scope are a factor tending to diminish public confidence in the inquest as a means of inquiry, particularly in complex or contentious cases.
55. In the last chapter we recommended that the bounds of any coroner investigation should so far as practicable and necessary establish the identity of the person who has died, the time and place of death and its medical cause. Other issues to be covered should be the immediate circumstances in which the death was discovered, the events immediately leading up to it and the actions of any individuals involved in those events, any relevant aspect of the dead person’s circumstances, situation, or history, any management or regulatory systems relevant to the protection of the dead person or others facing comparable risks, and the role of any

<sup>6</sup> *R. (on the application of Amin) v Secretary of State for the Home Department; R. (on the application of Middleton) v Coroner for West Somerset*; Times Law Reports (Court of Appeal), 18 April 2002.

<sup>7</sup> see *Jordan v UK* (2001) 11 E.H.R.C. 1, paras. 103-109.

<sup>8</sup> We look at the Article 2 issues in Chapter 10.

emergency services that were or might have been summoned to the situation. This implies a wider scope than has been traditional, though in more recent years many inquests have sensibly covered this sort of ground.

56. We emphasise that these are the questions to be addressed so far as it is necessary and sensible in the individual case to address them to find the cause and circumstances of the death and whether it might have been preventable. In many cases, whether dealt with by an investigation or a public inquest, the issues that need addressing will be relatively narrow. But in cases where wider issues arise it is sensible that they should be included within the parameters of inquiry.
57. Detailed decisions on scope should be made by the coroner or judge taking the inquest, after giving the family and other participants an opportunity to express their views. These judicial decisions would be subject to appeal within the new coronial jurisdictions that we recommend. They would not, as now, need to go to judicial review.
58. The “sequence of causality” examined in the inquest should be carefully limited to the circumstances and timescales necessary for the purposes of the investigation and inquest as we have defined them. Longer-term and speculative issues should not be within the scope. For example, in a case where someone with a history of mental illness had died in prison apparently through his or her own actions, we would regard the past medical history as within the scope in assessing the cause of the death and the role of the prison authorities (if they were or should have been aware of it), and the treatment given in the prison would be within the scope. But we would regard as outside the scope an examination of the suitability or otherwise of the health treatment of the individual at an earlier stage of life, or general policy issues about the scale or criteria on which mentally ill people are found in prisons.

### **Summary of Recommendations on Inquest Outcomes and Scope**

59. **We recommend that:**
  - a. **decisions on scope should be taken by the coroner in the light of the circumstances of the case, after considering any submissions from the family or other participants. Long-term or speculative issues should be excluded. This is an area where the Coronial Council might itself provide guidelines as experience of the new arrangements grows;**

- b. depending on the case and the points at issue the inquest should establish the identity of the person who has died, the time and place of death, and the medical condition or conditions or the injury or injuries which caused or contributed to the death;**
- c. the inquest should establish the location and circumstances of the death, the activities and situation of the deceased at the time of and in the run-up to the death, the activities and locations of any other people who may have contributed to the death or been in a position to prevent it;**
- d. it should also cover, as necessary and relevant, the history (including medical history) and lifestyle of the deceased, including any treatment received in the run-up to the death;**
- e. it should identify any protective or regulatory systems designed to protect the deceased or others facing similar risks, and consider whether any aspect of those systems or the manner in which they were implemented may have had an influence on the death;**
- f. the role of the coroner or judge presiding at the inquest should extend to resolving conflicts of evidence and should include being able to comment on the reliability of the testimony given.**

## CHAPTER 9 - THE HANDLING OF INQUESTS

**We recommend some changes in the arrangements for conducting inquests. This chapter deals with who should conduct them, and how they should be supported. It covers issues of process such as disclosure and self-incrimination and the use of juries.**

### Jurisdiction to Hold an Inquest

1. Under present arrangements each of the 136 coroner jurisdictions in England and Wales, and each of the seven in Northern Ireland, is a self-standing separate entity. The power to hold an inquest lies generally with the coroner of the district in which the body lies, not with the coroner of the district in which the death occurred if it is different.
2. Coroners may agree between themselves which of them should hold an inquest if there is doubt, for example because the death is one of a number which occurred in the same incident and the bodies were recovered to different districts or some were moved away. The Home Secretary has a power to make decisions in such cases if necessary.
3. These arrangements generally work without too much difficulty in a geographical sense but:
  - they do not allow or encourage the building up of expertise in particular types of case by individual coroners; they can inhibit sensible arrangements for the handling of deaths abroad;
  - there can be confusion or hesitation in disasters where bodies may be recovered from several areas;
  - it is hard to make suitable arrangements for the occasional case where the inquest might better be held outside the locality in which the death occurred or where the body was found.
4. The other respect in which the jurisdiction arrangements need review is that there is no provision for any inquest to be heard at a higher judicial level than that of the local coroner. In this respect the coronial jurisdiction is out of step with other legal jurisdictions.
5. Most civil cases, for example, are heard in county courts, but the more serious are heard in the High Court. Relatively simple criminal cases are dealt with by magistrates or District Judges, more serious cases are tried by Crown Court judges, and some exceptionally serious or complex cases are tried by High Court Judges.

6. Inquests vary in their scale, complexity and difficulty. Some may have complex issues of scope, and of relationship with other investigations. There may be multiple representation of public authorities and families by lawyers including Leading Counsel. Some inquests are highly contentious in local communities. Those which follow major disasters where there are multiple deaths can carry a great weight of family and public grief, anxiety, suspicion and expectation.
7. Other inquests are just as important to family and friends, but do not have the same handling complexities. The structures for dealing with inquests should reflect this range. The "one size fits all" approach has long ago been given up in other jurisdictions.
8. **We recommend some major changes to deal with these defects in structure:**
  - a. **the sixty or so new coroner areas which we recommend to replace the present 136 coroner districts in England and Wales should not be self-standing geographical jurisdictions in their own right, but components within a single England and Wales jurisdiction. Regional Co-ordinating Coroners should be able to allocate cases as between the areas in their regions, and the Chief Coroner should be able to allocate cases within the national jurisdiction. There should be a comparable arrangement for the Northern Ireland jurisdiction;**
  - b. **we expect that the large majority of cases should continue to be dealt with as now "where they lie", and expect the powers of allocation to be used sparingly. Examples of where they might be used include multiple deaths following disasters where the bodies are recovered from more than one area, the handling of some Armed Forces deaths and deaths occurring overseas, and in the development of particular centres of expertise in the handling for example of prison deaths, or the deaths of small children in circumstances of special uncertainty or complexity, or workplace deaths;**
  - c. **a small number of exceptionally complex or contentious inquests should be taken by suitably trained Circuit Judges, and a yet smaller number of still more complex inquests should be heard by suitably prepared High Court Judges, each sitting as Coroner. This provision, too, should be sparingly used.**

Allocation of inquests at Circuit Judge level would be arranged by the Presiding Judge of the relevant Circuit on application from the Regional Co-ordinating Coroner. Inquests at the High Court level might largely be confined to those following disasters with multiple deaths, though we do not exclude other cases where appropriate. They would be arranged by the Chief Coroner in liaison with the Presiding Judge of the Circuits on

application from the Regional Co-ordinating Coroner.

9. Changes on these lines would equip the inquest system more flexibly to deal with major challenges and would increase public confidence in it. They should lessen the demands for special judicial inquiries into complex and controversial events leading to fatalities, which need specific authorisation from Government and given at its discretion.
10. There is also a need to improve the support available to the Coroner in more complex inquests. Because the inquest is an inquisitorial process unlike civil and criminal proceedings, the presider cannot rely on the participants to bring the facts into court. He must do so himself. In effect the Coroner must decide whether there should be an inquest, what its scope should be, what evidence should be brought forward, what witnesses should be called and examined, what the outcome should be, or in a jury case what guidance it should be given on the range of proper outcomes. As things stand he also has to lead most of the questioning of witnesses. In a complex case, this is a wider range of functions, and a heavier burden, than it is reasonable to expect a single individual to carry.
11. We have discussed this with some coroners who have had long and complex inquests to cope with. Their experience and attitudes vary, but some have found themselves at or perhaps beyond the limits of their capacity to fulfil all the roles demanded of them to the judicial standards expected by the modern public. Others have acknowledged serious difficulty in coping with their day- to-day caseload of reported deaths on top of the detailed preparation for a long and complex inquest.
12. **We therefore recommend that in inquests of exceptional length and complexity the Coroner should appoint a lawyer to act as Counsel to the Inquest. The Counsel's functions would be, in consultation with Coroner, to choose and prepare the evidence to be brought into the court, to lead questioning of witnesses (though not to the exclusion of questioning by or on behalf of the family and other participants), and to provide such draft summaries of the evidence and the outcome options as the Coroner might require.**
13. Support of this kind is the norm in Scottish Fatal Accident Inquiries and in most of the Commonwealth jurisdictions we have studied.

### Consistency of Process in Inquests: Rules Committees

14. In England and Wales inquests are conducted under the Coroners' Rules 1984 which are made by the Lord Chancellor under powers vested in him by the Coroners Act 1988<sup>1</sup>. In Northern Ireland the rules are also made by the Lord Chancellor under powers transferred to him in the Judicature (Northern Ireland) Act 1978<sup>2</sup>.
15. Both sets of Rules are in broad terms. There is no provision for either to be regularly reviewed.
16. The recommendations we make on for example document disclosure and the removal of the ban on self-incrimination will require more detailed rules if coroners are to have clear guidance on handling these often complex issues in a consistent way.
17. Our recommendations on the scope, purpose and outcomes of inquests will also need to be reflected in Rules with clear legal status and links to the new primary legislation that will be necessary to establish the new service on a proper footing.
18. In other areas of judicial practice there are standing Rules Committees to keep the processes of using the court under review. There is a need for something similar in the coroner jurisdictions. Devising fair and workable rules of court needs the involvement of the professionals experienced in using them, but it will also be important for the rules to be the subject of consultation with lay user interests and with the other legal and public service interests such as the CPS and the Health and Safety Executive who would be affected by, for example, the disclosure arrangements.
19. **We recommend that in both the England and Wales and Northern Ireland coroner jurisdictions there should be standing Rules Committees<sup>3</sup> to establish the detailed rules of procedure for the conduct of judicial inquests, and keep them under regular review. Before new rules are adopted they should, in draft, be the subject of consultation with representatives of lay users and with other statutory investigative services likely to be affected by, for example, the disclosure rules.**

A recommendation for a Rules Committee was also made in 1936 by the Wright Committee.

<sup>1</sup> The Coroners Act 1988, s.32; the current Rules date from 1984 and were made by the Lord Chancellor under sections 26 and 27 of the Coroners (Amendment) Act 1926. In both statutes the rule making power is to be exercised "with the concurrence of the Secretary of State".

<sup>2</sup> The power lay with the Minister for Home Affairs following the 1959 Act and the current Coroners (Practice and Procedure) Rules (Northern Ireland) 1963 were made under this Act. The rule making power was transferred to the Secretary of State for Northern Ireland in 1973 and then to the Lord Chancellor in 1978. Some of the Rules were amended in 1980 and they were updated so as to be in line with changes to other legislation in 1997.

<sup>3</sup> These are normally appointed by the Lord Chancellor and carry out their work under his guidance and we envisage that this should be the practice here.

### Pre-Inquest Hearing

20. In more complex cases, some coroners already hold pre-inquest hearings. Families and other participants can then raise issues about scope, evidence and disclosure and which witnesses are to be called, and the coroner can give decisions on them. Participants can also say whether they intend to be legally represented and if so at what level. In this way, surprises are avoided and the participants can have their perspectives on key handling issues considered.
21. **We recommend that for complex inquests or inquests where seriously contentious issues may arise, public pre-inquest hearings should always be considered. We would expect them to become the norm in cases of significant complexity.**

### Disclosure

22. One of the examples most often given by lawyers and families of inconsistencies in coroners' practices is over disclosure of documents. Before any inquest starts the coroner will normally have collected various documents and reports. There will usually be an autopsy report, for example. In a hospital death there will also be reports from the doctors. If the death has occurred in prison the coroner will normally have the prison management report. There are likely to be witness statements from any private individuals who witnessed the death or have evidence to give on its circumstances. There may well be police investigation reports on road deaths, and Health and Safety reports on workplace deaths.
23. There are no rules requiring any written evidence to be disclosed in advance to families or other interests participating in the inquest, even though they will normally be able to question witnesses who provided such reports. Such questioning is of course limited in its usefulness when the written evidence of the witnesses is not available. The Home Office does, however, voluntarily provide advance copies of the prison management report to the family and other participants in advance of inquests into prison deaths. Some coroners do provide advance disclosure of some documents. Others generally do not.
24. The absence of any advance disclosure provision in the Rules no doubt reflects the traditional view that the inquest is a fact-finding inquiry and that its processes are designed to enable the coroner to achieve that function, and that disclosure practices found in adversarial litigation are not suitable to the inquest.
25. Nevertheless families who find that at the inquest they see for the first time complex and important reports which have been in the hands of for example the hospital and its lawyers for a long time in advance of the proceedings are bound to feel that the cards are stacked against them.



26. It is important that documents disclosed in advance of inquests should not be made public by anyone who receives them, or passed on to anyone else. This will include the media and in cases where there might be a future trial extremely careful handling will be necessary. Nor should there be any approach to their authors or to any people named in them.
27. **We recommend that for every inquest the coroner should be required to keep a schedule of all the documents held by him.**
28. **We recommend that the new Rules Committee should devise a set of rules on disclosure which reflect a presumption in its favour but contain such safeguards or limitations as can be shown to be necessary for the effectiveness of other essential investigations and legal processes such as prosecutions. The rules should contain safeguards against improper use of the material and should prohibit any approaches to its authors or people named in it.**

### **“Addresses as to the Facts”**

29. The England and Wales Rules state “No person shall be allowed to address the coroner or the jury as to the facts.” This is intended to prevent the family or other participants from pressing for a particular interpretation of the evidence or a particular outcome to the inquest in a summing up.
30. In practice some coroners do allow participants or their lawyers to put forward interpretations of how the death occurred, and in the Northern Ireland Rules there is an explicit discretion to allow this.<sup>4</sup>
31. Families or other participants are likely in a contentious case to see a ban on being able to say what they think happened as a denial of a right to be heard <sup>5</sup>. We think that it is better to admit as normal practice a right to address the coroner or the jury as to the facts, with the coroner being able to rule out those comments which go beyond this. **We recommend that the Rules Committee should address this point sympathetically, while emphasising that all participants in the inquest have a duty to assist the court in finding facts and avoiding matters outside the proper scope of the inquest.**

<sup>4</sup> Coroners (Practice and Procedure) Rules (Northern Ireland) 1963, Rule 20 says that “no person shall be allowed to address the coroner or the jury as to the facts unless the coroner shall so permit.”

<sup>5</sup> For a useful discussion of this issue, see the judgement (under “Reservations”) of Lord Justice Pill in the Court of Appeal case *Sacker v. H M Coroner for West Yorkshire* [2003]EWCA (iv 217).

## Self-Incrimination

32. Witnesses can be legally compelled to attend inquests – in Northern Ireland this is a provision which follows a ruling in the European Court of Human Rights that its absence infringed the European Convention on Human Rights<sup>6</sup>.
33. However the Rules also state that no witness at an inquest shall be obliged to answer any question “tending to incriminate himself”<sup>7</sup>.
34. In inquests into traumatic deaths, on the road or in the workplace, for example, or into police or other law and order service shootings, families are inclined to see this as a “right to silence” protecting the person or people who they think may have had a culpable part in the death.
35. On the other hand it has long been a principle of law that no-one should be put under pressure to provide evidence that would lead to his own prosecution. This is reflected in Article 6 of the European Convention of Human Rights.
36. However the right against self-incrimination is seen as restricting the capacity of inquests and other judicial inquiries to get at the full facts so solutions to the problem need to be considered.
37. We are including as part of the documentation being made available with our report an analysis of possible solutions prepared under the auspices of Anthony Heaton-Armstrong a member of the Review Group<sup>8</sup>.
38. Of the various alternatives we are inclined to prefer the option described as “Compulsory Disclosure under Limited Embargo”. Under this a witness not choosing voluntarily to waive the privilege against self-incrimination would be told by the coroner that he must truthfully and properly answer the question asked but given an assurance that any evidence he gives in answer to it will not be used in any criminal or disciplinary proceedings against him.
39. **We recommend that this option be pursued by the Rules Committee and that the Committee should prepare a standard direction which could be used to ensure consistent and accurate guidance to witnesses.**

<sup>6</sup> In the case of *Jordan v United Kingdom* (as also in the cases of *Kelly v UK* and *Shanaghan and Others v UK*) the Court found that the provision in the then Northern Ireland Coroners Rules whereby a person who might be charged following a fatal incident could not be required to attend the inquest as a witness was a breach of the Convention. The Lord Chancellor amended the relevant Rule in February 2002 but the privilege against self-incrimination remains.

<sup>7</sup> Coroners Rules 1984, Rule 22 says “(1) No witness at an inquest shall be obliged to answer any question tending to incriminate himself, and (2) Where it appears to the coroner that a witness has been asked such a question, the coroner shall inform the witness that he may refuse to answer.” Rule 9(1) of the Coroners (Practice and Procedure) Rules (NI) 1963 has an almost identical wording.

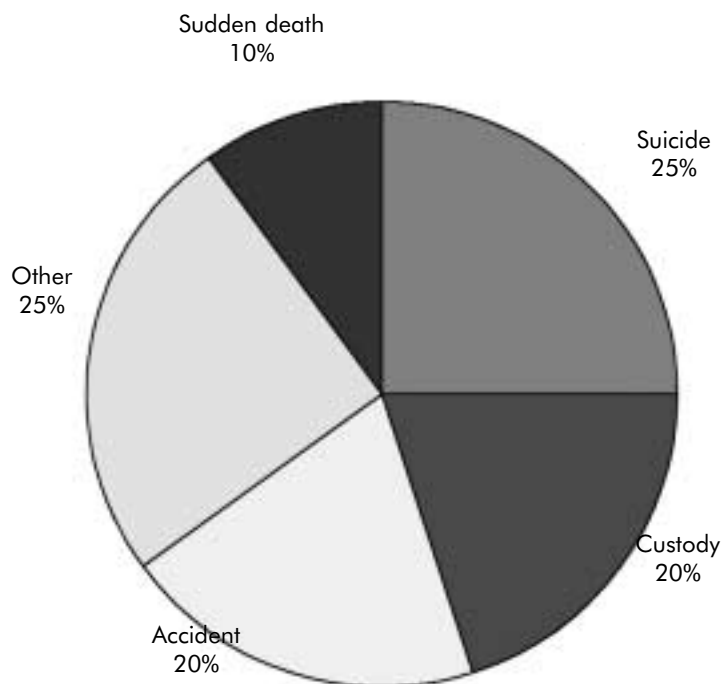
<sup>8</sup> The note on self-incrimination in Volume 2 was prepared by Anthony Heaton-Armstrong and Brett Weaver of 9-12 Bell Yard.

40. The number of occasions on which this direction would be used would probably be small, but in such cases it would increase the prospect of a thorough and reliable inquest outcome.
41. The procedure would not mean that prosecutions or disciplinary proceedings could not be brought against witnesses in these situations. It would protect them solely against their own inquest testimony being used against them in such proceedings. It would give no immunity against the use of their own testimony in civil proceedings. Nor would it give any immunity to corporate bodies against the use of inquest testimony by their employees in criminal or civil actions brought against them corporately.

### Juries

42. Some 3% of the 26,000 inquests held each year in England and Wales have juries. In Northern Ireland figures on jury inquests are not kept although the proportion is likely to be even lower.

#### Cases that have Juries by reason for reporting the deaths (England and Wales – based on 18 cases in the sample)



Deaths in prison, police related deaths, and deaths occurring on a railway must always be heard before a jury. In other cases it is for the Coroner to decide whether or not to summon a jury.

## Chapter 9 - The Handling of Inquests

43. There is some untidiness and lack of clarity about when exactly the law requires juries at inquests but broadly the position is that currently they are required:
  - a. when the death occurs in prison, in police custody or as a result of police operations;
  - b. for all workplace or other deaths reportable under health and safety, transport or other legislation;
  - c. where there appears to be a wider public health or safety interest in the death.
44. In addition coroners have discretion to use juries at other inquests and often choose to do so when there are contentious factual issues to be addressed.
45. Under present arrangements the jury choose the short-form "verdict" included in the inquest outcome, subject to any guidance the coroner gives them on the suitability and legality of the range of choices in the case.
46. We have recommended that the present short-form verdicts should be replaced by a range of outcomes concentrating on:
  - reasoned narrative and analytical findings about the cause and circumstances of the death;
  - a classification of the death by type, with no implied or explicit judgment about legality or liability;
  - whether there were systems failures which may have contributed to the death.
47. The outcome of inquests will as a result be longer, more narrative, and more complex. There is an issue about whether and if so how juries might fit into such a process.
48. One school of thought, represented by some but not all of the coroners, lawyers and judges with whom we have discussed the issue, is that the fuller reasoned judgments to be expected from the new approach would be a better substitute for a summary jury verdict and that juries would not fit in easily to the process of drafting the longer more complex conclusions. On this view, juries would no longer be involved in inquests.

49. The contrary view is taken by some families who have been through prison or workplace death inquests, for example. They see the jury as an important citizen presence, counterbalancing the case weariness that they think can incline the coroner service towards the big established public service and corporate interests.
50. This view is supported by human rights legal interests who also point to the potential of juries to bring a dimension of gender balance and racial diversity to inquest proceedings.
51. We think it would be a big step to remove juries altogether from the inquest system, and probably an imprudent one. We regard their participation as important in cases where someone compulsorily in the care of the state has died in unclear circumstances, or where a death may have been caused by agents of the state. We do not consider that with fuller and more reasoned findings as the outcome of inquests juries are essential in other cases.
52. **We therefore recommend that juries should be empanelled in such cases and in others which fall within Article 2 of the European Convention on Human Rights but not in other cases.**
53. On the role of juries in the Article 2 cases **we recommend that:**
  - a. **they should be able to ask questions of witnesses, subject to the coroner's rulings on questions of relevance;**
  - b. **they should choose the classification of the death, for example whether it was caused by the actions of one or more other person or a deliberate act of self-harm or injury by the person who has died;**
  - c. **the coroner should identify for them critical conflicts or uncertainties of factual evidence for them to resolve, giving such guidelines as he considers justified on the reliability of particular testimony;**
  - d. **the coroner should keep a record of the exchanges between himself and the jury;**
  - e. **the coroner should inform them of the main analytical and systems findings he is minded to make and give them an opportunity to say whether they agree with them, and record in the inquest finding any comment that they make.**
54. We do not propose any change in the size of inquest juries, which is in the range 7 to 11 members.

## Publicity

55. The Coroner's Rules state "Every inquest shall be held in public: provided that the coroner may direct that the public be excluded from an inquest or any part of an inquest if he considers that it would be in the interest of national security so to do".<sup>9</sup>
56. We consider that should remain the policy. **We recommend, however, that the coroner should have a power to forbid the publication of detailed material or evidence given in an inquest if he is satisfied that to do so would be in the interests of the privacy and well-being of the bereaved, and that there is no overriding public interest in access to the material.** We have in mind here suicide notes, for example, in cases where people take their own lives which are still the subject of a public inquest. We would expect that the number of such cases where this power would be used to be very small.
57. Press representatives have told us that many coroners appear to them to have no reliable system for giving public notice of upcoming inquests. They also say that some coroners seem to them deliberately to conceal some inquests from the press and the public. **We recommend that where there is to be an inquest the coroner should regularly and without exception follow the practice of the Courts Service in making available the details.**
58. We understand that the Judicial Studies Board have prepared guidance for Crown Court staff, Magistrates' Court staff, and the media on issues such as supply to the media of court documentation and information, and the proper application of reporting restrictions. **We recommend that similar guidance should be prepared for coroners and their staff.**

<sup>9</sup> Coroners Rules 1984, Rule 17. In the Coroners (Practice and Procedure) Rules (Northern Ireland) 1963, Rule 5 is identical.

## CHAPTER 10 - INQUESTS, INQUIRIES AND OTHER INVESTIGATIONS

**In this chapter we look at the relationship between Coroner investigations and inquests, and investigations or inquiries into deaths done through other processes.**

1. In the very early days of the coroner system, the coroner's inquest was in most cases probably the only form of legal inquiry into a death that was available.
2. The position is now very different:-
  - a. deaths with possible criminal involvement, including traffic deaths, are investigated by the police and the Crown Prosecution Service and may lead to prosecutions in the criminal courts;
  - b. any death where there is alleged negligence may lead to civil proceedings and awards of damages;
  - c. workplace deaths are investigated by the Health and Safety Executive or local authorities, and may lead to prosecutions;
  - d. deaths in rail, air or maritime incidents will be investigated by the appropriate statutory inspectorate;<sup>1</sup>
  - e. hospital deaths may be considered through an internal management inquiry, an independent inquiry set up by the hospital or Health Trust, the NHS complaints procedure, and/or an inquiry instigated by the appropriate Minister;
  - f. deaths in prison will be investigated in an internal Prison Service inquiry, and may be the subject of an independent inquiry commissioned by the Prison Service;
  - g. Armed Forces deaths will be investigated by a Board of Inquiry;
  - h. deaths at the hands of the police will lead to a supervised investigation by the Police Complaints Authority, and there may also be an internal inquiry by the Police Force concerned, and external inquiry by another Force;

<sup>1</sup> These are respectively the Rail Safety and Standards Board, the Air Accidents Investigation Branch and the Marine Accident Investigation Branch of the Department for Transport.

## Chapter 10 - Inquests, Inquiries and Other Investigations

- i. if there are allegations of negligence or incompetence against individuals they may face disciplinary proceedings as employees. If they are professionally regulated they may also face proceedings by the relevant professional body – the General Medical Council for example;
  - j. if the death occurs in a regulated or inspected facility such as a hospital or a care home, or a prison, the regulators or inspectors may do some investigation;
  - k. government Ministers with public service responsibilities have powers to set up statutory inquiries;
  - l. in a few very high profile cases, usually involving multiple deaths, the Government may appoint a judicial tribunal under the Tribunals of Inquiry (Evidence) Act 1921.
3. A large proportion of the deaths at present being subjected to an inquest are certain to have at least one other form of investigation. All workplace deaths, and all traffic deaths would be the subject of investigations by the Health and Safety Executive and the police respectively and those investigations may be followed by prosecutions.
4. Many hospital deaths which reach the inquest court are likely to be the subject of an internal inquiry of some kind. All deaths in custody or at the hands of the police or law and order services are likely to be the subject of at least an internal inquiry. A very significant proportion of the deaths which result in an inquest are the subject of some kind of other inquiry as well. Exceptions, typically, include unexpected non-traumatic deaths from heart attacks for example, and deaths from self-harm which occur outside any regulated setting.
5. The issues we have considered are:
  - whether there is avoidable duplication between these various procedures and the coroner's investigation or inquest;
  - how far should the coroner's inquiry and other forms of investigation rely on the same source of factual and technical investigative field-work;
  - where there is more than one investigation or inquiry, what should the time sequence be as between the inquest and the others;
  - inquest arrangements and the coroner's role after mass disasters;
  - what specific provisions are necessary to deal properly with death investigations which engage Article 2 of the European Convention on Human Rights.



## Multiplicity of Investigation

6. The coroner's investigation or inquest is concerned only to investigate deaths. All the other processes have a wider range of functions. They can be used to investigate the circumstances of a death, but they are also used to investigate other events. There are, for example, ten times as many serious injuries in traffic incidents as there are deaths, and the police will investigate all of them to varying extents.
7. The same is true in most of the fields in which death investigations are done by other agencies as well as the coroner. Aviation incidents are investigated by the Air Accident Investigation Board whether they involve deaths or injuries. Railway and maritime incidents are examined by the specialist inspectorates. Hospitals investigate adverse medical events whether or not they have fatal outcomes.
8. All these other procedures yield important outcomes, not least because they lead to service and safety improvements, and may well be the main and most important source of expert and broadly-based investigation for that purpose. There should, thus, be no question of standing any of them down in favour of the coroner's investigation, either generically, or in individual cases.
9. In Chapter 7 we include in the objectives we suggest for the coroner's investigation:
  - to contribute, along with other public services and agencies, to the avoidance of preventable deaths;
  - to help families understand the causes and circumstances of the death of the family member in cases of significant uncertainty which cannot be resolved through other processes.
10. The criteria for holding public inquests which we suggested in that chapter are also relevant. They include all deaths in detention or at the hands of the police or law and order services, and all traumatic deaths in public. They also include:
  - a likelihood that a public judicial inquest will uncover important systems defects or general risks not already known about;
  - any category of reportable death where there is significant enough uncertainty or conflict of evidence over the cause and circumstances to justify the use of a forensic judicial process.
11. Also relevant are our recommendations on the scope and outcomes of inquests in Chapter 8, and in particular the recommendation that the main outcome of an inquest should be a narrative and analytical finding, in place of the short-form "verdict" which in England and Wales now

tends to be the focus of attention in inquest outcomes. We also made it clear in that chapter that these outcomes should not establish or attribute criminal or civil liability for a death or the absence of such liability.

12. It follows that where another investigative process has the purpose of establishing whether there is such liability it will not in principle be duplicative of the inquest in relation to its purpose, though there may be some overlap of the factual ground on which each investigation is based. Police investigations and examinations by the Crown Prosecution Service have those purposes. So do police investigations of road deaths and investigations by the Health and Safety Executive of workplace deaths.
13. The same is broadly true of professional regulatory or employer investigations of suspected malpractice or misconduct. It is not true of statutory air accident, maritime and railway investigations. Their purpose is to find out what caused the incident and make recommendations for technical systems change which would make it less likely to happen again.
14. The other general point we would make is that where the other investigation or inquiry is in private, and particularly where the inquiry proceedings do not adequately involve the family (except perhaps to give a statement) and do not have outcomes which are published or made available to the family, there should be a presumption that it will not of itself satisfy the role of the coroner's investigation or inquest, if there remain significant matters of uncertainty or contention. Similarly, it is clear that the possibility of civil proceedings does not of itself satisfy the need for an investigation where there is a significant uncertainty about the cause or circumstances of death. This is because the costs and risks of civil litigation will not always be justified – for example where the victim is young and has no dependents – and civil cases are usually settled without public proceedings.
15. We look, therefore, at various issues of overlap and relative timing and fieldwork preparation in particular fields against this background.

### **Murder and Manslaughter**

16. The practice in England and Wales is that after a death apparently by murder or homicide an inquest is opened and adjourned while the police investigate and any prosecution proceeds. If there are matters about the death that need further investigation after the conclusion of criminal proceedings the inquest is resumed. Otherwise the coroner takes no further action. The most likely grounds for resuming an inquest are to find out whether there has been a systems failure to protect the victim, or to resolve any significant uncertainty over what type of death it was – for example through a fall, from injury inflicted by someone, or by the actions of the person who died.

17. We think this is the correct approach. There is no duplication of function between the two processes because the establishment of criminal liability is outside the scope and purpose of the inquest. It would not be sensible to hold an inquest before completion of the criminal investigation or any trial. Any delay in bringing the prosecution or investigating the cases can reduce effectiveness because evidence may go stale. Publicity at the inquest might be prejudicial to the criminal trial.
18. In Northern Ireland the process is different. Inquests are not usually opened and adjourned in such circumstances. The holding of an inquest is in any case discretionary in Northern Ireland. Prosecutions following deaths related to inter-community conflict have occurred in some cases but not in others, though investigations seem often to continue in form if not in actuality for long periods. There is therefore a risk that neither of the main judicial processes designed to deal with violent deaths – the inquest and the criminal trial – will be brought to bear on such deaths, or that there may be a prolonged, possibly even an indefinite, period of uncertainty over whether there is going to be an inquest. This is not satisfactory.
19. **We recommend that:**
  - **The England and Wales practice of opening and then adjourning inquests into violent deaths pending police investigations and any criminal trial and then resuming the coroner’s investigation if there are matters still to be resolved should continue. A similar process should be implemented in Northern Ireland.**

### Traffic and Workplace Deaths

20. Where the police are investigating the possibility of a manslaughter charge following a road or a workplace death or a charge of causing death by dangerous driving the inquest is adjourned in the same way and where appropriate resumed later.
21. However, when “lesser” traffic or health and safety offences are under investigation the inquest may go ahead before this is brought to a conclusion either through a prosecution or otherwise, though practice seems to vary considerably over whether this is done.
22. The family support groups from whom we have heard in these two areas feel strongly that the inquest should precede any health and safety prosecution or magistrates court proceedings against the vehicle driver. They argue that the inquest may disclose material relevant to the prosecution and that it may establish clearly that a death involving attributable fault occurred. One of their most persistent complaints is that traffic or health and safety prosecutions for offences less serious than

manslaughter do not in their opinion give enough weight to the fact that though the offence committed may have been less serious in a technical or legal sense, someone died as a result of it.

23. The TUC, in relation to workplace deaths, argue strongly that the inquest serves a necessary purpose which overlaps with but is different from the health and safety prosecution:

*“They [inquests] explain by investigation what happened, so that some conclusions can be reached, and where appropriate preventative methods can be applied. They do not perform the same function as a police, HSE, or other regulatory investigation, although they will necessarily cover some of the same ground – those are about prevention, too, but they directly serve the needs of the regulatory agency, rather than the colleagues and family of the victim, and there is no real mechanism for the families and colleagues to determine whether a police or HSE investigation has been satisfactory. ....One other concern is that without public inquests the decision about whether to prosecute will fall to a wholly private process involving the CPS, the HSE and the police and so on.”<sup>2</sup>*

24. The Health and Safety Executive takes a similar position. It argues strongly that the inquest should precede the health and safety criminal proceedings and that the investigation for the inquest should be largely separate from the HSE investigation of health and safety offences. It points out that inquests are delayed because of the difficulty in getting accommodation and arranging for juries, and that the consequent delay in starting health and safety prosecutions weakens their chances of success because evidence goes stale. It points to significant legal constraints on its ability to share information it has gathered for its statutory investigations with families.
25. Coroners with whom we have discussed these issues are apt to say that they have a very limited capacity of manpower and skill at their disposal to conduct their own investigations of workplace deaths, that in cases where there is the possibility of a manslaughter charge there are often significant delays in getting decisions on whether it is going to be brought, and that obtaining information from the HSE and/or or police for the purpose of the inquest can itself take a long time.
26. A new protocol agreed between the Association of Chief Police Officers, the British Transport Police, the Director of Public Prosecutions and the Health and Safety Executive and the Local Government Association has been issued<sup>3</sup>. It aims to improve coordination between the various

<sup>2</sup> Submission to the Review, December 2002.

<sup>3</sup> *Work-Related Deaths: a Protocol for Liaison*, published by The Health and Safety Executive, 18 March 2003.

prosecution and investigatory authorities. It confirms the general policy of holding inquests back while a manslaughter prosecution is considered or brought. It also confirms the policy of holding inquests in advance of decisions on whether to bring prosecutions for health and safety offences, unless to wait would prejudice the case. It says that the CPS should always take into account the consequences for the bereaved of the decision whether or not to prosecute, and of any views expressed by them. Where there is to be no CPS prosecution the CPS will set out its reasons in writing and send them to the bereaved, and will offer to meet them to discuss the reasons for reaching the decision.

27. We have looked at these issues against the objectives we have suggested in Chapter 7 for the coronial death investigation service. These are:
  - a. to satisfy the public that there is an independent and professional process for scrutinising deaths of uncertain cause or circumstances;
  - b. to help families understand the causes and circumstances of the death of the family member in cases of significant uncertainty which cannot be resolved through other process;
  - c. to contribute along with other public services and agencies to the avoidance of preventable deaths.
28. Using the coroner investigation or inquest as a preliminary proceeding to a criminal or other prosecution is not amongst the functions we foresee for it. It would not be sensible to go back in the direction of its historic role as a committal process, though if material of relevance to a prosecution should emerge in an inquest it should of course be communicated to the relevant authority.
29. In current circumstances the coroner's investigation or inquest may in work-place deaths have an important role in helping families to understand the causes and circumstances of the death, and also the workplace colleagues of the victim.
30. The inquest may also have a role in defining general risks and reducing future fatalities in similar circumstances, though exercise of that role must be secondary to that of the dedicated health and safety agencies.
31. There is nevertheless risk of duplication between the coroner's work in this field and the work of the specialist agencies, and the scale of that duplication would increase if the coroner service were fully equipped with the technical expertise and manpower needed to investigate all workplace deaths independently of the police, the Health and Safety Executive and the local authorities. Even if the necessary additional resources of specialist skill were available there would be an issue as to whether they were better deployed in the coroner service or to reinforce the investigatory resources of the Health and Safety Executive and the other

agencies. In practice coroners are bound to be significantly dependent on the police and the specialist health and safety investigators for the evidence needed in a workplace death inquest.

32. The new Liaison Protocol should lead to some improvements in clarity of process and responsibility amongst the prosecution and enforcement agencies, and perhaps to prompter handling of cases.
33. We have three recommendations from the perspective of the coroner service, two of them related to the longer-term but the first to the medium term.
34. **The first recommendation is that when the new national coroner jurisdictions are set up investigation of workplace deaths should be regarded as a specialist function on which expertise would be concentrated in one coroner in each of the new coroner areas or perhaps even one coroner in each region. A similar specialisation should be encouraged in a small number of coroner's officers working with that coroner. Expertise in handling the cases might thus increase, and the risk of duplicating skills within the coroner service be reduced.**
35. The other recommendations are that:
  - a. **The Health and Safety Executive and the other enforcement agencies should consider how far they could offer bereaved families the same opportunities to give a view of whether they should prosecute as the CPS is committed to doing, and make the same commitment to explain their decisions to families.** To the extent that this can be done, the pressure on the coroner service to provide factual explanations might usefully decrease.
  - b. **For the longer term the Coronial Council's programme of monitoring the coroner service should include a study of the role and effectiveness in workplace deaths of the coroner service in relation to other agencies in meeting the requirements of families and the wider public interest through its investigations.** It is clear from the material we have received that there are strong convictions in this area and it is desirable systematically to explore the underlying facts.
36. In the meantime we consider that the 300 traumatic workplace deaths a year should normally be the subject of public inquests and have included them in the suggested list of criteria for inquests in Chapter 7. We do not propose that they should be jury inquests.
37. On traffic deaths we consider that the determinants of whether there should be a public inquest should be mainly, as in other cases, whether, for example, any criminal proceedings have resolved relevant issues and there are significant uncertainties and conflicts of evidence which need a

public forensic process to unravel. Where that test is satisfied the inquest should be held. Where it is not the coroner should use the evidence that is available from the police investigation to provide the family with an account of the cause and circumstances of death as we recommend should follow other coroner investigations which are not the subject of an inquest.

### Multiple Fatalities

38. When there is a disaster involving multiple deaths there are likely to be a number of other investigations alongside the coroner's. The police and in due course the Crown Prosecution Service are likely to be involved. If it involves a plane or train crash or a maritime catastrophe the appropriate regulators and statutory safety inspectorates will all be involved. So too might the Health and Safety Executive.
39. There are often pressures for a judicial public inquiry to be set up by the appropriate Government Minister, and in a situation of special gravity there may be a possibility of or pressure for a judicial inquiry through Parliamentary resolution under the Tribunals of Inquiry (Evidence) Act 1921.
40. There may be several statutory investigative or other bodies involved on the investigative side as well as pressure for a special public inquiry. There will also be a large number of people and institutions with an interest. The transport provider, or the provider of the facility in which the disaster has occurred – for example a sports ground or leisure facility - contractors to and employees of that provider, their insurers, their statutory licensing or regulatory body, their staff unions or representative groups, will all be involved to some degree. The families of the people killed and injured individually and collectively, perhaps in different groupings, will be central participants, and there may also be issues about the emergency services that need to be covered.
41. In any formal inquiry process all the interests concerned will be legally represented, often by senior counsel.
42. If the Government sets up a special judicial inquiry it may substitute for the coroner's inquest. There is provision in the 1999 Access to Justice Act enabling the Lord Chancellor to arrange for the coroner not to proceed with an inquest. This is a sensible arrangement because it means that there will be no duplication of the overall judicial inquiry into the causes and circumstances of the deaths. The Coroner's role is then to deal with identification issues and do what may be necessary to determine the exact causes and circumstances of individual deaths.
43. Where there is no such ad hoc judicial inquiry, the coroner's inquest will be the main public judicial process to take an overview of the cause of the

deaths and the circumstances of the event which led to them.

44. It is in part to equip the coroner service to cope satisfactorily with such situations that we have recommended that there should be provision for inquests of exceptional complexity or contentiousness to be taken by a Circuit or High Court Judge. Proceedings of such complexity handled in the civil or criminal jurisdictions would be managed by judges at that level. If we have a generic death investigation system it ought to be equal to the largest as well as the smaller challenges that it will face. The fact that currently it is not may in part explain why there is often such pressure for ad hoc judicial inquiries to be set up by the Government.
45. It is also partly with these circumstances in mind that we have recommended that in complex inquests a Counsel to the Inquest should be appointed. It is unrealistic and unfair to expect the coroner or judge presiding over a complex judicial inquiry on inquisitorial lines to do so without such support.
46. When ad hoc inquiries are set up they are assembled from scratch because there is no standing mechanism that can be quickly brought into play, and there are few standard rules of process on which they can rely when in due course they start work. Large ad hoc judicial inquiries can take a long time and be very expensive.
47. When the Government decides not to set up such an inquiry, there can be a sense of bitterness and frustration amongst the families who feel that the State has failed to respond to the magnitude of the tragedy that has struck them. Under our proposal it would be for the senior judiciary responsible for the coroner jurisdiction to decide whether the Inquest should be presided over by a Circuit or High Court Judge. Where such an inquest was established it could immediately get to grips with the situation and rely on settled ground rules for conducting a fair and suitably comprehensive inquiry.
48. The utility of the inquest in such situations and others where there are multiple investigations would be further enhanced if the inquest presider had a clearer role, and, if necessary, clearer powers to obtain from the other statutory investigative bodies information on the scope and timing of their own investigations. This would be effected through pre-inquest public hearings of the kind we have recommended in Chapter 9.
49. We envisage that in such situations the coroner should hold a public pre-inquest hearing to determine, amongst other matters, the likely timescale and scope of the inquest. All the key interests would be represented at it. As well as the families and the providers of the facility in which the disaster had occurred the police and all the statutory regulatory and investigative bodies would be represented. So would any Government Minister with statutory inquiry powers enabling him to arrange for an ad hoc inquiry.



50. The coroner would invite all the investigative bodies to describe the investigations they had initiated or were intending to hold, with indications of their likely timescales, scope and purposes. Where a Government Minister was represented he would be able to explain whether he intended to commission a statutory inquiry under his own powers and if so what its scope purposes and likely timescale would be.
51. All the interests represented would be able to make their own representations on, for example, the scope and timing of the inquest. The coroner, after considering them, would announce his decision on the likely timing of the inquest and on its scope.
52. In doing so he would have regard to some general principles. We suggest that these should be:
  - a. the inquest, or a coroner's investigation, would be the main official process for identifying the circumstances of death of individuals;
  - b. where a technical investigation had been conducted by statutory body such as the Air Accident Investigation Board its technical inquiries and investigations should not be unnecessarily repeated or duplicated by the inquest or the coroners' investigators. Its findings on technical and associated factual matters should be accepted as presumptively correct. Evidence of those findings might be given to the inquest by senior members of the investigation team. They could be cross-examined on the scope and method of their investigation but not normally on its details unless these were the subject of significant dispute which needed to be resolved;
  - c. if the Government Minister indicated that there would be a statutory inquiry the coroner would not repeat in the inquest the matters within that inquiry provided that it was clearly independent and accessible to the families;
  - d. if there was to be no such public inquiry the inquest would cover all the matters that would normally be within the scope of an inquest as we have recommended in Chapter 8. These would include whether there had been systems failures without which the deaths would or might have been prevented, the activities of individuals and corporate bodies or institutions, consequent recommendations for remedy and any report to the prosecuting or enforcement agencies which the inquest findings and evidence justified;
  - e. the inquest would proceed as quickly as possible after the statutory technical inquiry was able to provide evidence on the technical causes of the incident.

53. A process on these lines would have significant advantages over present arrangements:
- i. the coroner would be presiding over an open public coordinating process between all the various Governmental and investigatory agencies with roles after disasters. He would not have powers to determine how or when they should each conduct the inquiries for which they were responsible but he would publicly be able to obtain information from them on their intentions;
  - ii. for families there would be greater clarity of process, more opportunity to find out about the overall follow-up to the disaster, and more opportunity to influence it;
  - iii. the inquest could deal with all suitable matters not being dealt with through other process, and it would be conducted with a greater degree of authority and thoroughness than the present arrangements allow.
54. There would no doubt remain situations in which special public inquiries set up under discretionary powers by Ministers would be necessary, but they would be less frequent. They would of course remain the most appropriate procedure where a special investigation was judged to be necessary but the issues did not involve deaths.
55. Overall, however, the Circuit or High Court Judge Inquest, supported by an Inquest Counsel, should have sufficient public and family confidence to reduce the pressures for special public inquiries. The fact that the scale and level of the inquest and its scope would be decided by the inquest Court after hearing the views of the families and other interests and not by the Government would be seen by many as an advantage.
56. The Association of Personal Injury Lawyers has suggested to us that there should be a Director of National Safety<sup>4</sup> for the management of all aspects of the follow-up to events with multiple fatalities. That proposal goes beyond our terms of reference. We would see advantage, however, in the heads of the two new coroner jurisdictions that we recommend becoming expert in the judicial and investigatory aspects of such events. To have a single experienced source of expertise and authority on those aspects would be a gain.
57. **We recommend that following disasters leading to multiple deaths:**
- a. **the inquest should normally be held by or at the level of the head of the coronial jurisdiction, or the inquest scope and arrangements should be settled after application to him;**

<sup>4</sup> Submission to the Review, 18 November 2002.

- b. there should be as soon as reasonably practicable after the event a pre-inquest hearing at which all interests should be represented to hear information from all the technical and other investigatory bodies with responsibility to follow-up the event. They would explain the nature and scope of the investigations they intended to carry out and their likely timescale;**
- c. if the possibility of a statutory inquiry under Government powers were at issue, the relevant Government Minister should be represented to explain the Government's intentions;**
- d. families would be represented at such a hearing and would be able to question the other participants;**
- e. the judge sitting as coroner would reach decisions on the timing and scope of the inquest in the light of the information elicited by the pre-inquest hearing;**
- f. the Inquest would hear representations from the leaders of the statutory technical investigations and examine them on the general scope and method of their investigations but subject to that the details of their investigations would not normally be subject to scrutiny or re-investigation by the inquest.**

### **Inquests in Cases involving Article 2 of the European Convention on Human Rights**

- 58. There are some similar issues in the handling of some cases which need to be investigated under Article 2 of the European Convention on Human Rights. The main requirements for such investigations are that they should be "prompt, independent and impartial, effective, public, and sufficiently inclusive of the next of kin to protect the interests of the deceased"<sup>5</sup>.
- 59. The obligation to arrange for a suitable investigation arises case by case and is on the State. It can be met through any investigative process or combination of processes which meet the Article 2 criteria. It does not have to be met through the inquest.
- 60. However, since the coroners' investigation and the inquest are generic mechanisms for investigating deaths it would be sensible to regard the inquest as the process most convenient and apt for the generality of Article 2 cases unless in a particular case there were good reasons for choosing

<sup>5</sup> This summary is from the submission to the Review from Tim Owen QC and Danny Friedman, *op cit.* The criteria themselves are from the Jordan case [Jordan v UK (2001) 11 B.H.R.C. 1, E.Ct.H.R. see paras 106 ff.]

another one. In current language the inquest should be the “default” process for handling Article 2 cases, in conjunction with other processes where necessary.

61. The scope and outcomes we suggest for the generality of inquests in Chapter 8 include full narrative and analytical findings, an examination of the bearing on the death of any protective systems relevant to its circumstances, and examination of and findings on the relevance to the death of actions or omissions by individuals involved in the events leading up to the death. We have also recommended that the coroner should make recommendations for systems change in cases where this is justified, that the evidential standards to which the various findings are established should be declared, and that where the outcome of or evidence given to an inquest would be of interest to a prosecuting or other enforcement agency the coroner should send it to them and say he is doing so. The responsibility for decisions then made – whether on recommendations for safety improvement or on material referred to a prosecuting or enforcement authority – would lie with the recipient body subject to their own processes of accountability and challenge.
62. We have recommended that the regulatory or inspecting bodies of public authorities to which coroners make recommendations for systems improvement should track the progress of those recommendations. The Directors of Public Prosecutions in England and Wales and Northern Ireland are subject to judicial review in the performance of their functions. The Crown Prosecution Service for England and Wales has given a commitment that in cases involving a death it is always prepared to meet relatives to discuss the basis on which a decision [whether or not to prosecute] was taken.<sup>6</sup>
63. All authorities concur with the advice we have had in emphasising that the processes for discharging the Article 2 investigation responsibility may differ according to the circumstances of individual cases. We would, however, expect the generality of them to be capable of being resolved satisfactorily within the parameters we have suggested for the coroner’s inquest, in conjunction with other processes where necessary.
64. There are some important cases outstanding before the House of Lords. The issues may need to be re-visited in the light of the judgements in those cases and others which will no doubt occur in the future.

<sup>6</sup> CPS Statement on the Treatment of Victims and Witnesses, available on the CPS website. A statement by the Attorney General in respect of the Northern Ireland Director of Public Prosecutions is quoted in paragraph 25 of chapter 17.

65. Subject to that we **recommend that in cases engaging Article 2 of the European Convention on Human Rights, the inquest should in principle be the main forum for the investigation, in conjunction as appropriate with other investigative processes for which the State is responsible. The recommendations we have made on the scope of the inquest, and the transmission of findings and evidence to other investigatory bodies should help to create the necessary linkages, though decisions on the details of appropriate process will always need to reflect the circumstances of the case.**

## **CHAPTER 11 - SOME SPECIAL CASES: DEATHS OF CHILDREN, HOSPITAL DEATHS, DEATHS IN CARE HOMES, SUICIDE, AND DEATHS ABROAD**

**In this chapter we look at these particular categories of deaths.**

### **Deaths of Children**

1. There is general acceptance of the need for special safeguards around the protection of children and the investigation of their deaths.
2. We have discussed the issues with the Royal College of Paediatricians, the National Care Standards Commission which regulates some services for children as well as care services for adults, with the National Society for the Prevention of Cruelty to Children (NSPCC), and with the Foundation for the Study of Infant Deaths (FSID). We have also discussed the issues with coroners and pathologists.
3. In Northern Ireland we have discussed them with representatives of the NSPCC and the Department of Health, Social Services and Public Safety, as well as with coroners and pathologists. In both jurisdictions we have discussed the issues with parents and those supporting them.
4. Some of the issues are examined in the NSPCC Report "Out of Sight, a report on Child Deaths from Abuse 1973 to 2000"<sup>1</sup>. The report includes a valuable study on Sudden Infant Deaths from the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI), and an FSID paper on the treatment of parents when the deaths of their child is being investigated.
5. The particular points of concern to us are:
  - what categories of death in infancy and childhood should be investigated by the coroner;
  - how can proper links be established between the coroner service and the main agencies involved in the care and protection of children;
  - what mechanisms should be employed in the support of parents who have lost children;
  - how is it ensured that the skilled and experienced professional attendance necessary at the scene of some child deaths is available;
  - what particular needs must be met to ensure the investigation of these deaths at autopsy.

<sup>1</sup> Second Edition, January 2001.

6. In 1999, there were 6,489 deaths of children and young people up to the age of 19 in England and Wales. 290 died in Northern Ireland.<sup>2</sup> Cot deaths, or cases of "Sudden Infant Death Syndrome", have fallen substantially over the years, mainly because of advice to parents about how babies can sleep safely. However, there has been some increase in the number of deaths where the cause is given as "unascertained".
7. In earlier chapters we have recommended criteria for reporting deaths to the coroner. They include all traumatic and unexplained deaths at any age, and specifically for children:
  - all deaths of children, or of any child looked after by or on behalf of a social services authority or on the "At risk" register or defined as being "in need" within the meaning of the Children Act 1989, or of a child privately fostered; or of any child in a family in which another child is or has been looked after or on the "At risk" register or has been "in need".
8. We have also recommended that there should be public inquests into such deaths unless the Statutory Medical Assessor certifies beyond reasonable doubt that the death is from natural disease, without any evidence of abuse or neglect.
9. In some coroner districts there are standing protocols between the coroner and the various children's services and child protection agencies setting out how the children's agencies should be involved in death investigations and how the coroner and his staff should work with them.
10. **We recommend that there should be such protocols in all areas, taking into account the characteristics of the areas and the configuration of the relevant children's health and social services and the child protection networks. These should include the National Care Standards Commission and its successor bodies<sup>3</sup>. The coroner, working with the Statutory Medical Assessor, should retain the responsibility for investigating and reporting on cases. Where any possible criminal behaviour needs investigation, the prime responsibility is with the police.**
11. **The objectives of these arrangements should be to:**
  - **provide the coroner and his staff with information on risks to**

<sup>2</sup> National Statistics: *Mortality Statistics: Series DH1 no.32. Table 6.*

<sup>3</sup> Legislation is before Parliament [The Health and Social Care (Community Health and Standards) Bill] to create new structures for the roles now fulfilled by the National Care Standards Commission. There are also recommendations in Lord Laming's Report into the Death of Victoria Climbié which seem likely to affect the future shape of the child protection arrangements and their oversight.

**children to assist the coroner in the selection of cases for investigation and the avenues of investigation that should be chosen;**

- **enable the coroner quickly to find out whether, when a child dies, there are family or other social circumstances relevant to the investigation, in particular any aspects of the family situation which trigger the reporting provisions in the paragraphs above;**
  - **provide such specialist support to the coroner and his staff as they may need;**
  - **set out the arrangements for visiting the scene of death, and interviewing the family;**
  - **set out arrangements under which the coroner's office will provide the children's and child protection services with information on the outcomes of investigations to help with their work;**
  - **summarise policy in the area for the support of families who lose very young children.**
12. A national outline of these protocols should be prepared under the auspices of the Coronial Council, after consultation with children's services and child protection interests. The area protocols would be expected to follow it in terms of coverage and general approach except where the particular circumstances of the area justified differences.
13. We do not make any detailed recommendations for its content but we hope that it will include a sympathetic reflection of the points made in the FSID's contribution to the NSPCC report about the need for skilled and sympathetic handling of the parents, and, for example, the importance of allowing them to hold their dead child.
14. **We also recommend that the coroners' offices should be forthcoming in providing feedback on investigated deaths to interested local and national bodies.** These should include local child protection networks, and the National Care Standards Commission and its successor bodies. Information on road traffic incidents in which children are killed should be included in this feedback since there is concern over the scale on which such deaths are occurring.
15. The importance and difficulty of supporting parents bereaved by the loss of a child are such that we would like to see each of the new coroner's areas develop in its staffing some particular expertise in dealing with the deaths of children and the support of their parents. We have in mind that depending on the locality and the distribution of its coroners' officers,



some of them should include specialisation in child deaths in their work and their training.

16. **We recommend that in each coroner area there should be at least one coroner's officer with some specialisation in handling children's deaths.**
17. All the interests we have consulted are at one in considering it essential that autopsies done on young children should always be done by a pathologist with specialist paediatric experience.
18. **We recommend that all autopsies on children should be done by a paediatric pathologist or a pathologist with specialist paediatric experience. In appropriate cases he should work jointly with a forensic pathologist.**
19. **All these recommendations should in principle be adopted for Wales and Northern Ireland, with suitable adaptations for differences of structure.**

### Deaths in Hospital

20. Many coroners have told us that they have in recent years seen an increase in the number of hospital deaths reported.
21. The voluntary body Action for Victims of Medical Accidents (AVMA) nevertheless considers that the coroner service has not done justice to the need for investigation of hospital deaths. They say:

*"It is AVMA's experience that medical deaths have been largely excluded from the inquest process. Where medical deaths have been subjected to a coronial inquiry, this has often failed to be more than a superficial inquiry restricted to the who, where and how questions, the how being subject to a very narrow interpretation.....AVMA believes that deaths caused as a result of a medical mishap or treatment omission should be included as a specific category subject to coronial investigation. Consideration should be given to mandatory inquests in certain categories of medical death. Medical deaths have been largely neglected by the coroner system which is perhaps part of the reason why it takes so long to identify the quite staggering problem that medical death represents".<sup>4</sup>*

22. Our recommended categories of death for reporting to the coroner include "Any death in which lack of care, defective treatment, or adverse reaction to prescribed medicine may have played a part, or unexpected

<sup>4</sup> From AVMA's response of November 2002 to the Review Consultation Paper.

## Chapter 11 - Some Special Cases

deaths during or after medical or surgical treatment"<sup>5</sup>.

23. All such cases which were reported would be investigated through the new and more accessible investigation process which we recommend in Chapter 7.
24. We are not proposing that public inquests should be mandatory for hospital or medical deaths. There would be public inquests in such cases as satisfied one of the general inquest criteria which we recommend – sufficient uncertainty or conflict of evidence to justify the use of a forensic judicial process, or the likelihood of uncovering important systems defects or general risks not already known about<sup>6</sup>.
25. The role of the new Statutory Medical Assessor should be helpful in handling medical and hospital cases. He will oversee and accredit each hospital's arrangements for the second certification of deaths and will be able to use that process to ensure that each hospital has a proper system for reporting deaths to the coroner. He will also be a link between the coroners' office and the systems of clinical governance and the new patient safety networks that are being built up following the creation of the National Patient Safety Agency. He should be well placed to help select cases which satisfy the criteria for inquests.
26. It is also worth drawing attention to the advice given and the suggestions made on the handling of hospital deaths by Messrs Owen and Friedman in their legal submission. They say that: *"The [Human Rights] Convention requirement of "an effective investigation or scrutiny which enables the facts to become known to the public and in particular to the relatives of victims"...can plainly be satisfied without the need for a "full panoply" inquest process with all its formalities and emphasis on oral evidence"*.
27. They also say: *"There are undoubtedly practical problems in ensuring that the investigative obligation has been complied with in any given case. A possible way of resolving this dilemma would be to set up an independent tribunal system (sitting locally in health authority regions) whose function would be to examine those hospital deaths in which there exist reasonable grounds to suspect that negligence was involved"*<sup>7</sup>. If further work is in due course done on the investigation of medical deaths or mishaps, the idea might be borne in mind.

### Deaths in Care Homes

28. Just over 7 percent of all deaths in England and Wales occur in residential

<sup>5</sup> Chapter 4, facing paragraph 18.

<sup>6</sup> Chapter 7, facing paragraph 49.

<sup>7</sup> These extracts are from 4.7 to 4.10 of the Owen/Friedman submission in Volume 2.

homes – that is over 38,000 a year in England and Wales. A further 10 percent, or 54,000, take place in nursing homes<sup>8</sup>.

29. There are over 20,000 care homes providing nursing or residential care. Many of the residents are elderly but some care homes cater for younger people with physical or learning disabilities or mental illness. General medical care is provided by family doctors.
30. The homes are regulated and inspected by the National Care Standards Commission, which is after current legislation to be replaced in this function by the Commission for Social Care and Inspection<sup>9</sup>.
31. The issues of most concern in the handling of care home deaths are:
  - the process for confirming that a death has actually occurred;
  - general concerns over risks to and care of residents, given their frailty;
  - the relative roles of the regulatory body, the Statutory Medical Assessor and the coroner in dealing with care home deaths.
32. When someone dies in a care home amongst the first responsibilities is to confirm that death has actually occurred. This is necessary before the body can be removed to the undertaker.
33. Many general practitioners will attend as soon as they can to provide such confirmation and, out of normal hours, a deputising service doctor will normally attend.
34. However, some doctors are reluctant to provide this service. If it is not forthcoming the care home is left in a dilemma – the undertaker will not normally remove the body until the death has been verified so the care home must retain it until such time as this has been done. Many care homes do not have facilities or space suitable for keeping bodies for any length of time, and the hiatus can be distressing to staff and other residents as well as the family.
35. In the chapter which deals with the verification and certification of deaths we have recommended that suitably qualified and trained personnel other than doctors should be able to confirm the fact of death, as in some localities is already done for some types of death, such as traumatic deaths in traffic incidents.

<sup>8</sup> Data supplied by the Office for National Statistics.

<sup>9</sup> In Northern Ireland these functions are carried out by the Northern Ireland Social Services Inspectorate and the Northern Ireland Social Care Council and in Wales by the Care Standards Inspectorate for Wales.

36. We have said that the staff that should in principle be able to perform that function should include fully trained nurses. However, many care homes do not provide nursing services or have any nursing staff. We do not, in any case, consider that nurses working in a care home should be able formally to confirm the death of a resident. We think it important that the body should be seen and the death should be verified by a suitable professional person independent of the care home in which the death has occurred. This is consistent with much comment we have had, including from professional nursing interests.
37. This could be a suitably qualified and trained nurse or other health care professional provided under arrangements made through the local primary care trust. It is envisaged in the new proposals for primary health provision that have emerged from the discussion of a new family doctor contract that the primary care trust would be responsible for providing some services now within the basic general medical services contract. Particularly in areas with large concentrations of care homes, we would expect the primary care trust to play its part in ensuring that care home deaths were suitably and promptly dealt with.
38. However, wherever and while there are no such agreed arrangements, we consider that family doctors or the emergency cover service should attend to confirm a care home death.
39. **We recommend that:**
  - a. **under existing arrangements, deaths in care homes should be verified as promptly as is practicable by the general practitioner or emergency service doctor;**
  - b. **under the new proposed contractual arrangements for primary health care, primary care trusts should arrange for suitably qualified and trained nurses independent of the home to attend to verify death. This may be particularly desirable in areas with high concentrations of care homes, but would be advantageous more widely.**
40. It will also be important that as part of their responsibility for auditing and supporting doctors certifying deaths, whether as first or second certifiers, the Statutory Medical Assessors should identify care home death certificates as a distinct sub-group of the certification record of the doctor and practice. **We recommend that Statutory Medical Assessors should identify, support and monitor care home death certification by first and second certifiers as a distinct sub-group of certification by doctors and practices.**
41. As in the child care field there should be close liaison between the coroner and the Statutory Medical Assessor on the one hand and the body with responsibility for care home regulation. This is currently the National Care

Standards Commission but will become the Commission for Social Care and Inspection<sup>10</sup>.

42. **We recommend that there should be regular exchanges between the Commission's offices in each local area and their coroner and Statutory Medical Assessor counterparts:**
- **to exchange information and any concerns on standards;**
  - **to arrange where appropriate joint investigations;**
  - **to identify any practical problems over verification and certification of care home deaths and draw them to the attention of primary care trusts or others as appropriate.**
43. We also recommend:
- a. **that the National Care Standards Commission followed by the Commission for Social Care and Inspection should be able to raise any anxieties about an individual death with the coroner;**
  - b. **that the Commission should be given on a confidential basis any information from individual death investigations that would be relevant to its inspectorial and regulatory functions;**
  - c. **that the Commission should have reciprocal arrangements with the coroner and the Statutory Medical Assessor, and for its part should make available to them relevant material from its inspections and regulatory work.**
44. In chapter 7, we recommend that the new statute providing the coroner service with modern powers should include powers to:
- investigate any group of deaths which have already been certified if, in retrospect, there are grounds to think that there might have been common factors not previously identified, and
  - require for any specified time that all deaths occurring in particular facilities should be reported to the coroner, even if they would not normally be in reportable categories.
45. These powers would be useable in relation to care homes, as to other facilities, if necessary. We would envisage that they would need to be used rarely if ever, but their existence in reserve would be of value.

<sup>10</sup> There are comparable arrangements in Northern Ireland and Wales and the Health and Social Care (Community Health and Standards) Bill contains provisions whereby the successor bodies to the National Care Standards Commission will be able to help with inspections in Northern Ireland and Wales.

## Suicide

46. In Chapter 7 we recommend that deaths by suicide should not automatically qualify for a public inquest, but that there were circumstances in which this would be the desirable. There would continue to be public inquests where there was a need to examine whether there had been any third party involvement in procuring the death or it had occurred in prison or when the person who died was detained under mental health legislation. A public inquest might also be the most appropriate way of investigating whether the death was an example of a pattern where further investigation might yield preventive recommendations.
47. We think this a very desirable shift in emphasis. Deaths by suicide are not routinely examined in public in most other countries. There is some general evidence that the publicising of means and locations of suicides may contribute to further deaths involving the same means and location. We have also heard of occasions when parents wished to spare younger family members some of the details of such deaths and were frustrated because they immediately became widespread knowledge through press reports of the inquest.
48. We also recommend in Chapter 8 that the short-form verdict of "suicide" should no longer be available and that instead there should be a classification of "death from a deliberate act of self-harm or injury". This would be part of a wider change away from using the inherited verdict structure towards a more neutral classification of deaths.
49. We add some brief comment here on the background to and implications of these recommendations.
50. Before the Suicide Act 1961, suicide was a crime. The verdict of "suicide" dates from the days when suicide was a criminal offence. The higher courts have since then taken the view that suicide must be proved and not presumed.<sup>11</sup>
51. Traditionally, therefore, the practice has been to require a suicide verdict to meet the criminal standard of proof "beyond reasonable doubt" rather than the ordinary civil standard of the "balance of probabilities" which has always applied to other inquest verdicts except "unlawful killing" where the criminal standard is also required.
52. Suicide ceased to be a criminal matter some forty years ago, but the handling of self-inflicted deaths in the coroner's court has been unchanged. One of the effects is to require proof of the *intention to end*

<sup>11</sup> *R v Cardiff Coroner* [1970] 1 W.L.R. 1475; *R v Dyfed Coroner, ex parte Evans* (unreported 24 May 1984) D.C.; *R v North Northumberland Coroner ex parte Armstrong* (1987) 151 J.P. 773 at 785; and others, cf. *Jervis on Coroners*, 12th edition 2001, pp 309ff, and *The Laws and Practice of Coroners*, 3rd Edition, Knapman and Powers 1985, pp 144ff.

*life*, not just that the death occurred as a result of the actions taken by the person who died. This intention is often hard to establish, since there may often be a possibility that the individual took the action leading to the death as a sign of acute distress and a signal for help, and that things may have gone further than was intended.

53. This, taken with the understandable wish of many coroners to avoid adding to the family's distress, means that the outcomes of coroners' inquests understate the scale of suicide. Open verdicts, or those of accidental death or misadventure are often used instead. In consequence the Office for National Statistics has to make adjustments designed to produce more realistic figures for the purpose of monitoring suicide rates. As well as failing to reflect the probable cause of death, this approach can be unfair to others who may unwittingly have been involved, such as the drivers of trains in railway suicides.
54. The alternative which we recommend should provide a surer basis for monitoring suicide rates and therefore in the long-run a better basis for preventive activity. It will also mean that coroners will not need to go into painful and often inconclusive examinations of intention.
55. The change will however mean that there may be some discontinuity in the ONS suicide figures. There may even be an apparent increase in the rate of officially recorded suicide as a result. This is of great importance because in its 1999 White Paper "Our Healthier Nation" the Government set a target of reducing suicides by at least 20% by 2010. Discontinuity in the statistics would make it harder to track progress against that target.
56. It is not unusual for definitions in statistical series to be changed for the better and there are ways of ensuring that a reasonable continuity of interpretation can be maintained.
57. **We recommend that if our recommendations for change in the way the coroner service treats self-inflicted deaths are accepted, the Office for National Statistics should do such studies and make such adjustments as are necessary to ensure a reasonably consistent interpretation of the figures over the period of change.**
58. The National Institute for Mental Health, and others concerned with suicide, have told us that suicide prevention strategies would be better supported and more effective if current or latest occupation and ethnic status information were available in the aggregate figures. They would therefore like coroners to provide this information when reporting cases to the Registration Service.
59. We comment in Chapter 15 on some wider issues about how to get consistent data through the coroner service, but the National Institute has made a good case in an important area. **We recommend that from the earliest feasible date, coroners should wherever they can return**

**information on ethnicity and latest occupation status when reporting self-inflicted deaths to the Registrar.** This information would not be publicly accessible in the individual case.

60. Data of this kind would enable suicide prevention campaigns to be better targeted. There are, for example, grounds to think that unemployed people of working age may be higher than average suicide risks, but the available data are not conclusive. Similarly, there are grounds to think that suicide rates amongst young Asian women may be abnormally high, but without good ethnicity data well founded preventive action is hard to design.

### Deaths Abroad

61. According to the survey of coroners cases carried out on our behalf by Peter Jordan, there are about 2,700 deaths abroad referred to coroners that result in some formal action. About 550 deaths abroad are subject to inquest on return of the body to the United Kingdom. The Foreign and Commonwealth Office receive around 250 requests a year from UK coroners for help in obtaining information from authorities abroad to assist with these inquiries.
62. The majority of those deaths abroad of people regarded as resident in the United Kingdom are from natural disease. In cases where a doctor abroad certifies that this is so, the death is registered with the British Consul. If the body is brought back for disposal in the UK there are no particular problems in the formalities.
63. If the death was traumatic or of uncertain cause and the body is brought back to England or Wales for disposal the case is generally considered by the coroner of the district into which it is repatriated. If the death is one of a number which occurred in a disaster or terrorist attack the practice is for the coroner at the port of entry for the return of the bodies to handle them all.
64. British consuls and their staff give the families of British people who die abroad all the help and support they can. They will, for example, advise on local registration and legal procedures, and can provide information on local lawyers and other professionals who can help.
65. Until 1982 it was assumed that coroners in England and Wales had discretion to hold an inquest into deaths occurring abroad when the body was repatriated but no obligation to do so arose even when the circumstances of the death were of a kind which would in England and Wales normally have led to an inquest.
66. In 1983 the courts ruled that there was an obligation to hold an inquest into a death which occurred abroad if the body was returned and the



circumstances of the death were of a kind to require an inquest.<sup>12</sup>

67. Since 1983 the position has been that there is in principle the same obligation to hold an inquest when a body is returned to England and Wales from elsewhere as there would have been had the death occurred here. The obligation is the same whether the death occurred overseas or in Scotland or Northern Ireland. In Northern Ireland there is not the same obligation to hold inquests into deaths occurring in other countries because the law governing inquests is different and based on the exercise of discretion.
68. Opinions differ about the value of inquests held into deaths in other countries. The evidence available may be poor and there is no power to compel extra-territorial evidence or witnesses. The findings have no legal force or standing in the other country. Other countries have their own investigative processes.
69. On the other hand, there can be circumstances – for example group holidays for children or other groups of young or vulnerable people – where the travel plans and precautions of the domestic organisers might reasonably be the subject of a domestic inquiry. An inquest at home can more easily access as witnesses the travelling companions of the person or people who have died.
70. The opinions of the coroners with whom we have discussed the matter are for the most part that holding inquests on deaths occurring in other countries should be at the coroner's discretion, as had been assumed to be the case until the court ruling in 1983.
71. We were told by the coroners in Ontario and Victoria that they can and sometimes do investigate deaths occurring outside their jurisdictions. However the Home Office which would normally receive requests for help and material from death investigators in other jurisdictions wishing to pursue deaths of their nationals in England or Wales have told us that they are not aware of any other jurisdiction in which this is regularly and systematically done.
72. Amongst the questions we put to Messrs Owen and Friedman on the obligations under the European Convention on Human Rights was a request for advice on whether the Convention requires signatory states to investigate deaths occurring outside their own jurisdictions. Their advice is that there is no such requirement.<sup>13</sup>
73. However, they suggest that if coroners in future have discretion whether or not to hold inquests on deaths occurring in other jurisdictions, the decisions whether to hold an inquest should be significantly affected by the existence of the Article 2 obligation. They mention grounds for

<sup>12</sup> *R. v. West Yorkshire Coroner, ex parte Smith*. Q B 335, 1983.

<sup>13</sup> Section 6 of their advice, which is reproduced in Volume 2.

suspicion that a real and immediate risk to life which the authorities abroad unreasonably failed to take action to prevent, and the compliance or otherwise with Article 2 principles of any inquiry being held in the foreign jurisdiction as factors which might influence the decision whether to hold an inquest here.

74. We doubt whether it is realistic to expect coroners to form judgements on the compliance or otherwise of overseas death investigations with the European Convention on Human Rights. For other signatory states, that responsibility lies with their own courts and ultimately the European Court of Human Rights. For non-signatory countries, it is not realistic to expect that if they are under no such obligations themselves they would on any significant scale co-operate with such an inquiry being held by the court system of another country with no clear standing or evidence acquisition powers extra-territorially.
75. On the other hand, in an increasingly 'international' world, with overseas travel occurring on a large scale and risks from international terrorism being at a high level we do not think it would be sensible to recommend that there should be no help given to the families of British people who die in tragic or difficult circumstances in other countries.
76. **We recommend as follows:**
  - a. **when a UK resident dies abroad and the body is repatriated into England or Wales, and the circumstances of the death are unclear or otherwise needing explanation, the coroner in the area concerned should as far as is reasonably practicable use his good offices to help the family in its dealings with the authorities of the country in which the death occurred. This help should consist of advice on how the overseas death investigation system works and how it is best approached. It may include correspondence with those authorities seeking help and information;**
  - b. **there should be a discretion, to be exercised on reasonable grounds, over whether to hold a public inquest into the death or deaths.**
77. **The circumstances most likely to justify public inquests are (a) where there are issues about the precautions taken or the plans made by the domestic organisers of collective trips abroad, particularly for children and young people and (b) there are mass disasters abroad with significant loss of British lives.**
78. So far as deaths in Scotland and Northern Ireland are concerned, where the body is brought to England or Wales, we doubt whether the coroner service should have any more than an advisory role over procedure. The authorities in both countries are accessible to families and the questions

that they might wish to raise, and we do not see the need to replicate their processes in England or Wales.

79. We would regard the death of a member of the Armed Forces abroad whilst on active duty as requiring an investigation or inquest under the first of the criteria, if the body is returned to England, Wales or Northern Ireland, whether or not the ultimate disposal is to be here or, as occasionally occurs, in a Commonwealth country.



## **PART 4:**

# **DELIVERY OF THE NEW SERVICE**

## CHAPTER 12 - THE RESPONSE TO FAMILIES

**In this chapter we bring together a range of issues about the role of and response to bereaved families. We recommend a statutory Family Charter for the new coroner service which will help to put families at the centre of the death investigation process. We propose a complaints system and we examine legal aid at inquests.**

### Introduction

1. This review was in part prompted by concern about families' experiences after a sudden or unexpected death.
2. We have held some 120 meetings with support groups and individual families who have experience of the coroner system, and considered around 140 letters and submissions that they have sent us.
3. We have kept in mind that people are more likely to approach us, or to join support groups which have done so, if they have had unhappy experiences than if they were appreciative of their contacts with coroners or their officers. Some of the families whom we met did tell us that their experiences were positive, and coroners themselves have provided us with a substantial amount of correspondence expressing gratitude for help given to families in difficult circumstances.
4. We have also been conscious that the coroner is charged with fulfilling a difficult role, where there can be competition between the two objectives of providing a bereaved family with sympathy in their loss and the need to undertake an impartial judicial inquiry. Decisions about how to proceed often need to be made quickly and this is not easy when families are experiencing a great weight of feeling and distress.
5. In our consultation paper we proposed an objective of "putting bereaved families at the centre of a reformed inquest process". Virtually all respondents agreed with this, but there were some reminders of the harsh realities of life and the complexities of human behaviour. For example, Selena Lynch, Coroner for Inner South London, said: *"...the review team have properly recommended putting bereaved people at the centre of a reformed inquest process. However, the interests of justice must be paramount. Many families are divided, and those cases involving more than one death involve families with different needs. Some families may have reasons to encourage, or to avoid, the exposure of certain facts."*<sup>1</sup>

<sup>1</sup> Response of November 2002 to Review Consultation Paper.

6. Others reminded us that there are frequently other participants than the family with an equal right to fair and objective treatment – doctors and nurses in healthcare settings, prison staff, and the drivers of trains used as a means of suicide, for example.
7. Nevertheless, it is clear that though coroners and their officers are often sympathetic and supportive, the systems and practices of the coronial system have fallen behind the standards aimed for in other public services in matters of informed participation, rights to information and where suitable influence, and the predictability and timing of activities such as inquests of deep concern to a bereaved family.
8. Many of the changes recommended in this review are concerned to address these issues by creating or strengthening families' rights of access to key people at key stages, and rights to information, and by improving the quality and utility to families of the outcomes of inquests and investigations. This is a recognition of the point put to us by so many of the individuals we talked to that finding out properly what happened to a relative who has died prematurely or traumatically can be an important part of their own mourning process.
9. The objectives we suggest for both the death certification and investigation processes include providing the family with explanations of the death<sup>2</sup>. There have not previously been any explicit objectives for either system. Their implied objectives hitherto have been more concerned with safeguarding the public and public health.
10. The new procedures we recommend for death certification give families a right of access to the second certifying doctor.
11. The coverage and outcomes we recommend for coroner's inquests are fuller than those traditionally available. We also recommend that where there is no inquest but a coroner's investigation its results should be properly written up and should be made available to the family who would also have a right to see the investigator. Where there is an autopsy its report should include an explanation of the cause of death in lay language.
12. We recommend a new right of review of coroners' administrative decisions – for example the decision to order an autopsy – and a new avenue of appeal against their judicial decisions which would be less cumbersome than judicial review.

<sup>2</sup> See Chapter 3, paragraph 3. For death certification the objectives include "...to give the medical cause of death which to the best of the certifier's knowledge and belief explain the death, are suitable for inclusion in the permanent record of the death, and enable the family to understand why it occurred". For coroners' investigations the objectives include "To help families understand the causes and circumstances of death of the family member in cases of significant uncertainty which cannot be resolved through other processes".

13. A new Coronial Council with statutory powers to encourage consistent and predictable practice throughout the currently fragmented coroner service should include at least one member specially chosen for insight into the experiences of bereaved families.
14. We also recommend a small coroner service inspectorate. Its function would be to check on timeliness of process, standards and suitability of the physical environment, and the provision of prompt and clear information to families and friends of people whose deaths are investigated by the coroner service. It would also operate a complaints procedure for issues that had not been resolved locally.
15. We recommend mandatory training for coroners and coroners' officers. Working supportively with bereaved families would be a core part of the training. We have been impressed by what we have heard of the training in these matters given to Police Family Liaison Officers, and indeed with the accounts many families have given us of the effectiveness of the Family Liaison Officers' work.

### Information for Families

16. It can be very difficult to communicate successfully with families after a sudden death. It may take some time for the police or the coroner's office to identify the person who has died and then to find out family contact details. Once the family is told of the death they are likely to be deeply shocked and disorientated particularly if the death has been traumatic. They may not be receptive to or able to retain information. There may be communication difficulties between surviving family members.
17. Giving information about the coroner's processes and in particular explaining the need for an autopsy in such circumstances can be a challenge to the human and professional skills of those who do it. It is nevertheless an essential part of the duties of all who work with families in these distressing situations.
18. **We recommend that it should be an obligation on the coroner's office to make contact as quickly as possible with the nearest relative of the person who has died and inform them of the location of the body, the arrangements for viewing it, any autopsy or other investigation proposed, the likely timescale and details of the investigation and the probable release timing of the body.**
19. If there is to be an autopsy the family should be informed as quickly as possible, given information on the process through which they can have the decision for (or against) an autopsy reviewed, told of their right to be represented at the autopsy by a doctor, and about organ and tissue retention issues. This is a lot for a family to absorb and retain at an intensely difficult time.



20. Leaflets can help, though many of the families we have seen say that anything longer than a page or two may not have much impact. There are nevertheless good and relatively simple guides. The Department for Work and Pensions has a clear and comprehensive guide to the various administrative processes that bereaved families need to go through – registering the death, and dealing with pensions and estate matters for example<sup>3</sup>. There is, too, a good short leaflet from the Home Office<sup>4</sup>. Another valuable source of information and advice is “Sudden Death and the Coroner: Coroner’s Post Mortem and Inquests” published by Victim’s Voice<sup>5</sup>.
21. An important issue is how best to help people who have suffered a sudden and traumatic loss to find some support and in suitable cases professional therapy. People react very differently in such situations. For some, the support of other family members, their friends and local communities can combine with the passage of time to diminish somewhat the severity of the grief. For others, the grief can be of unremitting severity.
22. There are support groups active in particular areas of loss – for example through traffic deaths, workplace deaths or after murder or manslaughter. They can be valuable sources of information and sympathetic companionship, and they have also in many cases developed effective campaigning voices. Some people may appreciate the companionship and support. Others may prefer to look outwards, away from the circumstances of their loss, and find help from more general bereavement support such as is provided by CRUSE. The coroner service needs to be able to put people in touch with a range of organisations if they request contacts.
23. However, if professional therapy or counselling is needed it is better arranged through referral to the individual’s general practitioner. There are good grounds for thinking that premature counselling interventions, or those not backed up by proper professional training, may do harm, particularly if they serve to reinforce bitterness or isolation<sup>6</sup>.

### Timing of Inquests and Help to Families at the Inquest

24. Particular concerns have been expressed about delays to inquests, a lack of notification in advance of inquests, a lack of explanation as to what happens in an inquest and what the bereaved can expect from the professional and lay attendees.

<sup>3</sup> What to do after a death in England and Wales, publication of the Department for Work and Pensions D49, October 2000.

<sup>4</sup> When Sudden Death Occurs, Home Office, February 2002.

<sup>5</sup> Victim’s Voice, P O Box 110, Chippenham, SN14 7QB, December 2002.

<sup>6</sup> Concerns along these lines have been put to us by medical practitioners including Simon Wesseley, Professor of Liaison Psychiatry at King’s College London, who has pointed us to the discussion in Emmerick et al “Single Session debriefing After Psychological Trauma - A Meta-Analysis” in the Lancet, 2002, Vol.360 pp 736-741.

25. An audited aim of the coroners' service should be to open and conclude inquests within a reasonable timescale and in non-contentious cases there seems no good reason why the inquest should not take place within a month or two of the death. A coroner said to us that:

*"Promptness is a commendable aim but can only be achieved by giving the coroners power to obtain information quickly from those involved. For example it is sadly not uncommon to suffer a three month delay in a relatively simple post mortem report. Reports from clinicians on a hospital death are also notoriously slow to appear. I will wait fourteen weeks on average for a traffic file from the police."*<sup>7</sup>

Inevitably there will continue to be a small proportion of cases where this timescale may be significantly longer due to the involvement of other inquiries, preceding the inquest, such as police or internal investigations.

26. In some instances coroners are able to make use of outside voluntary organisations, such as Victim Support and CRUSE, to provide practical assistance to bereaved families at inquests by guiding them on points of process and explaining in advance the nature of the occasion and helping the bereaved in understanding what is happening and where necessary encouraging them to play an active part in the proceedings by asking the questions they want answered. We have heard of a successful scheme in Bedfordshire under which Victim Support provides such assistance to families at the inquest. Such help could be provided either by arrangement with a voluntary body or through the coroner's own staff, as seems the best approach in local circumstances.

27. **We recommend that all coroner areas should:**

- a. **make arrangements to provide families with practical support to guide them through the inquest process, either by using their own staffs or through voluntary bodies;**
- b. **regularly audit their inquest and administrative investigation timings, distinguishing those which occur within two months of the death, between two and six months, between six and twelve months and longer than twelve months, with an analysis of the reasons for delay in the longer interval categories. The results of these audits should be published.**

## **A Family Charter**

28. In our consultation paper we proposed that there should be a protocol or Code of Practice having legal force which would set out the main

<sup>7</sup> Chris Dorries, HM Coroner, for South Yorkshire (Western District), November 2002. We have had other complaints of such delays.

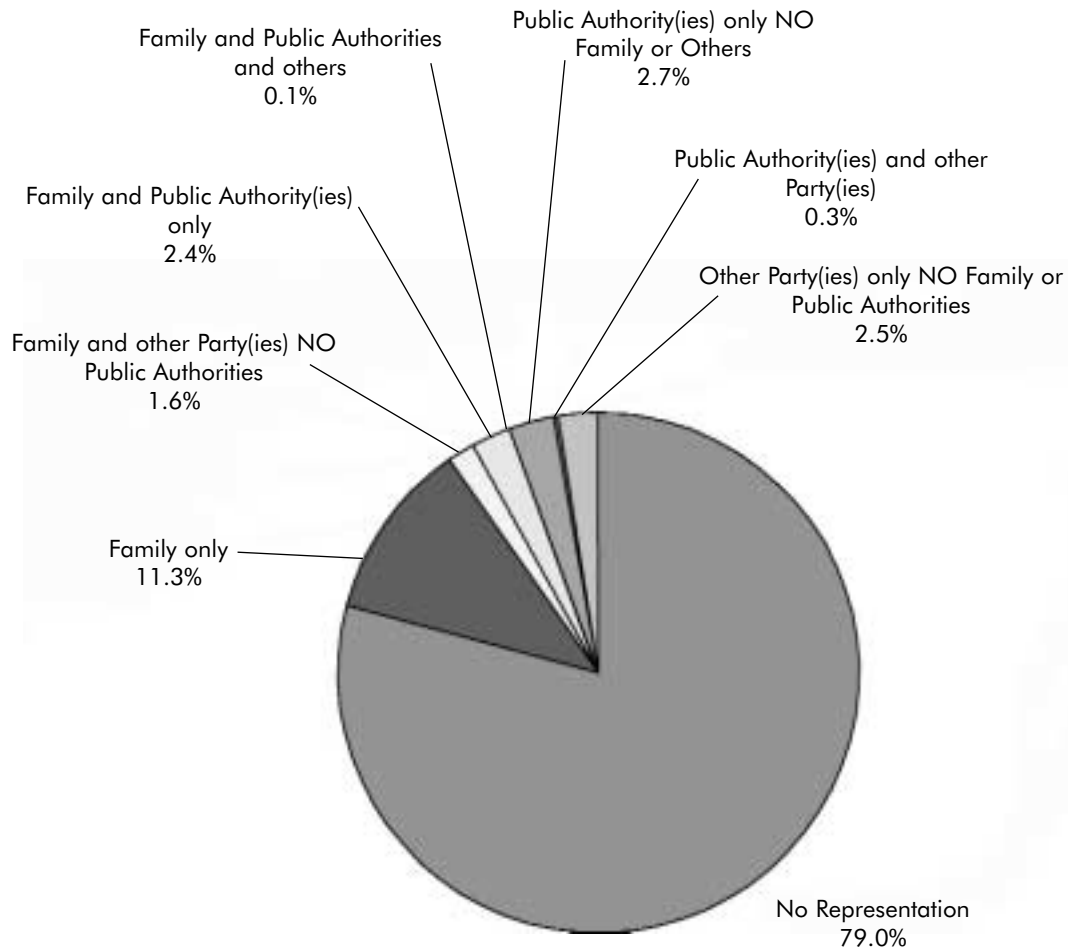
principles on which all coroners would work with and aim to support families. This was generally welcomed.

29. **We recommend that the Coronial Council should issue a Family Charter which all coroner areas would be obliged to follow to the maximum extent practicable. It should cover the provision of essential and timely information to families, their rights of access to key people and material, the processes for obtaining bereavement help, the likely timing of developments in their case, and the arrangements for giving some practical help at the inquest where this is necessary.** We offer a first outline at the end of this chapter.

### Legal Aid

30. Families can apply for legal aid to meet the costs of representation at inquests by solicitors or barristers. Applications are subject to an income test.
31. Cases are assessed on whether there is a significant wider public interest or overwhelming importance to the client. The Legal Services Commission, which deals with most applications in England and Wales, has informed us that legal aid can be expected in cases which engage Article 2 of the Human Rights Convention and for inquests into disasters with multiple deaths.
32. We have had a considerable number of representations to the effect that it is unfair to a family if, for example, at an inquest into a hospital death, the NHS Trust is represented by a barrister or solicitor paid for from the NHS budget but the family is on its own.
33. The findings of a study conducted by Peter Jordan (based on survey returns from fifty-four jurisdictions) suggest that the number of inquests where a public authority is represented but the family is not is fairly small, at just under 3% of all inquests. These findings are expressed in the chart overleaf, which shows that in nearly four out of five inquests currently held no participant is legally represented.

## Chapter 12 - The Response to Families



34. **We consider that the inquest should so far as possible be conducted in a style that is accessible to unrepresented lay people, and that the current criteria for awarding legal aid at inquests are broadly satisfactory. We recommend, however, that there should be a more liberal interpretation of the criteria in cases where a public authority is represented.**
35. This might cost some £3million a year. We understand that the Legal Services Commission's spend on representation at inquests is at present some £400,000 a year.
36. **We recommend that the arrangements for legal aid in Northern Ireland should be such as to have the same effect as our recommendations for England and Wales.**

## **OUTLINE CHARTER FOR FAMILIES**

### **Objectives and Values**

1. The objectives of the coroner service include:
  - to help families understand the causes and circumstances of the death of the family member in cases of significant uncertainty which cannot be resolved through other processes.
2. The service values include:
  - so far as is consistent with public safety and public health objectives, to respect individual, community and family wishes and feelings and expectations, including community and family preferences, traditions and religious requirements relating to mourning and the disposal of the dead: and respect for individual and family privacy;
  - to allow participation by families and bereaved people in the processes of certifying and where necessary investigating deaths, treating them sensitively and with dignity, and helping them find further help where this is necessary; and meeting their concerns and uncertainties as promptly and effectively as possible;
  - providing a seamless service when certifying or investigating deaths with a single point of access for families, thus avoiding unnecessary confusion and distress.

### **Information**

3. When a death is reported to the coroner the service will make every possible effort to contact the nearest family member as soon as possible to explain why the death has been reported, what steps are likely to follow the reporting of the death to the coroner and what timescales they may have.
4. The service will inform the family of any changes or developments in the investigation plan, and will give the family a contact point for checking on progress or raising questions. If there is any significant change of plan or in the likely timing of any part of the investigation the service will normally give an explanation for the change.
5. The service will provide the family with general written descriptions of the coroner service, its role in the investigation of deaths, and how investigation links to and may affect the timing of other actions that follow the death such as arranging registration, planning the funeral and settling the estate.

## Chapter 12 - The Response to Families

6. The service will give the family information on where they can view the body if they wish to do so and help them make the necessary arrangements.
7. Where there is to be an inquest the service will make available to the family, through its own staff or through any arrangement it may have made with other agencies, information and support to help the family in advance of and at the inquest to understand its purpose and processes, who else is likely to be there, what evidence is likely to be given and what opportunities the family will have to participate in the proceedings.
8. Where there is to be an autopsy the family will be told why it is necessary, and when and where it will be performed. They will be told of their right to have the decision to order an autopsy formally reviewed if they would prefer to avoid an autopsy, and of their right to be represented at the autopsy by a doctor of their choice. They will also be told of their right to review of a decision to not to order an autopsy.

### Participation and Access

9. The family will always be given opportunity to explain its own perspective on the cause and circumstances of the death.
10. The family will normally have a right to see reports of any autopsy or other investigation though the coroner may decide that some material needs to remain confidential to him permanently or for a period in order to protect the legal rights of third parties.
11. In cases where there is an administrative investigation but no inquest the family will have a right to meet the person conducting it, - the coroner, the Statutory Medical Assessor, or the coroner's officer. Where there is to be an inquest the family will have a right to meet a member of staff helping the coroner to prepare for it.
12. Documentation on an investigation which is made available to the family will be in orderly chronological form and will cover so far as practicable the roles and activities of all the main agencies involved in the aftermath of the death and its investigation.
13. At conclusion of the investigation or inquest the family can expect a clear, considered, written summary of its conclusions as to the cause or causes and circumstances of the death.

### **Links with Support and Bereavement Services**

14. The service will maintain information on all the main local and national voluntary bodies and support groups which offer help or support to people who have been bereaved generally or through particular types of death (for example traffic or workplace deaths, self-inflicted deaths, the deaths of children). It will make this information available to family members who request it. It will give help and advice to family members who might benefit from professional grief counselling on how best to obtain it – normally through the general practitioner.

### **Review and Appeal Rights**

15. Families have a right to a formal review of any administrative decision relating to the investigation of a death taken by the coroner, the Statutory Medical Assessor, or a coroner's officer. The review will be not be conducted by the person who took the decision the family wishes to challenge. If a family wishes to challenge a judicial decision by a coroner there is a legal appeal process available for doing so.

### **The Physical Environment**

16. The service will so far as practicable provide premises with disability access, opportunities of families to meet staff in privacy, and at inquests an environment enabling families to avoid close contact with other participants.

### **Timing of Investigations and Inquests**

17. The service recognises that delays in completing investigations, holding inquests or releasing the body for burial or cremation are likely to be extremely distressing for families. Sometimes investigations or inquests have to be held up while essential material is awaited from others. The service commits itself to keeping such delays to a minimum, and to keeping families informed when delays do occur.

### **Monitoring Service Standards**

18. The service monitors and will publish its record of timings – in the release of bodies to families, the time it takes to complete investigations, and to hold inquests.
19. These and other service standards are monitored by the Coroner Services Inspectorate. Their reports on local areas and on the service as a whole will be published.

### **Complaints and Comments**

20. Families or any member of the public wishing to make a complaint about the service may do so in the first instance to the area coroner. If not satisfied with the response, they may take the issue up with the Coroner Service Inspectorate.
21. The Coroner Service is committed to providing a service which meets the needs of families at a sensitive time, and welcomes comment from families about their experiences.



## CHAPTER 13 - SCIENTIFIC AND PATHOLOGY INVESTIGATIONS FOR THE CORONER

**In this chapter we examine the processes for providing coroners with scientific and pathology support. It covers the arrangements for appointing pathologists to support coroners, quality controls over pathology done for coroners, organ and tissue retention, the rights of families, and the scale on which autopsies should be done in support of coroners' investigations.**

### Introduction

1. A range of scientific and medical procedures can be performed after a death to help discover its cause or causes or other matters which may need investigation. They include taking samples of blood or other fluids from the body and analysing them to see whether they show signs of the presence of abnormal substances such as addictive drugs in the body, or substances such as medicines in abnormal or dangerous amounts. They can also include DNA tests to help establish identity.
2. The most common investigation is the autopsy or post-mortem examination of the body performed in a hospital or public mortuary. This normally involves an external examination of the body followed by dissection and the removal of the main internal organs – the heart, liver, kidneys, spleen and lungs, and very often also the brain – for weighing and dissection. Significant abnormalities can often be detected by visual inspection, but in some cases tissues, or more rarely whole organs, may need to be retained for further examination. Subject to that the organs removed for dissection are replaced in the body at the end of the procedure, though not necessarily in their original positions – the brain is usually put with the other organs in the abdominal cavity. The body is then closed.
3. The main legal powers governing coroners' autopsies in England and Wales are in Sections 19 and 20 of the Coroners Act 1988. They give the coroner power to order an autopsy in order to avoid an inquest where there is reasonable ground to suspect that "someone has died a sudden death of which the cause is unknown" and to provide evidence for an inquest. There is no specific appeal process against decisions by coroners under these powers. The legal route for any objections is through judicial review, which is not usually practicable in the short time available.

<sup>1</sup> "Autopsy" and "post-mortem" both mean the same. Post-mortem is the word that has been most commonly used in the United Kingdom, but "autopsy" is more commonly used in other countries and in international practice.

4. The Coroners' Rules 1984 broadly govern some aspects of the autopsy process. For example, they require in effect that:
  - a. autopsies should always be done by a doctor who should "wherever practicable" be a pathologist with suitable qualifications and experience and having access to laboratory facilities;
  - b. certain interests should be notified of the time and place of the autopsy. They include the general practitioner, the hospital (after a hospital death), and any relative who has "notified the coroner of his desire to attend or be represented at the post-mortem";
  - c. a relative who has given such a notification may be represented at the autopsy by a doctor;
  - d. "material" – that is organs or tissue which in the pathologist's opinion bear on the cause of death may be retained after the autopsy "for such period as the coroner thinks fit";
  - e. the pathologist should report the finding on a prescribed form, and shall not supply a copy of his report to anyone else without the coroner's authorisation;
  - f. if the death has occurred in hospital and the family consider that the treatment may have been at fault the pathologist performing the autopsy should not be employed at that hospital.

There are also various provisions governing "special" post-mortems which concern autopsies done in anticipation of possible homicide prosecutions for the police with the coroner's agreement in cases where serious crime is suspected.

5. In Northern Ireland the powers are in the Coroners Act (Northern Ireland) 1959 (as amended by the Criminal Justice (Northern Ireland) Order 1980).
6. There are no powers specifically relating to scientific or other medical investigations other than autopsies.
7. The legislation and Rules do not require any specific process for choosing or appointing pathologists to do autopsies. They simply refer to coroners "directing" or "requesting" doctors to do them.
8. Chapter 2 of our report gives figures for the number of autopsies in England and Wales and Northern Ireland respectively, with some comparisons with other countries. The overall cost of autopsies and other medical or scientific tests is some £36million a year, rather more than half the total direct cost of the coroner service which is estimated at

£71.4million a year.<sup>2</sup> The number of tests other than autopsies is not known, but it is for example standard practice to test all the victims of road fatalities for blood alcohol levels. The costs of forensic autopsies done for the police are met by the police and are excluded from these figures.

### Public and Family Attitudes

9. The opinion survey done for us by the Social Survey Division of the Office for National Statistics asked people whether they were upset by the thought of a post-mortem examination on someone they knew. 56% said that they were not upset. 38% overall, though a higher proportion of women, said that they would be upset, and 6% said that it would depend on the circumstances. Most of those in the first group gave as their reason the need to be sure about the cause of death. The reason most often given by those upset at the thought was the feeling that the procedure was upsetting and distasteful. Four fifths of those who were upset at the thought of a post-mortem said that they would feel better about it if they thought that the results would improve "medical knowledge of a particular disease or illness".<sup>3</sup>
10. Many of our own contacts with families took place not long after the Bristol and Alder Hey reports had been published and our England and Wales Reference Group included some members with experience of the events with which those inquiries were concerned. They were particularly critical of what they regarded as the lack of openness and honesty about the retention of organs and tissues without proper consultation with or information to families. There has also been an investigation by the Inspector of Anatomy on behalf of the Secretary of State for Health of serious allegations of organ retention malpractice following an autopsy on an adult who died in Manchester in 1987.<sup>4</sup>
11. Overall, our discussions with families showed that they had a spread of views about autopsies not dissimilar in range to the opinions gathered by the Omnibus Survey though we did not attempt any quantification of their views. A number of points came through with particular vividness, however:
  - a. in a significant number of cases, complaints that families were not informed that there was to be an autopsy, told when it would be, or that they had a right to be professionally represented at it;
  - b. outrage and deep distress, not significantly assuaged by the passing of time, where families felt that they had not been dealt with openly and honestly on the retention of organs or tissues;

<sup>2</sup> See chapter 19 for details.

<sup>3</sup> Omnibus Survey Report, op cit, paragraphs 3.6.2 and 4,7.1. The similar Northern Ireland results are summarized in paragraph 3.9. A.

<sup>4</sup> "Isaacs Report: The Investigation of Events that followed the death of Cyril Mark Isaacs." Department of Health, May 2003.

- c. amongst some, but not all, of those bereaved through suicide or traumatic deaths on the road or in the workplace or elsewhere, puzzlement over whether an autopsy was really necessary when to the lay eye the sight of the injuries and the circumstances of the death disclosed its cause all too distressingly and beyond any real doubt;
  - d. lack of clear information on the autopsy outcome;
  - e. lack of any process to challenge the need for an autopsy;
  - f. a general view that the coroner's apparently unfettered power to order autopsies is another example of the lack of predictability and accountability in the coroner system;
  - g. some families said that there should be more autopsies than there are and that families wishing to know the reasons for a death should be able to suggest an autopsy and have the right to a review if the coroner decides not to order an autopsy;
  - h. others questioned whether an autopsy should continue after a probable cause of death had been found, and in particular whether it was necessary to open the skull and remove and dissect the brain if a probable cause had been found in other organs.
12. A number of the families who had been distressed by the deception they considered to have occurred over organ and tissue retention said that they would have consented to some retention for teaching and research purposes if they had been openly and honestly asked for consent.
  13. Discussion with religious bodies was an important part of our consultation. Religious groups generally agree that the State should have the power to arrange for autopsies without consent in cases where this is necessary to find out whether there is evidence of murder or serious crime, or of serious neglect or mistreatment.
  14. However members of the Jewish and Muslim faiths, and some Christians, have strong objections to the scale on which compulsory autopsies occur in England and Wales. The Jewish and Muslim objections are two-fold:
    - their tradition is to bury the dead quickly, preferably on the day of death. Having an autopsy is likely to cause delay;
    - they both have strong religious and cultural objection to the mutilation they consider to be involved in the opening of the body after death and the removal and dissection of the internal organs.

Members of both faiths believe, along with some Christians, that the body should be returned to its Creator in as complete a state as possible, without mutilation. Muslims believe that the body will be brought back to

life on the day of resurrection. After death the person is either in bliss or torment, both physically and spiritually. That is why there is concern that the body should not be mistreated.

15. The Jewish community in Manchester has taken the initiative to develop and finance a scheme for conducting post-mortem examinations using Magnetic Resonance Imaging (MRI)<sup>5</sup> scans instead of pathological dissection; Muslims support this initiative. Some coroners are willing to refer cases to the scheme but others are not. The Department of Health is looking at the scheme in a wider review of possibilities of non-invasive post-mortem examination.
16. In our consultation paper of August 2002 we asked for comment on a suggestion that there should be a relevant national protocol, having legal status and produced by a publicly accountable body after consultation with expert and family interests. It would cover the sourcing, management and quality control of coroners' post-mortems and reflect the best judgement possible at any one time about the scope for non-invasive post-mortems. It would also cover the indications for having autopsies, specifying inter alia that they should not be routinely ordered. We suggested that there should first in each case be a study of all available information on the case from other sources, and where an autopsy is ordered there should be identified some specific uncertainty which cannot be resolved through other means.
17. Virtually all respondents supported this in principle. We consider that the responsibility for issuing such guidance should lie with the statutory Coronial Council.
18. **We recommend that the Coronial Council should issue statutory guidance to achieve consistent standards and practices in England and Wales on:**
  - a. **the mechanisms for choosing providers of pathology and other medical and scientific investigations for coroners, including the relevant appointment processes;**
  - b. **the rights of families to obtain advance information about autopsies and other investigations done for coroners, and their results;**
  - c. **the accessibility of such information to medical and public health interests with a need to know;**
  - d. **the criteria for ordering autopsies and other investigations;**
  - e. **the role of less invasive investigations;**

<sup>5</sup> This is a method involving diagnostic techniques which is non-invasive and similar to the taking of an x-ray.

- f. quality control arrangements for all investigations;**
  - g. procedures giving families a right of review of decisions to order, or not to order, autopsies and the provisions governing organ and tissue retention in coroners' autopsies.**
19. By statutory guidance we mean guidance issued under specific powers in the new legislation that will be needed to implement the range of recommendations that we make. The guidance would be legally binding on all coroners and those working with them, unless they could show good reason for departing from it in particular circumstances.
  20. The remainder of this chapter offers suggestions and recommendations about what, in broad terms, the guidance should say.

### **Roles, Appointment Processes and Contracts for Pathologists**

21. Most autopsies for coroners are done by pathologists working in NHS or University hospitals. Their work for the coroner is separate from their NHS or University work. It is arranged case by case with the coroner and remunerated through a fee payable for each case. In a number of places in England and Wales the coroner's autopsies are done through academic departments of pathology or forensic medicine, and the fees go to the departmental budgets. In Northern Ireland coroners' autopsies are done by the State Pathologist's Department.
22. There are no formal selection processes for the pathologists who do coroners' autopsies in England and Wales and they do not have formal contracts to cover the work.
23. In the majority of cases the work pathologists do for coroners is restricted to autopsies. However, we did come across arrangements where a pathologist provides informally a wider advisory service to the coroner, for example on the choice of cases where an autopsy is desirable or alternatively whether another investigation would be preferable and sufficient, and in some cases advising that no further investigation is necessary. Some pathologists we met told us that they are sometimes required by the coroner to do autopsies which they do not consider to be necessary; conversely, there may be some cases where autopsies should be done where they are not at present done.
24. It would be desirable in the new coroner service for the arrangements for pathology work and advice to coroners to be put onto a better and more transparent footing, as regards the choice and appointment of pathologists, their contractual position, and their role.

25. **We recommend that in each coroner area there should be an open process of application and appointment for coroners' pathology work. The selection of pathologists to work for the coroner would be made by a small appointment committee chaired by the coroner and including the Statutory Medical Assessor, or if preferred by the Statutory Medical Assessor on the coroner's behalf.**
26. Pathologists appointed to the panel should have **formal service contracts** with the coroner defining the duties of the role, the quality and service standards required, expectations for continuing professional education, and the obligations in respect of organ and tissue retention. The contracts should be for a defined term, say five years.
27. On our visit to Ontario we were able to observe an arrangement under which each morning the coroner, his staff and the duty pathologist considered the most appropriate handling and investigation of each death that had been reported overnight. We were impressed by the value of this collective application of relevant skills in the direction of the caseload. It led to carefully and expertly differentiated choices as between, for example, an external examination of the body, a full or partial autopsy, or a further examination of the clinical records.
28. The provision of medical skills to support the coroner and the coroner's office would be a matter for the Statutory Medical Assessor. It would be for him to decide when and how to arrange for the provision of specialist medical advice. If he thought it worthwhile to have pathology skills and experience available to help him and the coroner assess what investigations needed to be done in individual cases rather than to perform autopsies he should arrange for this accordingly.
29. The time is long past when it might be acceptable or necessary for autopsies to be done by anyone other than a suitably qualified pathologist, or for autopsies on young children to be done except by pathologists with paediatric experience.
30. **We recommend that the statutory requirements governing the conduct of autopsies should require all coroners' autopsies to be done by or under the supervision of fully trained and accredited pathologists. Autopsies on children should always be done by a pathologist with paediatric training and experience, working with a forensic pathologist in suitable cases.**
31. Some coroners accept that autopsies may be done by pathologists in training provided they are supervised by a consultant. This mirrors the position in clinical medicine. Nearly all autopsies are now being done for coroners; the number of consented hospital autopsies is very small. If pathologists in training are excluded from doing coroners' autopsies there will be damage to the future skills base.

## Quality Assurance of Pathology done for Coroners

32. A number of coroners have told us that they have no means of knowing whether the autopsies or other tests being done for them are to an acceptable standard, though many told us that they think generally well of the work pathologists do for them. When autopsy reports done for coroners are used in other contexts they can excite criticism. For example, the Confidential Enquiry into Peri-operative Deaths recently published a study of the quality of autopsies of cases it had reviewed<sup>6</sup>. It found that 35% of autopsy reports were less than satisfactory when judged against the general standards recommended by the Royal College of Pathologists<sup>7</sup>. There has, so far as we know, been no general study of coroners' autopsy reports against the standards required specifically for coroners' purposes. No such standards have been defined, and there is as things stand no public service or institution with the means and the responsibility to set such standards or conduct such studies, or any mechanism through which coroners' autopsies could then be audited.
33. The British Medical Association has suggested that quality assurance of coroners' autopsies could be done through the general audit and appraisal process for consultants. They say:

*"The national agreement on consultant appraisal specifies that all of the work done by a consultant should be included in one appraisal process and it is therefore appropriate that this appraisal encompasses the coronial aspects of a consultant's work. The work does not need to be part of a consultant's NHS contractual duties to be considered in the appraisal process."*<sup>8</sup>

34. This would be a worthwhile advance. **We recommend that work done by consultant pathologists for coroners should be covered in the general appraisal of their work.** It would be important that the coroner and the Statutory Medical Assessor should be given opportunity to contribute to those assessments.
35. We have a further recommendation to make about the quality assurance of pathology for coroners. It is **that the Commission for Health Audit and Inspection should periodically undertake thematic inspections of pathology done for coroners.** The new Commission, which is being developed from the existing Commission for Health Improvement, will no doubt have a full agenda. However, much coroners' pathology is done in NHS mortuaries and laboratories. The Alder Hey and Bristol reports show

<sup>6</sup> *Changing the Way We Operate – The 2001 Report of the National Confidential Enquiry into Perioperative Deaths*, Chapter 2, published December 2001 by NCEPOD.

<sup>7</sup> 89% of the autopsies in this study were done for coroners, and 11% were consented hospital autopsies. The report does not say whether the results were the same for both groups.

<sup>8</sup> Memorandum of 27 November 2002 to the Review.



the need for proper scrutiny of practice in this sensitive area, and the comments we had from many families in our own Review make plain that there are significant issues of public confidence around this aspect of the coroner system. Regular, proactive and independent checks would be a worthwhile safeguard.

### Organ and Tissue Retention

36. It is sometimes necessary in an autopsy to remove organs or tissues and retain them for a period to establish a diagnosis of the cause of death. In many cases the pathologist doing the autopsy can make a judgement by looking at the body and the organs. In other cases, to be reasonably sure, tissues, or more rarely whole organs, need to be taken to a laboratory and examined through a microscope after preservation.
37. In the majority of cases the organs or tissues can be returned after a few days or weeks. In a small number of cases the organs or tissues may need to be retained for longer if there is the likelihood of legal proceedings requiring re-examination of the tissues or, when a child has died, it is desirable to keep some material in case of other sibling deaths later on. It can then be of importance to see if tissue examination can show parallels between two deaths in the same family.
38. Generally, it is a professional matter for the pathologist how far he needs to retain tissue for such purposes, and he may not always be able to make that judgement in advance of the autopsy. However, a coroner's autopsy is done using coroner's legal powers and therefore does not require family consent so the coroner, or the Statutory Medical Assessor on his behalf, must be able ultimately to decide what is done with human material obtained under powers which lie with him and for the use of which he is answerable.
39. **We recommend that:**
  - a. **tissues or organs should never be retained for any purpose not directly stemming from the justification for a coroner's autopsy, and in particular for teaching or research purposes, without the full and informed prior consent of the family;**
  - b. **families should be informed in advance of the autopsy of any tissue or organ retention which may be predictable;**
  - c. **where tissues or organs are retained for any essential diagnostic or medico-legal purpose there should be one or more specific reasons for the retention in each case and the reason should be recorded in the post-mortem report as**

**should the quantity and type of material retained<sup>9</sup>. Whether or not the family choose to see the autopsy report (see paragraphs 41-49 below) they should be informed of the retention and its likely duration, so that they can decide whether or not to delay the funeral until the material has been restored.**

40. **We also recommend that the arrangements for seeking and obtaining family consent in cases where it is required, and the machinery for supervising and enforcing the consent arrangements, should be the same as, or as close as possible to, those which emerge from the work of the Retained Organs Commission and the work being done by the Health Departments in preparation for new Human Tissue legislation.**

### Information for Families

41. We have said in Chapter 12 that if there is to be an autopsy the family should be informed as quickly as possible, given information on the process through which they can have the decision for (or against) an autopsy reviewed, told of their right to be represented at the autopsy by a doctor, and about organ and tissue retention issues.
42. After the autopsy or other investigation the family should normally have a right to see the report<sup>10</sup>. If they prefer to hear the outcome through a doctor they should be able to discuss matters with their relative's general practitioner – the large majority of general practitioners would we think be willing to see the family for this purpose. They should also be able to talk to the pathologist who performed the autopsy if they wish to do so.
43. The autopsy report should contain a short summary of the cause or causes of death in simple language comprehensible to lay people<sup>11</sup>.
44. Where the autopsy report discloses information of relevance to the health of the family members such as disposition to genetic disease this should be made clear to them and they should be advised to consult their general practitioner.
45. **We recommend that the Coronial Council's statutory Code of Practice should cover the family's normal rights to information about the autopsy or any other investigation intended, their rights to review of a decision to have, or not to have, an autopsy, their**

<sup>9</sup> The post-mortem examination report form prescribed under Rule 10 of the Coroners' Rules 1984 asks whether "there is any further laboratory examination to be made which may affect the cause of death", and then leaves a space for comment. It should be revised in the light of this recommendation.

<sup>10</sup> Where there has been a forensic autopsy or rarely in some other circumstances the report may not be shown to the family.

<sup>11</sup> Recent guidance from the Royal College of Pathologists advocates such a summary. The prescribed Post-Mortem Report form referred to in footnote 8 should be revised to accommodate this.

**rights to information on timing and representation at the autopsy, issues of organ and tissue retention including their rights to give or withhold consent to the retention of any organs or tissues for research or teaching purposes and to be told of retention for diagnostic or medico-legal purposes, their right to see the autopsy report if they wish to do so, or to have it sent to the general practitioner, and to be told of any autopsy findings relevant to the health of family members.**

### **Making Fuller Use of Autopsy Findings**

46. The Coroners' Rules 1984 provide that autopsy reports should not be shown to anyone other than the coroner except with his permission. There may be circumstances connected with criminal investigations in which withholding information on the findings is justified, but they are likely to be rare.
47. It is clear, however, that there is little consistency between coroners over making available such reports to others, including the doctors who have treated the person who has died. Some coroners regularly volunteer such reports to them, some make them available on request, and we have had some (though not many) complaints from hospital consultants that it is difficult to get autopsy reports and sometimes they are asked to pay for them. We have also been told by some coroners that when they do generally make the reports available the level of take-up and interest on the part of doctors can be low.
48. As well as being of interest to the family the findings of autopsies and other investigations are potentially of value to the clinical doctors who have treated the patient before his death. They may also point up areas of medical practice which need attention from a quality and safety perspective, or risks to public health.
49. Amongst the roles we envisage for the Statutory Medical Assessor is to improve the coroner service's links with and contributions to the networks of clinical practice, public health and public safety. The results of autopsies and other investigations should as part of this responsibility be systematically reviewed under the direction of the Statutory Medical Assessor and matters potentially of interest to individual hospitals or departments within them, individual general practitioners or practices, public health interests in Strategic Health Authorities and "public health observatories" should be reported to them. Where there is suitable material, reports should also go to the Commission for Health Audit and Inspection, the National Patient Safety Agency, and the bodies regulating care homes.

50. We recommend that to maximise the health and safety contribution of the coroner service:
- **where appropriate autopsy and medical investigation reports should be sent to the hospital consultant or general practitioner responsible for treating the patient at the time of the death unless there are legal grounds for withholding them, or the family requests otherwise;**
  - **Statutory Medical Assessors should periodically review all autopsy and investigation reports in their area and send to healthcare, public health and other interested agencies in their areas information on trends and findings that would be of interest to them.**

### Role of the Autopsy

51. In Chapter 2 we have compared the rate of coroners' autopsies in England and Wales with the rates elsewhere in the United Kingdom and some other Commonwealth countries for which there are comparable figures. That comparison suggests that the England and Wales autopsy rate, at 22.8% of all deaths, is between double and triple the rates of the other countries in that comparison.
52. There are no reliable figures for wider international comparisons but information helpfully provided through the Royal College of Pathologists suggests that the autopsy rates in some central European Countries may be higher than in England and Wales though it is not clear whether the rates mentioned, some of them between 30 and 40% of deaths, were for deaths in hospital or all deaths<sup>12</sup>. No recent figure for the USA is available. The Federal Centers for Disease Control published autopsy rate figures until the mid-1980s when the USA average was 15% of all deaths. It is generally believed to have fallen since then. The rates in other European Union countries are generally significantly lower than here.
53. Within England and Wales, there are significant variations in the proportion of deaths reported to the coroner in which autopsies are done. The median rate is 64%. In the Wirral the rate is 32.5%, in East Riding and Hull it is 35% and in Nottinghamshire it is 37.5%. At the higher end of the spectrum, the rate in South Northumberland is 95.5%, North Tyneside 96%, North and East Cambridgeshire 97 % and Lowestoft 97.5%.
54. There can be legitimate reasons for variations. The incidence of traumatic deaths and of deaths from occupational disease will vary considerably between districts. So too will the proportion of deaths accounted for by

<sup>12</sup> We were provided with information on autopsy rates in Hungary by Dr Peter Gonda. It was to the effect that autopsy rates in hospital deaths there had been at 42% but were declining.

visitors from abroad or others with no accessible medical records. The scale of representation in a locality of teaching hospitals performing highly advanced and complex procedures may influence autopsy rates. No proper study of the variations has ever been done, but it is unlikely that such a study would be able to find good justification for the scale of variation that exists.<sup>13</sup>

55. There is, indeed, a general lack of evidence about the utility of and justification for coroners' autopsies on the scale on which they are practiced in England and Wales. If the 121,000 autopsies a year that are now performed were surgical procedures carried out on living people there would long ago have been an evidence base compiled to assess the utility of and justification for the scale of intervention. From such work there would have emerged evidence-based guidelines on when the investigation was likely to be justified. No such work has been done, and no such guidelines exist.
56. The Office for National Statistics have told us that the relationship between the rate of autopsy and the quality of their mortality data is "weak".<sup>14</sup>
57. As well as the issues about public attitude and family feelings to which we have referred there are some legal issues.
58. Amongst the matters on which we requested advice from Tim Owen and Danny Friedman was whether the provisions in the European Convention on Human Rights relating to privacy and family life were of relevance to the use of the power to order unconsented autopsies.
59. Their advice is that:

*"In our view, Articles 8 and 9<sup>15</sup> of the Convention impose upon coroners a duty to consider whether a post-mortem is genuinely necessary in order to answer the question as to how a person came by his death. In exercising any discretion to hold a post-mortem, the views of the bereaved family will always be relevant. Where, for religious or other reasons, bereaved relatives oppose the holding of a post-mortem, the coroner would have to be satisfied that the conduct of an operation which he knew to be against the family's wish was a proportionate interference with their rights in order to protect public health and/or investigate a possible crime. This duty to consider whether a post-mortem is really necessary is particularly relevant in relation to uncontroversial deaths where proper consultation with the*

<sup>13</sup> It would be difficult to do such a study at present because though data on the number of deaths reported to the coroner are available by coroner district the total number of deaths in each coroner district is not systematically available. Without this information it is impossible to examine either district reporting rates or their autopsy rates in more detail.

<sup>14</sup> Memorandum to the Review from the Chief Medical Statistician, ONS, 25 November 2002.

<sup>15</sup> Article 8 confers the right to respect for private and family life, and Article 9 confers the right to freedom of religion and belief.

*treating doctors of a recently deceased person might be sufficient to avoid the invasive post mortem operation. The extent of a coroner's duty to make further inquiries from the family and/or treating doctors will depend on the circumstances of the case. It is submitted that the following propositions apply:*

- i. where the available evidence discloses no positive indication that a death is suspicious, the coroner must take into account any relevant information from the next of kin and medical practitioners that might enable him/her lawfully to avoid conducting a post-mortem;*
- ii. in circumstances where initial inquiries indicate that the nature of a suspected fatal disease will be of justifiable relevance to the protection of public health (e.g. by preventing similar fatalities), it will be legitimate for the State to order post-mortems, notwithstanding private or religious conviction. But a simple bureaucratic desire to gather general statistics on the incidence of one natural disease rather than another would not, in our view, be sufficient to override religious or other objections based on the rights contained in Articles 8 and 9 of the Convention".*

60. This overlaps to a degree with comments made to us on behalf of the British Medical Association:

*"The question of how rigorously individual deaths should be investigated .... is at the heart of the post-Shipman debate. To be absolutely sure of detecting criminal activity would require post-mortems and toxicological investigation of all deaths outside hospital. However, the examinations currently undertaken are unlikely to be successful in doing so and may be of little value except for mortality statistics. A smaller number of more focussed post-mortems would be preferable".<sup>16</sup>*

61. We have already made recommendations which would be likely, in the medium and longer –term, to reduce the scale of deaths reported to the coroner:

- the introduction of a two-tier death certification system in which the second tier would comprise doctors chosen and supported by the Statutory Medical Assessor, and would be a first point of access for the family if the latter had anxieties about the death or about the way in which it was being certified;
- a relaxation of the "14 day rule" to bring it onto a par with the position in Northern Ireland so that doctors would be able to certify a death if they had seen the patient within the previous 28 days.

<sup>16</sup> Memorandum of 27 November 2002, op cit.

62. As well as reducing the number of deaths reported to the coroner these changes should help to reduce the autopsy rate because the number of natural disease cases being autopsied should decrease in parallel with the number being reported, and the handling of such deaths at all stages should be more confident.
63. We would also expect the involvement of pathologists on an advisory basis in the coroners' and Statutory Medical Assessor's selection of investigations to reduce the number of cases referred for autopsy, through further examination of the existing clinical records, and that other investigations such as toxicology tests might increase.
64. The introduction of a right for families for review of decisions to order (or not to order) autopsies may also reduce the autopsy rate. We were told that in Victoria, Australia, the review process there was used in some 7% of the cases where the coroner had proposed an autopsy.
65. These various changes should lead to a significant reduction in the England and Wales coroners' autopsy rate. However, because there is no evidence base from which to assess properly the indications for autopsy as opposed to other investigations by coroners, there is no foundation on which to build a detailed reduction target.
66. We have some **recommendations to support this process:**
  - a. **any medical investigation, whether autopsy or other test, should be to clarify a defined uncertainty or range of uncertainties and should be at the lowest level of invasiveness likely to resolve the uncertainty. Referrals for autopsy or other technical investigations should never be routine or automatic. This may apply equally after traumatic deaths, though when forensic autopsies are needed for criminal investigations they should be carried out;**
  - b. **where possible before any significant technical investigation is ordered, the medical records should have been scrutinised and the doctors and others who had attended the patient should wherever possible be contacted as well as the family;**
  - c. **in cases where the family object to an autopsy it should not be proceeded with unless there is positive indication of the need to investigate a possible crime or lack of medical or other care, or a public health risk that requires the cause of the individual death to be established in order to assist in preventing similar fatalities.**

67. We have some **recommendations directed at the future:**
- a. the Coronial Council should set in hand research and survey work to establish a proper evidence base from which good practice and sound policy in the selection of medical investigations can be derived;**
  - b. that evidence base should include, in due course, the outcome of the project already initiated by the Department of Health into less invasive forms of investigation. We make this recommendation without prejudice to the outcome of this work which should be scrupulously evaluated.<sup>17</sup>**

<sup>17</sup> Owen and Friedman in their opinion say " Moreover, States have a duty to consider continuing technological developments in order to find alternative non-invasive post-mortem procedures. In this respect the Strasbourg Court has held generally that measures that interfere with privacy rights "should ...be kept under review having regard particularly to scientific and societal developments" - paragraph 8.2.



## CHAPTER 14 - RESPONSIBILITIES IN GOVERNMENT

**In this chapter we recommend changes in the allocation of responsibilities within government for death certification and coroner services; and the creation of a statutory Coronial Council to monitor the performance of the new structure and ensure that the services adapt to future challenges. The Council should be supported by a small inspectorate. We also suggest ways to increase the public profile of the coroner service.**

### Introduction

1. In England and Wales there are two Government Departments mainly responsible for death certification and the coroner service:
  - the Home Office has policy responsibility for both areas;
  - the Lord Chancellor's Department makes the Coroner's Rules under the 1988 Act with the concurrence of the Home Secretary, and is responsible for disciplining coroners.
2. Other Departments with significant interests in the two areas are:
  - the Office for National Statistics (ONS) has responsibility for registration and the registration legislation. It maintains and publishes the national mortality statistics. These are based on death certificates and coroners' notifications. The Registrar General is based in the ONS, which reports to Treasury Ministers;
  - the Department of Health, which is responsible in England for public health and health care. In its public health role it is a user of the mortality statistics, of which doctors in the health care system are the main source through their death certificates. In Wales, health matters are the responsibility of the Assembly where they are the province of the Ministry for Health and Social Services;
  - the Department for Culture Media and Sport, through its responsibility for Museums and Galleries, has the policy interest in Treasure.
3. A wide range of other Government Departments have some interests in the death certification and coroner systems. They include the Crown Prosecution Service, the Consular Service of the Foreign and Commonwealth Office for deaths abroad, the Ministry of Defence for deaths of Armed Forces members, the Department of Transport for road and other transport service deaths, and the Health and Safety Executive for workplace deaths and occupational disease.

4. As well as having responsibility for the coroner service the Home Office is responsible for burial, exhumation and cremation law and policy.
5. The Health Departments also have the major interest in bereavement services, in issues of organ and tissue retention, and through the National Service Frameworks, an interest in deaths which occur in particular groups such as children in intensive care, older people and those with mental illness.
6. In Northern Ireland responsibility for the coroner service lies with the Northern Ireland Court Service, which is headed by the Lord Chancellor. Death certification policy responsibility is with the Department of Health, Social Services and Public Safety. The Northern Ireland Statistics and Research Agency is responsible for Northern Ireland mortality statistics and the Northern Ireland Registrar Service. It is an Agency of the Northern Ireland Department of Finance and Personnel. The State Pathologist's Department is the responsibility of the Northern Ireland Office.<sup>1</sup>
7. Having "policy responsibility" means that the Ministers of the Department concerned are responsible for carrying out functions given to them in the legislation covering the subject in question, such as making statutory regulations, issuing guidance or making administrative decisions which the legislation puts into their hands. They are also responsible for reviewing the legislation and generally answering for the subject to Parliament. They and their Departments are responsible for using their instruments of influence to support the subject such as research and statistical monitoring. If the service is publicly financed from their own spending programme, they are responsible for ensuring that it is suitably resourced.

### **Policy Responsibility for Death Certification**

8. As shown in Chapter 5 there are growing problems in death certification arising from changes in medical practice, particularly the use of deputising services at night and over weekends. The Health Departments are the main users within Government of the mortality statistics which death certificates generate. They hold the Government's responsibilities for the health care systems through which death certificates are produced. They are also the main source of contact with and influence over the medical education system.
9. Death certification is much closer to the Health Departments' main interests and responsibilities than to the interests and responsibilities of the Home Office. The Health Departments have potentially much better

<sup>1</sup> Of the Northern Ireland Departments mentioned, the Department of Health, Social Services and Public Safety and the Department of Finance and Personnel are part of the devolved Northern Ireland Executive. At the time of writing the Executive is suspended.

means of influencing death certification practice and the priority the subject is given. The more death certification can be seen as a natural extension of the responsibility for caring for patients while alive, the better it will be done.

10. **We recommend that policy responsibility for death certification in England and Wales should transfer from the Home Office to the Department of Health and, for Wales, to the Assembly's Ministry for Health and Social Services.**
11. The responsibility in Northern Ireland already lies with the Department for Health, Social Services and Public Safety. No change is needed there.

### **Responsibility for the Coroner Service**

12. We recommend in Chapter 15 that the coroner service should cease to be a local government responsibility and should be re-modelled as small national judicial jurisdictions in England and Wales and Northern Ireland respectively. The Lord Chancellor would become responsible for coroner appointments in England and Wales as he already is in Northern Ireland.
13. A consequence of these changes would be that the overall administrative and financial responsibility for the service as a whole would pass to the Lord Chancellor's Department and the Ministerial responsibility to the Lord Chancellor.
14. At present the Lord Chancellor is responsible for disciplining coroners, but the initial investigation of complaints against them is done by the Home Office. Families who have tried to bring such complaints have told us that they feel that they simply get passed from one Department to the other and that their complaints are never resolved. The integration of responsibility for the judicial aspects of the service into one department and for its overall support and financing would bring clarity of accountability.
15. **We recommend that, when the new national coroner jurisdiction for England and Wales is introduced, the general responsibility for supporting and financing the service within central government should transfer to the Lord Chancellor's Department, and that all responsibilities for the appointment and discipline of coroners should be brought together in that Department.**
16. In Northern Ireland these responsibilities already lie with the comparable department which the Lord Chancellor heads so no change would be needed there. There has for some time been an intention that in due course the responsibility for justice matters should be devolved to the

Northern Ireland Assembly and Executive.<sup>2</sup> If this occurs the coroner service would be amongst the responsibilities that would be so devolved.

### **The Wider Interests in Death Certification and the Coroner Service**

17. The objectives, activities and outcomes of death certification and investigation are of profound importance to a wide range of public policies and to the Government Departments and Agencies with responsibility for delivering them.
18. They are of equal concern and importance to the families and friends of people who have died. Their interests are in prompt, fair and supportive treatment and in an approach to the treatment of the human body after death that combines the realistic requirements of public health and safety with a recognition of the need to respect so far as possible individual, family and community wishes.
19. It has been a major theme of this Review that there is currently no mechanism for ensuring that the coroner or death certification services act with consistency and that they adapt to change.
20. So far as the challenges are legal and judicial the creation of new national jurisdictions, the structured and mandatory training, the better and more accessible review and appeals processes, and the Rules Committee which we recommend should go a long way towards avoiding the problems that have built up in the past.
21. However the legal and judicial mechanisms will not of themselves address the wider public policy interests in public health and safety or in the service standards for the support of families and friends. It is also clear that there is at present a lack of effective and reliable machinery within Government for determining objectives and such key issues as the links between coroner investigations and current public health concerns.
22. The Office for National Statistics has told us, for example:

*“There needs to be a uniform requirement for categories of deaths that should be reported to coroners for investigation.....A lack of definition has led to a divergence in coronial practice on certification and inquests into deaths from AIDS, and CJD related to BSE for example. No Government Department has accepted responsibility for addressing this”<sup>3</sup>*

<sup>2</sup> See the footnote to paragraph 6 above.

<sup>3</sup> Memorandum of 9 January 2003, op cit. In chapter 4 we recommend that the Council should be responsible for defining the categories of deaths that should be reported to coroners, and we suggest what the categories might be. We also recommend that the Council should be responsible for deciding which categories of disease constitute so serious and immediate threat to the public health as to require coroner investigation and where appropriate autopsy.

23. For those wider purposes there needs to be a wider forum with the capacity, within the law, to influence the objectives, priorities and processes of death certification and investigation, and which can keep the public informed about the way in which these systems are developing.

### **A Statutory Coronial Council**

24. **We recommend that there should be an independent statutory Council with powers to monitor the general performance of the new structures in death certification and investigation, and to give statutory guidance on issues of policy and process. Its terms of reference should be to:**
- a. **keep the performance and objectives of the death certification and coroner services under review, from the perspectives of public health and safety, accessibility to the public, public confidence in and satisfaction with the handling of deaths, costs, proportionality of process, effectiveness, and adaptability to changing circumstances;**
  - b. **give or recommend such statutory or other guidance on those services as may from time to time seem appropriate to the Council, provided that no such guidance should impinge on the roles of the courts in determining law;**
  - c. **periodically make public reports on the development of the death certification and coroner services, and on related matters concerned with public health and safety.**
25. **The Council should be appointed by the Lord Chancellor after consultation with other Ministers. Its membership would include members chosen by Ministers for their insight into the experiences of bereaved families. It would also include the Chief Medical Officers for England and Wales, the Registrar General, the senior judicial figure in the England and Wales coroner jurisdiction, a representative of the Home Secretary, a representative of the police, and a representative of any statutory body set up under legislation regulating human tissue and organ retention.**
26. **If those responsible in Northern Ireland for death certification and the coroner service wish to participate in the Council's work the membership should be extended. Otherwise there should be a comparable body for Northern Ireland.**
27. The Council would have a strategic, reporting and guidance role. It would not have influence over individual cases, or matters more properly within the influence of the courts.

## *Chapter 14 - Responsibilities in Government*

28. It would be responsible for issuing, or for recommending for issue by Ministers, amongst other things, the statutory Family Charter and the Code of Practice on autopsies and other investigations recommended in Chapters 12 and 13 respectively. It would be responsible for reviewing and updating them periodically. Such material should be the subject of consultation with the full range of interested professional bodies and with groups representing the interests of bereaved families.
29. The Council would also be responsible for deciding on the regular statistics needed to monitor the services and for publishing them.
30. It should also have an important research – commissioning role. The responsibility for commissioning research into specific areas of public health and safety such as road safety and epidemiology would lie with the Departments and other institutions concerned – the Departments of Transport and Health and the specialist institutes. The Council should commission research and survey work into the operation of the death certification and coroner systems.
31. We suggest three areas of focus:
  - families' experience of the systems – we would like to see structured user surveys conducted regularly;
  - the wider public's understanding of the systems and their purposes;
  - the key service issues in death certification and the coroner service. Initially these would certainly include how the two-tier death certification system was operating and developing, particularly in Northern Ireland and for the communities in England and Wales which value prompt disposal of the dead. They should also include the use in the coroner service of the public inquest and the administrative investigation. Another essential early priority would be the scale of reduction in the autopsy rate, and other work designed to establish properly researched ground-rules for the relative roles of the autopsy and other investigations (such as the use of MRI techniques) in the work of the coroner service.
32. The Council should have access to the research commissioning resources of expertise and money of its participating Departments for this work.
33. We envisage that the Council would make public reports periodically on how far the death certification and coroner services were meeting their public safety, public health and other public policy objectives, and what standards they were achieving in their interactions with and support of bereaved families.

34. The monitoring statistics would be published annually. The Council would decide on the frequency of the wider general monitoring reports. Many such bodies make annual reports. That can be a treadmill for the staff, and the source of much dust-gathering on recipients' shelves. We suggest that they should be at intervals no longer than two years apart.

### Helping to Make a Safer Society

35. There is a considerable amount of guidance and analytical material available on preventable deaths in particular fields. In road deaths, for example, the Department of Transport publishes regular analyses of death and injury rates and their circumstances to underpin their preventive campaigns. There is similar material issuing from the Department of Industry about domestic equipment risks and the Health and Safety Executive issues material on workplace risks. There is a substantial amount of material available on public health and health care risks. The National Patient Safety Agency will focus attention on treatment risks and how to reduce them. The annual reports of the Chief Medical Officers highlight matters of public health and health care concern.
36. It may nevertheless be of value to bring together and give publicity to preventable deaths as they are identified by the coroner service, bringing together the main findings of its investigations over the country into deaths that may have been preventable. Without going into complex detail this could bring together some simple messages for the public and public authorities about how to save lives through simple precautions or changes of behaviour. It could reinforce the need to observe speed limits and health and safety regulation, emphasising the lives that could be saved and the grief of family and friends that could be avoided. It could highlight any emerging trends and findings in the coroner service's work, with a particular emphasis on new risks to life becoming evident from its work.
37. In Chapter 15 we identify two options for restructuring the coroner service as a national jurisdiction in England and Wales. One is to be a small general jurisdiction supported from the Courts Service. The other was to become a Tribunal. Most Tribunals are under the general surveillance of the Council on Tribunals. It is not likely that the range of monitoring and guidance functions we envisage for the Coronial Council could satisfactorily be performed by the Council on Tribunals which has no medical or public safety representation and a very wide range of bodies within its scope. A possible solution might be for the Tribunals Council's perspective to be represented on the Coronial Council through some cross-membership at member or chairman level.

### A Small Coroner Service Inspectorate

38. To help the Coronial Council and the head of the jurisdiction to monitor standards of administration in the coroner service it would be desirable to have a small coroner service inspectorate.
39. The main focus of its work would be to assess how far the service was reaching the standards set out for it in the Family Charter that we recommend should be issued as statutory guidance by the Council. The inspectorate would have no role in respect of professional legal or medical decisions made by the service. Its concern would be with timeliness of process, standards and suitability of the physical environment and the provision of prompt and clear information to families. The inspectorate could also examine complaints made by members of the public, and could deal with those complaints which cannot be resolved by the area coroner.
40. We estimate that with around sixty coroner areas the task of periodic visits and monitoring could be performed by an inspectorate of perhaps six people. The inspectorate might be combined with the existing Magistrate's Court Inspectorate if this would lead to efficiency in the sharing of skills and costs.
41. The inspectorate would make its reports to the coroners in each area, and to the head of the jurisdiction. They should also be made available to the Council, and should be published.
42. **We recommend that there should be a small Coroner Service Inspectorate to monitor standards of interaction with families and the standards of the service's physical environment. The Inspectorate should make its reports to the coroners of each area and to the head of the jurisdiction. They should be made available to the Council, and published. The Inspectorate could be combined with the Magistrate's Court Inspectorate. The inspectorate would also examine complaints from members of the public that had not been resolved locally.**

### The Public Profile of the New Service

43. We were struck on our visits overseas by the high and positive profile that the coroner services in Ontario and Victoria evidently enjoy, and by the steps they take to help the public understand what they do and its purposes.
44. We suggest that:
  - a. coroners, Statutory Medical Assessors and their staffs should see it as a normal part of their functions to address support and other groups;



They should pay attention not just to bereavement groups but also for example to Rotary, the Women's Institute and the Mothers Union. They should also talk to faith groups;

- b. they should make contact with schools and offer contributions to current affairs and citizenship sessions;
  - c. they should proactively make contact with institutions in which unexpected deaths may occur, including colleges and universities. We have had more than one representation from the parents of young people who have died while away at college which suggest that university and college managements might welcome friendly advice on what they may face in such circumstances;
  - d. as well as using the usual range of information outlets (Post Offices, local authority offices, NHS facilities, and Registrars' offices) coroner service areas should use the web to give information on their roles and services and contact arrangements. Most North American and Commonwealth coroner jurisdictions have their own web-site, but the search engines suggest that there are very few here with easily accessible sites. We would also expect to see the coroner service listed amongst the essential public services at the beginning of the telephone directory. It is not there at the moment in most localities;
  - e. the Government's own web-site's coverage of the coroner service and death certification should be significantly expanded, as should its coverage of sources of help in bereavement.
45. **We recommend that the new coroner service and each coroner area should have a high and proactive public profile. It should aim to inform the general public about its role and purposes. It should be proactive in offering presentations of its work and make use of accepted means of contact and communication such as websites.**

## CHAPTER 15 - STRUCTURES FOR DELIVERING THE NEW SERVICES

**In this chapter we recommend major changes in the structures through which coroners are appointed and the coroner service is supported. We recommend an enhanced coroners' officers service. We also recommend a framework for the employment of Statutory Medical Assessors, and give an overview of the new service structure.**

### Introduction

1. In earlier chapters we have recommended that:
  - a medically qualified Statutory Medical Assessor should work alongside the coroner to support and audit the death certification process, which would continue to be performed by doctors in clinical practice. This doctor should also deal with or supervise the handling of most natural disease deaths reported to the coroner, liaise with public health and safety networks, and support the coroner in his judicial work and in the choice of medical tests and examinations;
  - the coroner service should be redefined as a *general death investigation service*. It should continue to hold public inquests and it should work to judicial standards, but the investigation of deaths without inquests should be done to defined standards involving greater accessibility;
  - the coroners' officers' range of skills should continue to be broadened and there should be some specialisation amongst them;
  - there should be mandatory training of all coroners, coroners' officers and other personnel;
  - there should be more consistency of approach between coroners;
  - there should be powers exceptionally for Circuit and High Court Judges to hold inquests.
2. We also recommend a new focus on the needs of families.

### Present Local Structures

3. These changes have implications for the way the service is structured and paid for.

4. In England and Wales the 123 coroners are appointed by local authorities to individual local jurisdictions.
5. The large majority are “part-time” which means that they may do other work. Those who are legally qualified often work as solicitors in private practice. Some hold other part-time judicial offices such as Deputy District judgeships or working on Appeals Tribunals, or as chairs of local Mental Health Review Tribunals. The remainder, mainly in the larger cities, have full-time posts.
6. Whether full-time or part-time, all coroners are expected to provide permanent cover in their districts, though they can arrange for cover during their absence through deputy and assistant deputy coroners.
7. Coroners’ officers are employed mainly by the police though some are employed by local authorities. They are managed by and answerable to their employer, not the coroner whose work they support.
8. Coroners’ expenses are met by their appointing local authorities. Some submit their expense claims to the authority which reimburses them. Others have a standing imprest from which they pay their costs.
9. The local authority is responsible for meeting all costs of the service, including medical test and autopsy costs, mortuary charges and the costs of transporting bodies to the mortuary. However, where the police authority provides coroners’ officers the cost of doing so comes from their budget.
10. The overall cost of the service in England and Wales is about £70 million a year, including police costs for the coroners’ officer service.<sup>1</sup>
11. In Northern Ireland the service has since 1979 been supported financially and administratively by the Northern Ireland Court Service, which is a central government Department. Coroner appointments are made by the Lord Chancellor. The coroner for Greater Belfast is full-time. The coroners in Derry/Londonderry, Fermanagh and Omagh, East Tyrone and Magherafelt, North Antrim, Armagh, and South Down are part-time. The annual cost of the service was £455,000 in 2001<sup>2</sup>. There are no coroners’ officers. Casework support is provided through the police service by uniformed or special branch officers. Except for the Belfast coroner who has a small support staff, secretarial support is provided through the offices of the firms in which the coroner does part-time law practice. Though the service is supported administratively and financially by the Court Service not local authorities, the coronial responsibility is still essentially local and is not provided through a national jurisdiction with links into the general justice system.

<sup>1</sup> Details are given in Chapter 19.

<sup>2</sup> The cost of the State Pathology Department which is financed by the Northern Ireland Office and which provides pathology support for coroners is estimated to be £1.3m.

12. There are no dedicated avenues of appeal, in England and Wales or in Northern Ireland, against the outcome of an inquest or the decisions whether to hold one, or against the administrative decisions of a coroner, for example whether or not to order an autopsy. The only recourse available is to apply for judicial review. For the application to be allowed the litigant has to show that the decision at issue was unreasonable.

### **Attitudes to the Present Arrangements**

13. Most coroners told us that they had satisfactory relations with their local authorities though it is clear that many feel they would not get much response if they applied for extra resources for training, for example. Some reported difficulty in getting suitable space for inquests. Most expressed satisfaction with the service they had from coroners' officers, whether they were provided through the police or the local authority. There were, however, significant exceptions, and some coroners, particularly many of those in full-time jurisdictions, felt that the service was poorly resourced and unsuitably structured.
14. It is of particular interest that those coroners who hold other part-time judicial office as Deputy District judges or in Tribunals virtually without exception compared the support and training they receive as coroners very unfavourably to what is available in relation to their other judicial work.
15. A considerable number of coroners said that they attach importance to their local links, and that they see themselves as local figures safeguarding the local community and knowledgeable about it. Many hold these views very strongly but recognise that their service overall has fallen badly behind other judicial services in support and standards. Attitudes amongst Northern Ireland coroners we found to be generally similar, except that coroners there outside Greater Belfast are more consistently and fiercely critical of the still more slender resourcing that their service has had in the past from the Northern Ireland Court Service.
16. Of the families we talked to few expressed strong interest in structural issues though some saw a link between the unpredictability and lack of consistency in the coronial system and its fragmented base in the world of local government. Some questioned whether coroners can be genuinely independent if they are appointed and resourced by public service authorities responsible for local roads and the provision of some services for vulnerable adults and children.
17. Those concerned with deaths at the hands of the police, including the Police Complaints Authority, think the provision of casework support through the police service undermines the coroner service's independence, and the same view was expressed by some concerned with deaths in custody.

18. There is a widespread feeling amongst all we talked to in Northern Ireland, including the police themselves, that the absence of any dedicated casework support of the coroners there and the involvement of the regular police service in that role is unsuitable and needs to be changed.
19. Many of the lawyers and doctors we talked to about their experience and perceptions of the coroner service compared its structures and standards unfavourably with the other professional contexts in which they work – the mainstream justice and health services.
20. *The police, too, though often enjoying harmonious relations with individual coroners, tend to take a similar view. Railway Safety, reporting on its sadly considerable experience of handling deaths on railway lines following trespass or by suicide, said; “Some coroners understand railway circumstances better than others but as a generalisation it is evident that of all the agencies who have to attend fatalities on the railway it is the coroners and their representatives who are the least professional”*<sup>3</sup>
21. On the question of appeals process, there were some who argued in favour of judicial review on the grounds that the quality of judgement would generally be high. But the large majority of the interests we consulted said they thought a more accessible and expedient appeals process would be preferable.

### Physical Amenities and Support

22. During our regional visits we saw individual coroners so far as possible in their offices or -where they have them- their inquest courts.
23. We saw some impressive facilities, modern and purpose-built – for example in Hammersmith and Fulham, and the suite of offices for the Liverpool coroner and his staff situated alongside the local Registrar.
24. Generally, however, the provision of facilities varies greatly between the appropriate and the highly inadequate. Some coroners do not have an office but work out of their private houses. Others work from the premises of their private law firms, sharing the accommodation with colleagues in the practice. Some have small offices of their own. Others work out of the town or county hall.
25. Coroners’ officers sometimes work alongside the coroner, but elsewhere are out-stationed in the local hospital or police station.

<sup>3</sup> Submission from Railway Safety dated 30 September 2002 in response to the Review’s Consultation Paper (Railway Safety has since become part of the Rail Safety and Standards Board).

26. Some coroners have dedicated inquest courts though not all of these are suitable for jury inquests. Others use local authority meeting rooms. Others use court-rooms hired by the local authority from the Courts Service. Many coroners report anxiety and dissatisfaction over the availability of inquest facilities. The Home Office has acknowledged in correspondence with a coroner that there is no public authority with an inescapable legal duty to provide suitable inquest facilities.<sup>4</sup>
27. We saw some dispiriting environments, and some with no obvious or satisfactory disability access. In many of the courts and offices we visited there was nowhere private for families to meet with the coroner or his officers. A frequent complaint from families is that they had been forced into distressingly close proximity with other inquest participants whom they regard as responsible for the death.
28. We also observed that secretarial and administrative support staff are frequently in very short supply and in some cases do not seem to exist at all.
29. In some parts of England and Wales and in Northern Ireland outside Greater Belfast the service lives what appears to be a hand-to-mouth existence. Overall it has not had the investment in physical or human capital that other judicial and public services have had in recent decades.

### Arrangements for the Future

30. The root cause of these problems lies in the fact that in England and Wales the coroner service is not considered by local or police authorities to be a mainstream service. It is perceived as a small independent judicial service, outside the effective scope of their influence and with little relevance to the crime prevention and law enforcement responsibilities of the police or the preoccupying service delivery priorities of local government in education and other large public services.
31. In our view the role of local authorities in the support of the coroner service should cease and the coroner service should be re-sited within the national justice services. The arguments for this change are:
  - the coroner service is essentially a judicial, investigative and public safeguarding or regulatory service, which should in all its functions work to judicial standards. It is more likely to develop such standards reliably and consistently if it has a structure similar to and linked with those of mainstream judicial services, which are organised into national jurisdictions and are led by the higher judiciary;

<sup>4</sup> Personal communication from a coroner to the Review.

- The service should so far as possible be structurally separate from executive and service-providing authorities so that it is and is seen to be independent of the services in which the deaths it investigates occur.
- A modernised judicial structure for the coroner service would enable exceptionally complex or contentious cases to be handled by the higher judiciary, and would provide a more suitable, expedient and accessible appeal mechanism than that available through the judicial review process.

32. **We therefore recommend that:**

- a. **the coroner services should be remodelled into national coroner jurisdictions covering England and Wales, and Northern Ireland, respectively;**
- b. **the responsibility for appointing and supporting coroners in England and Wales should pass from local authorities to the Lord Chancellor who broadly speaking should exercise the same responsibility for the judicial aspects of coroners' work as he has for the mainstream judiciary;**
- c. **each of the new national coronial jurisdictions should be headed by a member of the permanent or senior judiciary, and should include arrangements for enabling exceptionally complex inquests to be heard at higher judicial levels;**
- d. **they should also have appeal arrangements, suitable to the circumstances of each jurisdiction, enabling appeals against coroners' decisions to be made without recourse to judicial review.**

33. Within the justice services there are broadly two possible approaches to the structuring and administration of the coroner service:

- a. it could be a small general jurisdiction within the general judiciary, supported by the Court Service, and similar on a smaller scale to the criminal or civil court jurisdictions;
- b. it could be treated as a Tribunal, and supported by the new Tribunal Service which is to be set up following the Review of Tribunals by a group under the leadership of Sir Andrew Leggatt<sup>5</sup>.

<sup>5</sup> *Tribunals for Users: One System, One Service* Report of the Review of Tribunals by Sir Andrew Leggatt published by the Stationery Office, March 2001.

34. There are some points in favour of treating the coronial jurisdiction as a Tribunal:
- many Tribunals have an inquisitorial role, as coroners do;
  - Tribunals are more informal and perceived to be more responsive to the needs of their users;
  - we understand that the Government intends to develop the new Tribunals Service from 2004, and that timescale would suit the creation of new coroner services.
35. On the other hand the Court Service is already established and some of its buildings are already used for inquests.
36. The Government's announcement of its decision to implement major features of Sir Andrew Leggatt's report came at a late stage in our review so we are not able to make a definite recommendation as between the two approaches<sup>6</sup>.
37. Whatever route is chosen, it is desirable for the coroner service to retain some customary features of presentation, including the use of the words "coroner" and "inquest".
38. We have some further recommendations to make on its general structure and characteristics.

### **Support and Investigation Services – Coroners' Officers**

39. Though some local authorities provide and pay for the employment of coroners' officers the predominant pattern in England and Wales is for the police service to do so.
40. The Association of Chief Police Officers has argued that this is no longer justified. Their main points are that the coroner service has moved away from its historic role as an important selector of criminal deaths and its case-work is now predominantly in the non-criminal area; and that police priorities and resources should be concentrated on their law and order responsibilities.
41. Some individual police officers take a different view and would prefer coroners' officers to continue close links with the police. Amongst the coroners' officers with whom we discussed the matter, those with police backgrounds usually argued strongly in favour of retaining the links while

<sup>6</sup> The official announcement was made on 11 March 2003 by the Lord Chancellor's Department.



those with other career backgrounds tended to think that the police should no longer have the responsibility. The Coroners' Officers Association share this latter view but add the proviso that if the link is to be broken another body should be charged with providing structured training and professional development specific to the role of coroner's officer.

42. The decisive points in our view are:

- though investigation skills of the kind learned in the police are a vital component in providing support to coroners, the skills base in recent years has widened to include people with backgrounds in the care services and other backgrounds. With the inclusion in the coroner service of the Statutory Medical Assessor to supervise its response to the large majority of natural deaths reported to it, that process needs to continue;
- it is inherently wrong for the coroner service to have no management control over or budgetary responsibility for its own case-working staff and a clear responsibility for developing their skills;
- the introduction of proper training for coroners' officers is one of the most needed and urgent reforms. It is unlikely to happen unless the service itself has that responsibility;
- though deaths in police custody or in the course of police operations are rare it is better for the coroner service to be and be seen to be independent of the police.

43. **We therefore recommend that:**

- **In England and Wales responsibility for provision, management and financing of coroners' officers should be transferred from the police service and local authorities (where they have assumed the responsibility) to the Court or Tribunal Service, depending on which is chosen as the new base for the coroner service.**

44. In Northern Ireland coroners' officers do not exist as such and support for coroners is provided by uniformed members of the police service as part of their normal duties. All the Northern Ireland interests we have consulted are unhappy with this arrangement. In cases where there is any suspicion of law and order service involvement in a death the system lacks independence. In cases where the death is not in any way criminal, for example, unexpected deaths in hospital, it is inappropriate. **We recommend that in Northern Ireland a coroners' officer service should be created independent of the police and that responsibility for its development and management should be vested in the Northern Ireland Court Service.**

45. In Chapter 3 we recommend that the statutory basis for the new service should be modernised to provide a general investigation power and a duty to determine the causes and the circumstances of death. This new statutory base should replace the present obsolete statutes, with their emphasis on processes and activities.
46. In the new arrangements we envisage, both the coroners and the Statutory Medical Assessors would be statutory office-holders, and the coroner would have an overall accountability for all casework. However, we hope that the new statute will not imply that in practice all casework will necessarily be settled in each individual case by the coroner or by the Statutory Medical Assessor. We would expect many cases to be appropriately settled by coroners' officers working under their general supervision.
47. We also think it would be advantageous if in each of the new coroner areas one or two coroner's officers were appointed to be statutory registrars of deaths. They could then directly register all deaths dealt with in the office. We appreciate that the implications of this proposal will need careful assessment in the development of the Registration Service.
48. **We recommend that consideration should be given to appointing some coroners' officers in each of the new areas as statutory registrars of deaths.**

### Full-time Leadership

49. There are at present over 200,000 deaths reported to coroners in England and Wales. They are dealt with in 136 separate local coroner districts. Of these 23 are headed by full-time coroners, and the remainder by part-time coroners. The average reported death caseload is 1,500 but the range is from less than 500 to over 5,000. The full-time city coroners have the largest loads.
50. We consider it desirable that the leadership of the new coroner service should be full-time at the top in each jurisdiction and in each locality. This would make clear that a dedicated professional and fully independent judicial service was being provided. It would be valuable, as in other legal jurisdictions, for the full-time core to be supplemented as case-loads and local circumstances require, by part-time coroners, just as the full-time judiciary is supplemented by Recorders and Deputy District Judges, for example.
51. **We recommend that:**
  - a. **each national coroner jurisdiction should be led by a full-time Chief Coroner, perhaps at Circuit Judge level in England and Wales;**

- b. each local or area coroner should be full-time;**
  - c. the local or area coroners should be supplemented by part-time coroners as case-loads and local circumstances require.**
52. By full-time, we mean that the appointees should not combine their coroner appointments with private client practice. There would be no objection to combining the coroner work, so far as time permits, with other part-time judicial work. Indeed, it might be an advantage.

### Local Coroner Service Areas

53. The recommendation in favour of full-time leadership of the coroner service locally as well as nationally has implications for the size of coroner districts. So too do the recommendations for some specialisation by coroners' officers since this would not be possible if the numbers in districts remained at its present average of about four.
54. If some consolidation of coroner districts is desirable, as we believe it is, there are two broad options for achieving it:
- a regional base for the service. There might for example be 9 regional coroners in England, and one in Wales, supervising a number of local coroners;
  - a geographical unit somewhere between the present 134 districts and the 9 regions, perhaps based broadly and flexibly on the boundaries of police authorities. There are 43 police authorities in England and Wales. One of them is the Metropolitan Police Service which has 6 districts. If account were taken also of the need for a sensible recognition of the needs of rural areas and long travel distances, there might be around 60 coroner areas.
55. The regional approach has in its favour that the number of regional coroners relating directly to the Chief Coroner would be manageable. It would also be helpful in the development of some specialisation amongst coroners themselves as well as their officers.
56. On the other hand, unless the regional coroners were to have largely guidance and administrative functions, there would be a danger of sucking the more interesting and challenging work up to the higher level. This would have adverse consequences for interest and standards at the more local tier of the system, and for the service's local accessibility. Generally we doubt whether it is necessary to have the coroner system structured in three tiers within its own jurisdiction.

## Chapter 15 - Structures for Delivering the Service

57. The structure based broadly and flexibly on police districts has more to commend it:
- it would give each area coroner 2,000-3,000 deaths a year to deal with as well as the supervision and support responsibility for a further 6,000-7,000 deaths certified by doctors;
  - on average there would be around 10 coroners' officers, on the basis of existing numbers.
58. This would give each area a significant "critical mass" of resources and responsibilities. There would be more scope for training and the development of professional expertise.
59. Compared to the present 136 districts there would be a risk of some loss of local presence and knowledge amongst coroners and their staffs.
60. An important point in favour of this approach is, however, the need to maintain a close and constructive relation with the police after the responsibility for providing the coroner officer service transfers from them to the coroner.
61. Though the arguments in favour of the transfer are strong, the police will continue to have a role in and a reliance on the coroner service. Sudden deaths in public places are in practice likely to be attended by the police since they are the service which the public calls in such cases. All traumatic deaths on the road, and most in the workplace, or in public transport incidents, are likely to be both attended and involve investigation by the police. In disasters the police have essential control and investigation responsibilities as well as providing essential assistance to the coroner with any identification procedures.
62. It will therefore be essential for the police and the new coroner service to work closely together. In each locality they will need to agree which cases are attended by the police, and which need the presence of a coroner's officer at the scene of death. For the various different types of situation they will need to agree at what point the responsibility passes from one service to the other. This co-operation will be easier if there are congruent boundaries between the two services. They can then be settled between one Chief Constable and his coroner counterpart or possibly in some areas two counterparts.<sup>7</sup>
63. The wide span of relations between the Chief Coroner and the perhaps 60 or so area coroners would be more manageable if the Chief Coroner were to designate 10 or so area coroners as "Regional Co-ordinating Coroners" for administrative purposes and perhaps also some limited

<sup>7</sup> The position in London might be that there were 6 coroner areas to correspond with the 6 Metropolitan Police Service areas.

appeal or review functions. The nearest parallel would be with Presiding Judges of the Circuits – they exercise the same jurisdiction as their colleagues at the same judicial level but have a lead role in representing the circuit and dealing with case allocation issues in the circuit.

64. **We recommend that in England and Wales the present coroner districts should be reduced from the present 136 to a structure of areas broadly and flexibly aligned with Police Authorities (in London with the 6 MPS areas). The needs of rural areas and others with large geographical boundaries should be taken into account in settling the details of the new structure. The Chief Coroner should designate some area coroners as regional co-ordinating coroners.**
65. The Northern Ireland coronial jurisdiction, with around 14,500 deaths a year, would have a somewhat larger overall case-load than the average we have suggested for the new areas in England and Wales. However, if the present relatively low proportion reported to the coroner were to remain unchanged the number of reported deaths would not be out of scale with those in the England and Wales areas. It would be for those responsible for the jurisdiction to settle whether it should be singly structured at the service level or whether in some aspects it should be divided.
66. We emphasise that the area structure we recommend does not dictate in detail the disposition of services locally. In many of the present coroner districts coroners' officers are spread around in more than one location. We envisage similar arrangements for the new areas.

## Appeals

67. As we have said the absence of any accessible and expedient appeal mechanism against coroners' decisions needs to be addressed.
68. We consider that new appeal procedures should satisfy two purposes:
  - for the review of an administrative decision by a Statutory Medical Assessor or a coroner;
  - for appeal against a judicial decision by a coroner.
69. Coroners make a large number of administrative decisions on the handling of cases reported to them. They include decisions to order, or not to order, an autopsy, to agree or not to agree to the expatriation of a body for burial overseas, and to give a cause of death in cases where there is no inquest. Under the new arrangements some of these decisions will be made by the Statutory Medical Assessor, and others by the coroner.

70. There is at present no formal method for arranging for such decisions to be reviewed.
71. We propose that there should be avenues of review of administrative decisions as follows:
  - a. where the decision has been made by the Statutory Medical Assessor, it would be reviewed by the coroner;
  - b. where it has been made by a coroner it should be reviewed by the Regional Co-ordinating Coroner or any other coroner he may designate;
  - c. where it has been made by the Regional Co-ordinating Coroner it should be reviewed by any coroner designated by the Chief Coroner for the purpose of dealing with such applications.
72. Appeals against the judicial decisions of coroners could be on points of law, against a decision not to hold a public inquest, or to have an inquest outcome set aside on the grounds of unreasonable decisions by the coroner; on the inquest scope; the choice of evidence; or on the grounds that the inquest finding is wrong.
73. Appeals would be made from decisions of the coroner to the Chief Coroner of the jurisdiction or to a High Court Judge authorised to hold inquests. Any further appeal would go to the Court of Appeal. Appeal against judicial decisions would include a process of application for leave, and would need to be on points of law.
74. With appeal arrangements on these lines it would not seem necessary to retain the procedure under which the Attorney General's fiat is required before a coroner can be ordered to hold a second inquest.
75. **We recommend that review and appeals processes be introduced in England and Wales:**
  - a. **for administrative decisions by the Statutory Medical Assessor, review by the coroner; for decisions by the coroner, review by the Regional Co-ordinating Coroner; for such decisions by the Regional Co-coordinating Coroner, review by the Chief Coroner or such other coroner as he may designate for the purpose;**
  - b. **appeals against judicial decisions by the coroner would go to the Chief Coroner, or a High Court Judge authorised to hold inquests. Further appeal would be to the Court of Appeal.**

- 76. We recommend that in Northern Ireland the judicial authorities should give effect to similar review and appeals processes through the means most suitable in their jurisdiction.**

### **The Statutory Medical Assessor**

77. We have recommended that this post should be created in each of the 60 or so coroner areas to deal with the large majority of the “natural disease” deaths reported to the coroner or referred to his office for advice. Other functions would include helping the coroner in the handling of cases needing circumstantial investigation, advising him on the choice of pathology and other medical/scientific investigations. Doctors in these posts would also support and audit the death certification done by doctors in clinical practice and select and support the second tier of doctors in the two-tier death certification scheme we have recommended. They will also be crucial links between the coroner’s office and public health and safety networks, and clinical practice.
78. We see these doctors as holding statutory offices, as would the coroners with whom they will work. This means that the functions of their posts would be broadly set out in the main legislation and given in more detail in a statutory instrument. They would be under a legal obligation to perform those functions objectively and professionally being answerable ultimately to the courts.
79. Statutory Medical Assessors will be located in the area coroner’s office and will be working with the coroner and the coroner’s officers. His particular responsibility for dealing with natural disease deaths will mean that he will supervise and support the coroner’s officers in their dealings with natural death cases referred to the office.
80. It will be important that he maintains good connections in the worlds of public health and health care and that he does not become isolated from the mainstream of health care development and education. To achieve that, it would be helpful if his employment or service contract were with a health care body which would then second him into the coroner’s office. His contract and job specification would be agreed by the coroner, who would also be on the appointment committee which recommended his appointment.
81. It would be unsuitable for the Statutory Medical Assessor to be employed by or in contract with any direct provider of healthcare because he will be exercising a regulatory role in death certification being done by doctors in clinical practice.
82. He might be in contract either with the Director of Public Health in the Government Office in the Region in which his coroner area lies, or perhaps with the Strategic Health Authority. The new NHS structure was in

the process of being created when we did most of our fieldwork so we do not make a definite recommendation one way or the other. Whatever the details of structure for supporting these doctors and their secondment into coroners' offices, they should be within the professional leadership domains of the Chief Medical Officers though absolutely and by law independent in their handling of individual cases.

83. **We recommend that in order to maintain their role in the world of healthcare and public health practice and development Statutory Medical Officers should be employed or in contract with either National Health Service Strategic Health Authorities, or, through the Regional Director of Public Health, with Government Offices in the Regions. They would be seconded into the coroner's office. Their function should be laid down in statute and statutory instrument to reinforce their professional independence.**
84. We envisage that there would normally be one Statutory Medical Assessor for each of the 60 or so coroner areas, though there might be a need for some part-time support. The posts should suit doctors from a range of backgrounds – in specialist clinical medicine, general practice, pathology and public health. We would expect them to attract doctors who after a substantial career in one or another of these specialities would like to spend the final decade or so of their active professional lives doing work to which their specialist skills and experience would bring value but was broader in focus.
85. The NHS is expanding and doctors are generally in short supply. However, we doubt whether there would be difficulty in filling the modest number of posts we envisage. There are some 110,000 doctors in active practice<sup>8</sup>. Some medically qualified coroners who did not wish to apply for a new coroner post might be interested. So too might doctors with backgrounds as police surgeons, or cremation referees though the range of duties would be much wider than either now have. We attach importance to doctors performing the role of these new posts having had recent experience of medical practice.

### **An Overview of the New Service**

86. We envisage, for England and Wales, a new unified national coroner jurisdiction and service with some 60 areas.
87. At the head of the jurisdiction would be a **Chief Coroner** with perhaps Circuit Judge status. He would be responsible for setting its judicial standards, conducting a small number of inquests himself, and acting in an appellate capacity.

<sup>8</sup> This is a UK figure.



88. He would need to be supported by a **Deputy Chief Coroner** who would give leadership to the service in its administrative functions and take responsibility for giving the service a national infrastructure that would enable it to have common standards, and develop a common database for the causes and circumstances of investigated deaths. This should be accessible to the coroner areas and help to build up a national store of knowledge on avoidable risks to life.
89. The Deputy should also be responsible for ensuring consistency and suitability of response to certain types of cases or situations such as deaths on the railways, deaths abroad and Armed Forces deaths. At the moment there is no single point in the system with which, for example, Rail Safety, or those concerned with the deaths of children, or with the handling of disasters, can liaise and be confident that a consistent national response will ensue. The Home Office and the Coroners' Society for England and Wales are as responsive in such matters as they can be, but the Home Office has limited powers, and the Society is a purely voluntary association of individual coroners, as is its counterpart in Northern Ireland.
90. We envisage that either in its own right, or through the Coronial Council, the leadership of the new service would be proactive in making available information on the activities of the service, and in particular in the public reports drawing attention to avoidable risks to life and measures to reduce them. We would expect, for example, that it would periodically draw together information on the recommendations made by coroners for safety and systems improvement, and that it would consider having a dedicated internet site or other form of communication with the public and interested parties.
91. Each of the 60 or so coroner areas would be headed by a full-time **Area Coroner** who would have responsibility for and the management of the death investigation services in the area and ultimate responsibility for all the casework. He would conduct some investigations and inquests himself. Working with him would be the **Statutory Medical Assessor** would deal with or supervise the responses to the large majority of the natural disease cases reported to the coroner. He would assist the coroner in the medical aspects of circumstantial investigations, participate in the appointment of pathologists, and act as a bridge between the work of the coroners office and public health, public safety and clinical governance networks in the area. He would audit and support the death certification in the area, select the second medical certifiers, and credential hospitals' second certification arrangements.
92. In each area there would be as many part-time **Deputy Coroners** as were necessary for the area's caseload of investigations and inquests.

*Chapter 15 - Structures for Delivering the Service*

93. Each area coroner's office would employ on average around 10 **Coroners' Officers** to handle the casework, liaison with families, and do some investigations. They would have a mixture of investigative and healthcare skills. In each office there would be some specialisation, for example in child deaths, self-inflicted deaths and workplace deaths.
94. Nine area coroners in England and one in Wales would be designated **Regional Co-ordinating Coroners**. They would have the same area jurisdictional functions as other area coroners but would have in addition some case allocation and review functions.
95. This overall structure is illustrated schematically in Figure 1 overleaf.
96. At Figure 2 is an illustration of a possible structure for an area office.

Figure 1: Overall structure of the new service

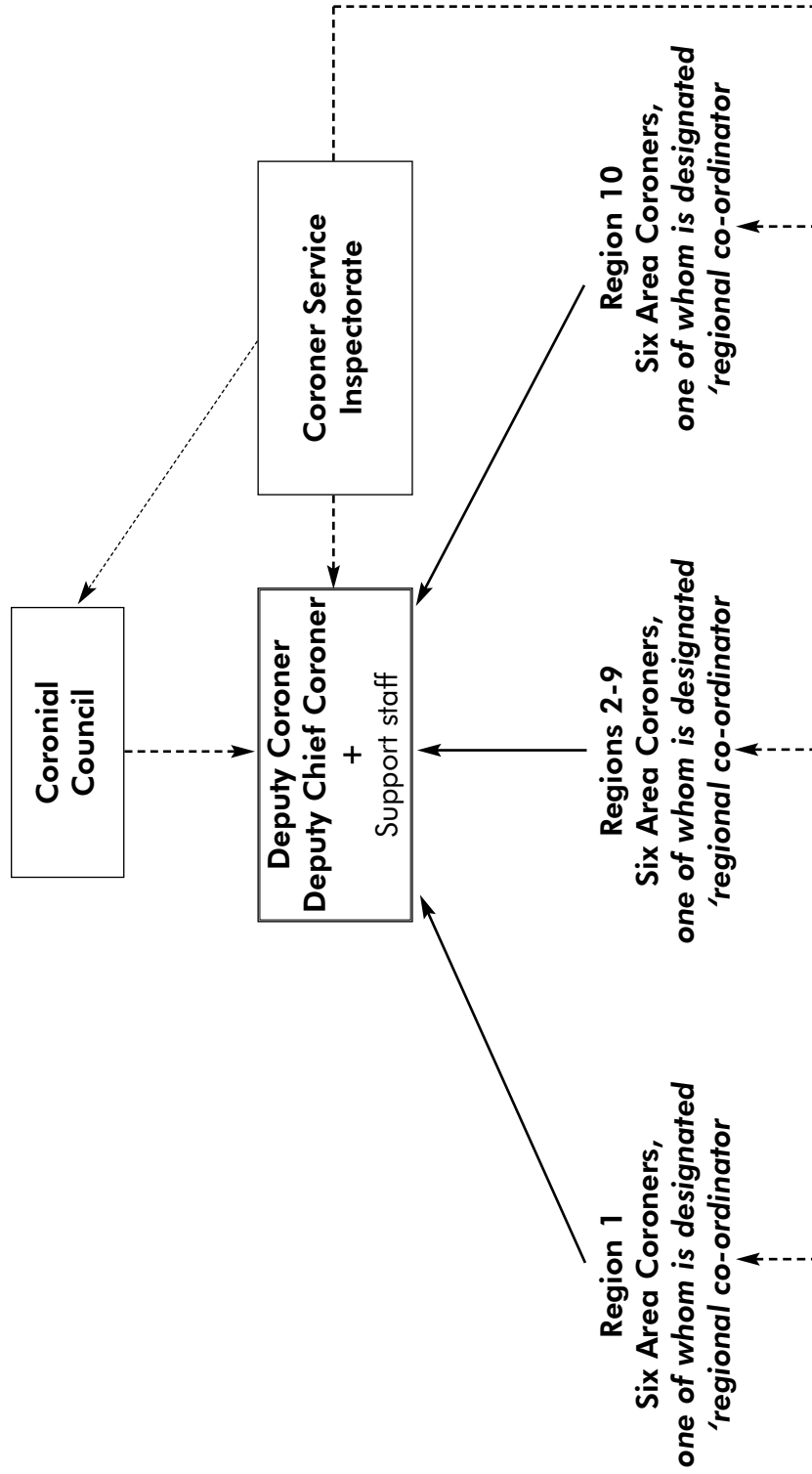
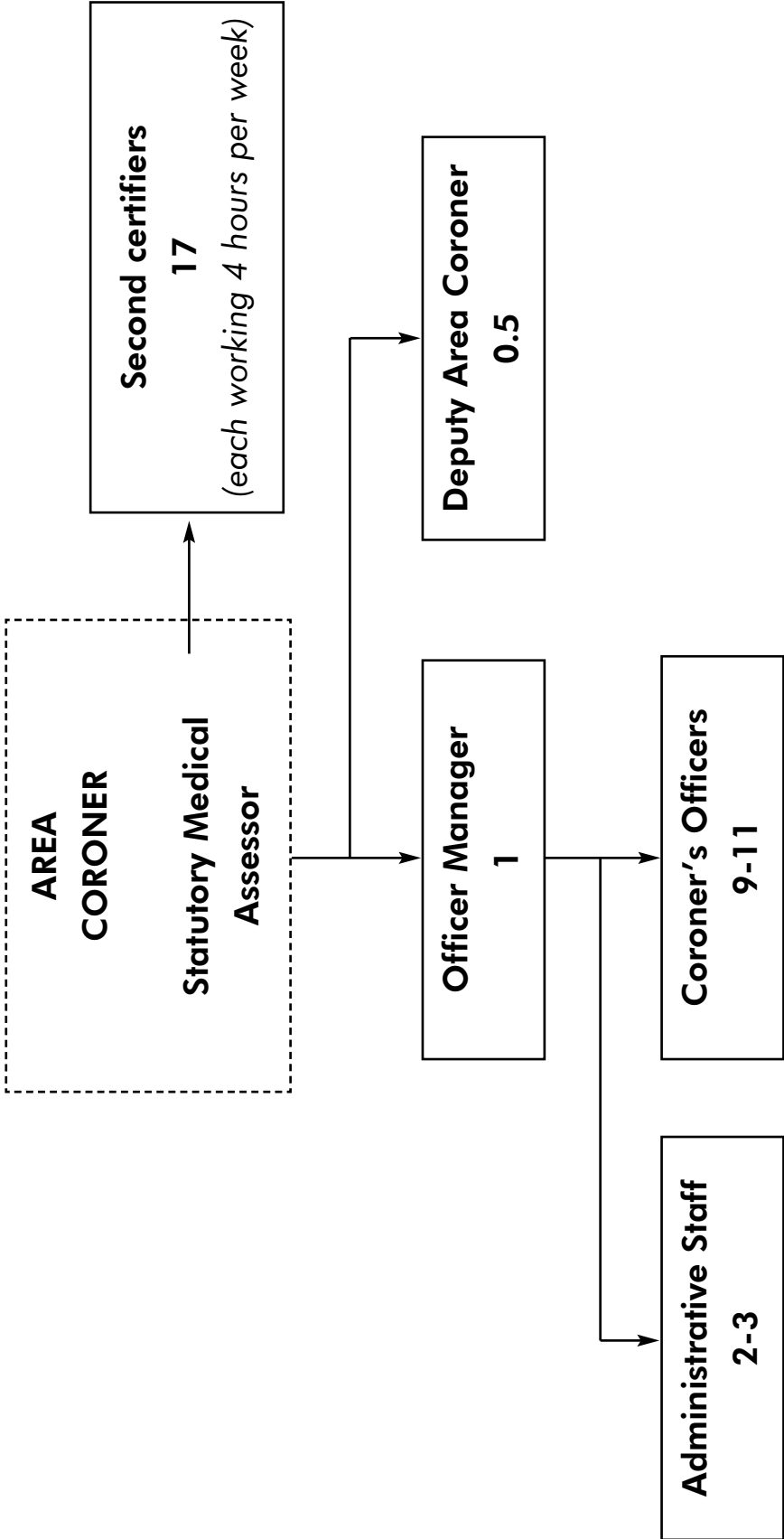


Figure 2: Structure of an average Coroner's Office



## CHAPTER 16 - APPOINTMENTS AND TRAINING

**In this chapter we recommend arrangements for appointments and training to support the new structures.**

### Introduction

1. As explained in earlier chapters the arrangements for existing appointments in England and Wales are:
  - a. coroners are appointed by local authorities and deputy and assistant deputy coroners by the coroner for whom they work subject to the approval of the appointing local authority;
  - b. coroners' officers are employed either by the police or local authorities, and are appointed through their normal processes;
  - c. there is no particular appointment process for pathologists performing autopsies for coroners;
  - d. the Home Office arranges residential training weekends for coroners, and some induction courses;
  - e. there is no nationally organised training for coroners' officers.
2. In Northern Ireland coroners and deputy coroners are appointed by the Lord Chancellor. The Northern Ireland Judicial Studies Board holds occasional events for coroners and Northern Ireland coroners may attend Home Office training events.
3. We have recommended that pathologists doing work for coroners should be appointed after an open appointment process involving the coroner and the Statutory Medical Assessor<sup>1</sup>.
4. We have also recommended that Statutory Medical Assessors should be appointed either by Strategic Health Authorities or by the Government Offices in the Regions, and seconded to work with the area coroner. The appointment committees should include the area coroner with whom the doctor will be working.<sup>2</sup>

<sup>1</sup> Chapter 13, paragraph 25.

<sup>2</sup> Chapter 15, paragraph 83.

## Coroner and Deputy Coroner Appointments

5. In Chapters 7 and 14 we recommend that the coroner service should be reformed into two national jurisdictions, covering England and Wales, and Northern Ireland, respectively, that the Lord Chancellor should become responsible for coroner appointments in England and Wales as he already is in Northern Ireland, and that coroners should be qualified as barristers or solicitors.
6. In our consultation paper of August 2002 we suggested that appointment should be after consultation with local interests and that the criteria should include suitability to work with bereaved people. This was widely supported.
7. We envisage an open public process for each appointment following advertisement of the vacancy, and that there should be interviews by an appointment committee which would then make recommendations to the Lord Chancellor.
8. It would be desirable for the same process to be followed in the appointment of deputy coroners. We do not think the present process of appointment by the coroner with whom the deputy will be working is a satisfactory method of appointing a judicial official, though it would be important for the coroner to be a member of the appointment committee which recommends the appointment of the deputy.
9. **We recommend that in England and Wales as already in Northern Ireland the Lord Chancellor should appoint coroners and deputy coroners after considering the recommendations of an appointment committee. Vacancies should be publicly advertised. The appointment committees should include a member nominated by local government in the area of appointment. The appointment criteria should include suitability to work with bereaved families.**

## Coroner and Deputy Coroner Terms

10. Under present arrangements coroners are judicial office-holders who may not in law be subject to binding contractual conditions by their local authorities but in practice have expectations of continuing service up to age 65 or 70.<sup>3</sup> Deputy coroners, as the personal appointees of coroners, appear to have no tenure in their posts.
11. Given the heavy administrative task that coroners will have, in addition to their judicial functions, there is a case for setting a retirement age of 65. As judicial officers coroners should have security of tenure up to the

<sup>3</sup> For a description of coroners' appointment status, see *Jervis*, pp34 – 39.

normal retirement age. However, there is clearly a danger of staleness or even “burnout” after prolonged exposure to work concerned with traumatic deaths. It would therefore be desirable for coroners to review their situations with the Chief Coroner or his deputy periodically, say every five years. In cases where a move to different judicial work seemed desirable – for example in the Tribunals field- we would hope that it could be arranged.

12. A number of deputy coroners have drawn our attention to the unclear and unsatisfactory nature of their status. It would be desirable for this to be clarified in the new structure. We suggest that they should have renewable five-year terms of office.
13. Coroners and Deputy coroners will be judicial officers in new national jurisdictions. We would expect the financial aspects of their terms to be settled on the basis of recommendations from the Senior Salaries’ Review Body, which covers other judicial salaries.
14. **We recommend that coroners should have tenure until 65, though there should be provision for review at five yearly intervals and in any case where this was desirable the opportunities for moving to other judicial work should be explored. Deputy coroners should have renewable five-year appointments. Financial terms for coroners and deputy coroners should be settled following review by the Senior Salaries’ Review Body.**

### **Transition to the New Structure: Appointment Issues**

15. In Chapter 7 we recommend that, with the increased emphasis on the investigation and judicial functions that will occur in the work of the coroner after the creation of the new Statutory Medical Assessor posts, the professional qualifications to be required for appointment as coroner, or deputy coroner, should be legal. There would be no further coroner appointments of people with medical qualifications but no legal qualifications or experience.
16. We also recommend that the present 136 coroner districts in England and Wales should be reduced to around 60 areas, each to be headed by a full-time coroner with additional part-time deputy coroners as necessary to deal with expected caseloads.
17. At the point of transition into the new structure, all existing coroner, deputy coroner and assistant deputy coroner appointments would lapse, and there would be a process of application and appointment to the new coroner and deputy coroner posts.
18. Although we recommend that all coroner and deputy coroner posts should in future be filled by people with legal training and experience, we

think it would be reasonable for those with medical qualifications and significant experience as coroners (or deputy or assistant deputy coroners) within the present system to be able to apply for the new coroner and deputy coroner posts.

19. **We therefore recommend that medically qualified coroners (and deputy and assistant deputy coroners) within the present structure should be able to apply for coroner and deputy coroner posts in the new structure, alongside those with legal qualifications and experience.**

### Coroners' Officers

20. Coroners' officers are responsible for completing many of the practical tasks associated with the function of the coroner; they are often the first and continuing point of contact for both the families and all other organisations to whom the coroner relates. Frequently their work has to be undertaken under pressure and with minimum support services. Very few of them have been recruited through public advertisement and there is no nationally-agreed job description, salary scale, system of career progression or official training.
21. A recent Home Office Working Party<sup>4</sup> examined the situation of coroners' officers and our review recognises that any reform of the coronial system must include a reappraisal of the role of coroners' officers as a key indicator of change. We endorse the Working Party's conclusion that matters needing immediate attention include: - *"the development of a nationally agreed job description and public advertising for all posts; the development of structured training models to include a clear understanding of the different functions undertaken by coroners officers and, finally, a system of support through effective management systems recognising the responsibility undertaken by them in stressful circumstances."*
22. **We recommend that the development of nationally agreed job descriptions and structured training models for coroners' officers should be a priority task in the preparation of coroner service reform. It should take account of our recommendations for some specialisation amongst coroners' officers in Chapter 11, for example in deaths from self-harm, the deaths of children, and workplace deaths.**
23. Since we expect the number of coroners' officers in the new structure to increase somewhat, and we are not proposing any mandatory minimum qualifications for appointment, we would expect all existing coroners' officers to be offered the opportunity of transferring into the new structure.

<sup>4</sup> Report on the Provision of Coroners' Officers, Coroners' Officers Working Party, April 2002.



## Training

24. The training issues that need to be addressed are:
- whether there should be mandatory training for coroners, their officers and others working in the area;
  - who should oversee its provision;
  - what it should contain.
25. The proposition in our consultation paper that for coroners and coroners' officers there should be mandatory training on and after appointment was widely supported, not least by their respective representatives and by many members of the public. The Royal College of Pathologists added that the training needs of pathologists working for coroners should also be considered.
26. Coroners are the only judicial group who are not required to have initial and continuing training. All the members of the legal and medical professions from which coroners are drawn are required to have continuing professional education and development.
27. We would expect the Coronial Council to have a major input into the new service's training policies which need to cover the service's administrative as well as its judicial work. The Judicial Studies Board in England and Wales are already taking an interest in coroner training and we understand that the impact of its involvement is already being felt and appreciated. The Community Justice National Training Organisation, which covers national occupational standards and vocational qualifications, and sector workforce development planning in some justice fields, including juvenile justice and probation, may have a role to play in the development of training and qualifications for coroners' officers.
28. On the content and coverage of training for coroners and their officers, we have received a large number of suggestions, including:
- Bereavement Issues
  - Accident Causation, Risk Management and learning to set incidents in the relevant context
  - The Human Rights Act and its application to coroners' investigations
  - Communication Skills
  - Public Interest aspects of Inquests
  - Medical Issues, including e.g. Epilepsy- Related Deaths
  - Child protection issues
  - Diversity and awareness of cultural issues
  - Religious and spiritual issues
  - Human organ and tissue matters

29. For the general training of coroners, Statutory Medical Assessors, their officers and others working with them we would regard human rights, bereavement and diversity and related religious issues as core components of training and cultural and religious diversity.
30. **We recommend that:**
  - i. **all coroners, Statutory Medical Assessors, and coroners' officers should have mandatory training on first appointment, and should be required and enabled to pursue approved continuing professional education and development annually thereafter. Such training should also be available to pathologists working with coroners;**
  - ii. **the Coronial Council should be responsible for determining the new service's training strategies, but there will be continuing important roles for the Judicial Studies Boards in both jurisdictions, and there may be a role in relation to coroners' officer training for the Community Justice National Training Organisation;**
  - iii. **human rights, bereavement and diversity issues should be core training components.**

## CHAPTER 17 - NORTHERN IRELAND

**In this chapter we summarise the application of our recommendations to Northern Ireland, and examine some issues specific to Northern Ireland.**

1. The death certification and coroner systems in Northern Ireland are summarised in the introductory chapters of our report and some more detail is given in the chapters dealing with particular issues.
2. The death certification arrangements are very similar to those in England and Wales. The coroner system in Northern Ireland reflects the same historic legacy shared with England and Wales and the Republic of Ireland, but there are some significant differences:
  - since the Coroners Act (Northern Ireland) 1959 the coroner service has been supported and financed by central government not local authorities as in England and Wales. Since 1979 this responsibility has been discharged through the Northern Ireland Court Service by the Lord Chancellor, who also appoints coroners in Northern Ireland;
  - all the seven Northern Ireland coroners and their deputies must by law be solicitors or barristers. Medical appointments have not been made since 1959;
  - there is no provision for “short-form” verdicts such as “accidental death” and “unlawful killing” in the outcomes of inquests in Northern Ireland. There are instead “findings” which are generally brief and neutral in import;
  - there are no dedicated coroners’ officers as in England and Wales. Casework support is provided through serving police officers;
  - autopsies for Northern Ireland coroners are mostly done by the State Pathologist’s Department for which the Northern Ireland Office is responsible;
  - Northern Ireland coroners generally have discretion whether to hold inquests.
3. The Coroners Act (Northern Ireland) 1959 was a more considered and thorough-going enactment than any legislation for support of the England and Wales coronial service during the second half of the twentieth century. As well as transferring the responsibility for appointing and supporting coroners from local to central government, it implemented some recommendations of the Wright Committee of 1936, including the requirement that coroners should be legally qualified.

4. The members of our Northern Ireland Reference Group are given in Annex A. The more than 70 people including family members and support groups whom met on our visits to Northern Ireland are listed in Annex B, and the four visits themselves, which included Derry/Londonderry and Omagh as well as Belfast, are outlined in Annex C<sup>1</sup>.
5. In the standard reference book on the Northern Ireland coroner system<sup>2</sup> by John Leckey and Desmond Greer the authors, writing in 1998, have this to say about the implications of sectarian conflict during the 1970s, 1980s and part of the 1990s:

*“The civil unrest and widespread violence in Northern Ireland since 1969 has resulted in more than 3000 sudden or unexpected deaths, many as a result of paramilitary activity, sectarian disturbance or the actions of the security forces. Each of these deaths was in the normal course reported to the coroner for the district in which the deceased died; in most cases the coroner ordered a post-mortem examination to be carried out and held an inquest into the circumstances and cause of death. A number of these deaths occurred in controversial circumstances and were invariably followed by well-publicised and highly contentious inquests. This was particularly the case where the death resulted from direct intervention by members of the security forces whether police or army. The limited nature of the investigation into the circumstances of such deaths which could properly be carried out by the coroner led to growing criticism of the adequacy and scope of inquests in Northern Ireland.....”*

*“The conduct of inquests in England and Wales and Northern Ireland has, however, become increasingly subject to judicial scrutiny since 1980. Applications for judicial review have brought into sharp focus the legal basis of the coroner’s jurisdiction and the application of the rules of practice and procedure governing the conduct of inquests ..... the past twenty years or so has witnessed a dramatic rise in the number of challenges to coronial decisions in Northern Ireland as well as in England and Wales.”*

6. In Chapter 3 we outline the six major changes we generally recommend for death certification and the coroner services. We consider each of them in relation to Northern Ireland.
7. The introduction of a **consistent professional service based on full-time leadership**, reformed into a single Northern Ireland jurisdiction with a Chief Coroner, a Coronial Council to oversee death certification and the

<sup>1</sup> In addition to these four Group visits, the Review Chair with the Northern Ireland member attended a considerable number of ad hoc meetings in Northern Ireland.

<sup>2</sup> Coroners’ Law and Practice in Northern Ireland , Leckey and Greer. Full details given in paragraph 16 of Chapter 1. The quotation given here is from p xvi of the Preface.

coroner service, a Rules Committee to promote consistency of practice in inquests and structured and mandatory training for all key personnel should have the same advantages in Northern Ireland as in England and Wales.

8. The promotion of **consistency of service to families** through a statutory Family Charter would also be equally valuable in Northern Ireland and could be of great help to the support groups working with families whom we met.
9. The introduction of the **Statutory Medical Assessor** to deal with deaths from natural disease, improve liaison between the coroner service and public health and healthcare, and audit death certification would equally be of benefit.
10. The objective of gaining a **proper recognition for the work of coroners' officers** needs in Northern Ireland to be preceded by the creation of a coroners' officer service separate from the police.
11. The replacement of the present "three-tier" death certification process for cremations with a "two-tier" process applying to all deaths, with doctors in the second tier being chosen and supported by the Statutory Medical Assessor, would in principle have the same advantages in Northern Ireland as in England and Wales. It would, however, need careful management and monitoring to ensure prompt and smooth operation so that the Northern Ireland tradition of prompt burial continues to be respected and supported. The introduction of a formal death verification process would have the same benefit in Northern Ireland as in England and Wales.

### Changes to Coroners' Investigations and Inquests

12. The changes recommended in Chapters 7 – 10 will be of great importance in Northern Ireland, particularly in relation to the handling of contentious deaths.
13. We recommend new powers for coroners to determine the scope and scale of the investigation necessary to find the cause and circumstances of death, and to obtain any document, report or other material from any source subject only to any public immunity interest exclusions that might be claimed in individual cases (Chapter 7, paragraph 27). We also recommend that exceptionally complex or contentious inquests might be held by members of the senior judiciary supported by a Counsel to the Inquest; and that the right to avoid self-incrimination in an inquest should be replaced by an undertaking that the testimony of an inquest witness should not be used against him in any subsequent criminal prosecution<sup>3</sup>.

<sup>3</sup> See paragraphs 32 to 39 of Chapter 9, and the memorandum prepared under the auspices of Anthony Heaton-Armstrong in Volume 2.

### Some Mandatory Inquests

14. We also recommend a new structure for determining when public inquests should be held. The criteria for holding mandatory public inquests, facing paragraph 46 in Chapter 7, would require a public inquest to be held following:

“any death of a person held in prison, police custody, or a bail or asylum hostel, or of any person compulsorily detained under mental health legislation, unless the Statutory Medical Assessor certifies beyond reasonable doubt that the death was caused by natural disease;

“any traumatic death occurring apparently or possibly as a consequence of police or other law and order operations”.

15. These and the other criteria we recommend would mean that all deaths of prisoners or of those in custody of other kinds and of people detained under mental health legislation would always have public inquests unless it was clear beyond reasonable doubt that the death was from natural disease. Deaths at the hands of the law and order services would always have a public inquest. So, too, would traumatic workplace deaths. There would always be public inquests on the deaths of children unless it was clear that the death was from natural disease, and there would be public inquests into deaths occurring in public transport crashes or in the sinking or collision of commercial vessels. There would also be public inquests where significant uncertainty or conflict of evidence justified a public forensic process or where there were other public interest grounds. The existing Northern Ireland discretion to hold public inquests into suicides and other cases would broadly be retained and extended to England and Wales.
16. At present in Northern Ireland there is a statutory requirement to hold inquests into prison deaths and certain other categories of death involving notifiable disease, but otherwise the holding of an inquest is at the coroner’s discretion. That discretion must be exercised reasonably, but in our consultation a number of Northern Ireland interests, including the Northern Ireland Human Rights Commission and the Committee for the Administration of Justice suggested that certain categories of inquest should be mandatory, including those concerning deaths in detention and at the hands of the law and order services. We agree.
17. **We recommend that in Northern Ireland the criteria for holding public inquests should be the same as we recommend for England and Wales. Public inquests would become mandatory for certain kinds of death including those apparently at the hands of law and order services.**

## Opening and Adjourning Inquests

18. The practice in England and Wales is that after any death apparently by murder or homicide an inquest is opened and adjourned while the police investigate and any prosecution proceeds. If there are no criminal proceedings, or if they take place but leave significant issues unresolved or unexplored, the inquest is resumed. Otherwise the coroner takes no further action. The most likely grounds for resuming an inquest are to find out whether there has been a systems failure to protect the victim, or to resolve any significant uncertainty over what type of death it was – for example through a fall, from injury inflicted by one or more third parties, or by the victim’s own actions.
19. In Northern Ireland the powers exist for a similar procedure to be followed, but because the holding of most such inquests is at the discretion of the coroner the process is not usually brought into play.<sup>4</sup>
20. Prosecutions following deaths related to inter-community conflict have occurred in some cases but in other cases they have not, though investigations seem sometimes to continue in form if not in actuality for long periods. In such cases there is a risk that neither of the main judicial processes designed to deal with violent deaths – the inquest and the criminal trial – will be brought to bear on such deaths, or that there may be a prolonged, possibly even an apparently indefinite, period of uncertainty over whether there is to be an inquest. This is not satisfactory.
21. **We recommend that in all cases of apparent homicide the England and Wales practice of opening and then adjourning inquests pending police investigations and any criminal trial and then resuming the coroner’s investigations if it would serve a purpose should be systematically implemented in Northern Ireland.**

## Scope and Outcomes of Inquests

22. Coroners’ inquests in Northern Ireland do not deliver “verdicts” as in England and Wales, but “findings”. The Coroners’ Act 1959 provided for verdicts, but in the 1980 Rules they were replaced with “findings” in the form of a short narrative or description of who died, where and when, and how the deceased came by his death. Some attribute this to compliance with the recommendations of the Brodrick Report of 1971 which advocated the replacement of verdicts with findings, though this change was not made in England and Wales. We have not examined the history, but it is clear that the type of outcome given in contentious cases as findings are often regarded as too perfunctory to be an acceptable or satisfactory product of a serious investigation.

<sup>4</sup> The powers are in Rules 11, 12 and 13 of the 1963 Rules.

23. Our own recommendations for the outcome of inquests also envisage that short-form verdicts should no longer be used. Thus, "Accidental Death", "Misadventure", "lawful killing" or "unlawful killing" would no longer feature in the outcome of any inquest. There would instead be outcomes based on a full narrative and analytical examination of the death.
24. This examination would include its immediate circumstances, the actions of individuals who may have had a hand in the death or a responsibility if possible to prevent it, and any failure of systems designed to protect against relevant risks to life. There would be conclusions summarising the coroner's or jury's determinations of such issues and others within the scope of the inquest, together with any comment that was necessary on the evidential standards to which the various conclusions had been established. The death would also be classified by type, so that when there was for example doubt about whether the death was caused by the actions of one or more third parties, the conclusion would make this clear.
25. The conclusions would not determine any questions of civil or criminal liability. Where a coroner considered that an inquest outcome, or any evidence given at an inquest, might be relevant to the work of any enforcement or investigatory agency, including the police and the prosecuting service, he would send the material to them and say in public that he would do so.
26. The recipient agency would then be accountable for its response through the normal processes for such accountability. In the case, for example, of the prosecuting services this would include a liability to judicial review. There would also in suitable cases be the prospect of an explanation of any decision not to prosecute in line with the statement made on behalf of the Northern Ireland Director of Public Prosecutions by the Attorney General on 1 March 2002:

*"...The Director recognises that there may be cases in the future, which he would expect to be exceptional in nature, where an expectation will arise that a reasonable explanation will be given for not prosecuting where the death is, or may have been, occasioned by the conduct of agents of the State. Subject to compelling grounds for not giving reasons, including his duties under the Human Rights Act 1998, the Director accepts that in such cases it will be in the public interest to reassure a concerned public, including the families of the victims, that the rule of law has been respected by the provision of a reasonable explanation. The Director will reach his decision as to the provision of reasons, and their extent, having weighed the applicability of public interest considerations material to the particular facts and circumstances of each case."*<sup>5</sup>

<sup>5</sup> Extract from Attorney General's Statement to the House of Lords, 1 March 2002.



27. In Chapter 10 paragraphs 58-65 we explain how we see the inquest, along with other processes as necessary, meeting the investigatory obligations in cases which engage Article 2 of the European Human Rights Convention.
28. We consider that the recommendations we have made relating to the scope and outcomes of the inquest should provide, in Northern Ireland as in England and Wales, a substantially deepened and improved judicial process for the investigation of complex or controversial deaths more likely than any existing arrangements to provide proper explanations of how such deaths occurred.
29. **We recommend that the new arrangements for the scope, handling and outcomes of inquests, including inquests in cases engaging Article 2, outlined in Chapters 7-10 of this report should apply also to Northern Ireland.**

### Delays in Dealing with Reported Cases

30. According to the Northern Ireland Court Service, at the end of 2001 there were 1,897 deaths still awaiting either an inquest or a decision whether or not to hold an inquest. One of the consequences of the discretionary inquest system as it has developed in Northern Ireland is that there is an accumulation of reported cases where, because of the practice of waiting until all other investigations and inquiries have concluded, the coroner has not yet decided whether to hold an inquest.
31. The Northern Ireland Court Service have told us that this is a trend that has been increasing year on year, there having been 1,392 cases outstanding in 1998; 1,477 in 1999; and 1,634 in 2000. The part-time nature of most coronial jurisdictions in Northern Ireland and the lack of support staff have no doubt also contributed to this.
32. The Court Service has no information on how many of these cases are likely to result in inquests. If the proportion receiving inquests were to be the same as the overall proportion of reported cases receiving inquests the number of inquests outstanding might be in the range 120 – 170.
33. Whether one counts reported cases unresolved or inquests unheard, the backlog at the end of 2001 was equal to nearly two-thirds of the annual caseload of reported deaths or inquests. This is unacceptable. It is encouraging that the Court Service have addressed this in Greater Belfast by appointing an additional Deputy Coroner but it is clearly important that the backlog should be addressed very actively, and that the Court Service should introduce methods for monitoring the handling of cases in Northern Ireland which will enable them to keep the position under close review.

34. **We recommend that the Northern Ireland Court Service should publish each year a summary of the number of outstanding reported cases in Northern Ireland, with an analysis of the reasons for delay and a statement of the measures they intend to take to deal with any continuing backlog and to ensure that bereaved families receive a prompt service in future.**

### Delays in pathology reports

35. Coroner's autopsies in Northern Ireland are usually carried out by the State Pathologist's Department (SPD). This department was created in 1958 as a service to the coroners and is based in purpose-built premises in the grounds of the Royal Victoria Hospital, Belfast. It has 13 staff comprising 3 consultant forensic pathologists, a trainee forensic pathologist, laboratory staff and 4 secretarial staff. It does all the forensic pathology work in Northern Ireland, as well as a large majority of the general autopsies for Northern Ireland coroners.
36. The autopsy rate in Northern Ireland is low compared to England and Wales, at 9 % of all deaths compared to nearly 23% in England and Wales.
37. Many of those who spoke to us cited the length of time after autopsy it takes for some pathology reports to reach the coroner as a factor contributing to delay in inquests. We have not seen any data which identify either the scale of delay or its various causes though we understand that there have been difficulties in recruiting pathologists to the service.
38. **We recommend that the State Pathology Department publish annually figures for the number of autopsies it does for coroners, the average time taken between the completion of the autopsy and the delivery of the report to the coroner, and the range of times for delivering reports. The figures should include the number of reports delayed for one month or more, six months or more, and 12 months or more, with reasons for delay.**

### Casework Support for Coroners

39. There is provision in Northern Ireland under the Judicature (Northern Ireland) 1978 Act for the Lord Chancellor to appoint coroner's officers. None has been appointed and there is no casework support as such for coroners. A number of functions carried out by coroner's officers in England and Wales are in Northern Ireland carried out by the regular officers of the Police Service. None of the interests in Northern Ireland with whom we discussed the issue is happy with this arrangement. It is not generally a good use of police manpower. Where there is a death to be

investigated in which the law and order services may have been implicated it lacks independence. In cases with no criminal involvement it is unsuitable for the police service to be involved.

40. **We recommend that coroners' officers should be created in Northern Ireland along the same lines as in England and Wales. They should be independent of the police and employed by the Court Service. They should support the Statutory Medical Assessor as well as the coroner, and their professional backgrounds and training should be developed as we recommend for England and Wales.**

### **Deaths apparently involving the Police**

41. In cases where the coroner is investigating a death apparently involving the Police Service it is desirable that he should have access to the help of the investigation staff of the independent Northern Ireland Police Ombudsman. We understand that though this is generally agreed in principle, and that a protocol for such support to coroners is in preparation, there may be a legal uncertainty about using Ombudsman's staff in this way. **We recommend that when suitable legislative opportunity occurs the legality of investigative support to coroners by the Northern Ireland Police Ombudsman should be put beyond doubt.**

### **Legal Aid**

42. The arrangements for delivering Legal Aid in Northern Ireland differ to those which exist in England and Wales. In Chapter 12 we have set out our recommendations for the availability of legal aid at inquests. We also recommend that arrangements should be introduced in Northern Ireland with the same effect.

## CHAPTER 18 - THE CORONER'S INQUEST AND TREASURE

1. The coroner's interest in treasure trove appears to date from medieval times when it was customary to bury gold and silver with a view to uncovering it at a later date and when treasure trove was a source of revenue for the Crown.
2. Until the Treasure Act 1996 coroners had the role, when gold and silver items had been found, to inquire into the intent behind the burial: had it been deliberately buried with the intention of recovering it at a later date; was it on land currently owned or managed by a known person; and were the direct heirs of the original owner known? If it had been deliberately hidden and the owners or heirs were not known, then it was declared "treasure trove" and it belonged to the Crown by prerogative right.
3. If the item or items were not declared to be treasure then the coroner was required to deliver it up to the rightful owner. The coroner had no power to determine the owner and it still is the case that the coroner does not have powers to resolve disputes of ownership but only to find facts. The former role has always been one for the higher courts. However, in practice, finders of valuable and historic objects that are not going to the Crown tend to use the coroner's court as a means of informal dispute resolution.
4. The Treasure Act 1996 replaced the common law of treasure trove and provided an objective definition of treasure. Essentially the object must be at least 300 years old and contain 10 percent or more gold or silver. However, the act did not repeal the former definition but prolongs it by saying treasure also comprises "any object which would have been treasure trove before commencement." The intention is, no doubt, not to lessen the opportunities for acquiring valuable and ancient objects for museums since this is the way in which the Crown prerogative is now exercised – the object, if treasure, is offered to the British Museum to acquire on behalf of national or local collections. If this course is followed then a valuation is made by the British Museum and the same amount is given to the finder.
5. This process can be lengthy. Local museums may not want the item if it is not going to add to what is already known and retained of local history. Or they may want it to complete a collection but regard its market value as less than might be obtained by a good vendor of curiosities and memorabilia. Those who have been involved in finding artefacts that might count as treasure tell us that they prefer the former system, where the local coroner had the pivotal role, to the present arrangements centred in the museums. Speed of resolution of the issues is the main reason that they give, followed by a greater trust in the local coroner than in a museum which stands to benefit, as they see it, from the advice given and the decisions made.

6. The coroners themselves, in those areas where many artefacts are found, regard their role in a treasure inquest and the expertise that they have developed with some degree of satisfaction. They and many of the groups who look for artefacts as a hobby have expressed to us a preference for retaining the former system of handling treasure trove. The powers given to coroners in this regard and the former definition of treasure have not been repealed in the 1996 Act. The procedures in the 1996 Act are simpler if more remotely administered and the interests of the museums are formally represented – although the British Museum have told us that they would like to see stronger policing of the failure to declare a find.
7. The thrust of our work on the role and powers of the coroner has been to say that their investigations must be carried out within a framework of powers that are more clearly defined than at present and that their investigations should be focused on delivering what cannot be delivered through any other agency.
8. One of the effects of the Treasure Act 1996 has been to remove the need for an inquisition to determine the intention behind hiding artefacts as the principal means of declaring whether they are treasure. This is now done by means of a statutory test applied by experts on antiquities, though the old “treasure trove” concept is carried forward in the new legislation, along with the new statutory tests.
9. One would expect the number of items that require a determination from the coroner to be fewer as a consequence of the new definitions in the Treasure Act. Anecdotally we are told that reports of finds to the coroner have increased significantly, but mainly, it appears, because of a preference amongst finders to go to the coroner if they have to go to someone at all<sup>1</sup>. At least with the coroner, it is said, you will find out more quickly whether you are going to be remunerated by the Crown for finding treasure or whether you can have the object back to sell privately.
10. These issues have not been addressed in the annual report on the working of the Treasure Act, nor in the original Code of Practice approved in 1997, or in its revision which has been in force from 1 January 2003.
11. The other residual powers of coroners with regard to treasure are not legally determinative in that the coroner cannot try title as to whether objects found belong to the Crown or to another by right of their own occupancy or management of the land on which a find was made. Nor is the coroners’ inquest conclusive when there are rival claims to possession of a find. It can make declarations of fact to which those participating can

<sup>1</sup> The number of treasure finds reported to coroners was 54 in 1997, 213 in 2000 and 168 in 2001, Home Office Statistics Bulletin (HOSB 3/02).

either voluntarily agree or decide to take their dispute elsewhere. We would question whether providing this kind of informal dispute resolution service is an appropriate use of the coroners' inquest.

12. The consequence of our recommendations elsewhere for the future of the coronial service can only be that coroners must relinquish their role in treasure. It is also clear that the 1996 legislation has left significant uncertainties about the role, effectiveness, and necessity for the coroners' involvement in treasure issues<sup>2</sup>. The introduction of more objective tests for the items themselves that are being regarded as treasure, would seem to make a judicial style of inquiry less necessary.
13. **We recommend that the provisions in section 30 of the Coroners Act 1988 which give the coroner jurisdiction in respect of treasure should be repealed.**

<sup>2</sup> Chapter 16 of *Jervis, op. cit.*, contains an analysis of the problems - see 16-44 and 16-45 in particular.

## CHAPTER 19 - INDICATIVE COSTS OF THE PROPOSED CHANGES

**In this chapter we present estimates of the cost of the changes that we propose.**

### Introduction

1. Many aspects of the costs of the present system for dealing with deaths are indeterminate so we have had to make estimates of the present, as well as future, costs. The best data that we have on current costs is for the year 2000-2001, and, unless otherwise stated, all our cost estimates refer to that year and are for England and Wales.
2. All of the cost figures assume that the changes have had time to bed down so that the system is running efficiently. However, because many of the tasks implied by our recommendations are new, and in some cases the resources they consume will depend on the demand that materialises, it is not possible to be definite about their costs. Accordingly the figures in this chapter are to be considered as indicative estimates.
3. The detailed calculations underpinning the estimates were carried out for us by Peter Jordan and have been made available to the Home Office.

### The present system

4. The costs we have identified in the present system for England and Wales are:
  - £30.8m for the provision of cremation certificates;
  - £71.4m for the costs of the coroners' system;
  - £5.8m for the costs of registration of deaths;
  - £0.2m for the cost of Home Office oversight of coroners;
  - £0.4m for the cost of legal aid in Inquests.
5. The cost of paying fees to doctors for the provision of cremation certificates is borne by families except in those cases where the coroner certifies the death in which case no fee is required. These cremation certification costs are therefore private expenditure.
6. The other costs are met from public expenditure. Most of the £71.4m spent on the coroner service is local authority expenditure. The remainder is expenditure by police authorities where they provide coroners' officers. Registration expenditure is also through local authorities.

7. Of the £71.4m for coroners' costs, over half is incurred for the purposes of moving bodies, storing them in mortuaries and conducting autopsies and other tests. Excluding these fees and payments, the annual cost of the coroners and their staff including on-costs and overheads is £33.2m.

### The future system

8. The recommendations in the report require the creation of a Statutory Medical Assessor; significant increases in the training provision for Coroners and their officers; and an increase in the intensity of effort in scrutinising individual cases. The Statutory Medical Assessor will lead in the scrutiny of the medical aspects of cases and will also have responsibility for maintaining a new 'two-tier' system of certification.
9. These improvements will require increased expenditure, but there will also be offsetting savings mainly arising from an anticipated reduction in the use of autopsy.
10. Taking account of these factors, we estimate that the annual costs of the coroners' services will increase by a little over 10% to £79.0m.
11. This includes £6.7m (including overheads) for the cost of creating the new Statutory Medical Assessor posts. We envisage that Statutory Medical Assessors would be seconded into the coroner service from Strategic Health Authorities or the public health components of Government Offices in the regions. The role of these posts is closely linked to the objectives of the public health programme. There is a case for leaving their costs on the budgets of the seconding organisation.
12. There will be a reduction of £30.8m in private expenditure on fees for cremation certificates and an increase in public expenditure on second certification fees and retainers of £23.9m, as a result of the transfer of the responsibility for meeting such certification costs from the private to the public sector. There will also be a cost of £3.6m incurred in training the second certifiers and monitoring the quality of certification.
13. We also recommend that the registration of some deaths might be effected through the Coroner's Office. Bearing in mind the recent White Paper on changes in the registration system we estimate that the future costs will be £3.3m., representing a saving of £2.5m on present registration costs.
14. The other significant cost increase that we anticipate is an increase in legal aid for families in those cases where a public authority is represented. Our best estimate of this is an increase from £0.4m to £3.7m.



## *Chapter 19 - Indicative Costs of the Proposed Changes*

15. In most respects the increases in Northern Ireland would be proportionate but if the creation of a coroner's officer service there were all to be financed from new money rather than transfer from police expenditure the extra costs would be higher.
16. We have not estimated transitional costs.

## CHAPTER 20 - TIMESCALES AND TRANSITIONS

**In this chapter we briefly summarise issues about the timing of reform.**

1. The programme of reform that we recommend needs Parliamentary legislation to introduce the new coroner jurisdictions in England and Wales and Northern Ireland respectively. That legislation would also be the vehicle for setting up the statutory Coronial Council that we see as essential for the introduction of consistent standards in the coroner service, a proper unity of approach between death certification and investigation, and the development and adaptation of both systems to meet new challenges as time passes. It would also create powers for the Statutory Medical Assessor. It would probably be a medium-sized Parliamentary Bill. It would require close working between the Home Office, the Health Departments and the Lord Chancellor's Department. Northern Ireland could be covered in the same legislation, but has its own legislation in these fields and might prefer to retain it, reformed as necessary.
2. Before the legislation could be prepared in detail, the Government will wish to bring together the outcome of this Review with related matters in further reports from the Shipman Inquiry. It will also wish to make the necessary connections with the work of the Retained Organs Commission and the reforming legislation being prepared on human tissues and organs.
3. Another area of essential connection is with the follow-through of the White Paper on the reform of the Registration Service.
4. All these matters taken together constitute a complex programme of interlinked reform and modernisation. It is unlikely that legislation could be introduced as early as the session beginning in the autumn of 2003, but we hope that it will be introduced in the following session. If the new legislation became law in 2005, the changes dependent on legislation could be implemented, after the necessary detailed preparation, in 2006.
5. We appreciate the pressure of demand for legislative time. We hope, however that the long history of structural neglect of the services we have reviewed, the benefits of change in terms of better safeguards and services to bereaved families, and the widespread recognition of the need for change will lead to an early Government commitment to reform.

6. There is both scope and need to make improvements before the new legislation. In particular:
  - doctors working with the NHS Strategic Health Authorities or the Health Departments could be allocated to work in an advisory capacity with the Registration Service and local coroners to begin the process of auditing and supporting the death certification process;
  - the existing Coroners Rules in England and Wales and Northern Ireland respectively could be reviewed in the light of our recommendations on the outcomes, conduct and scope of inquests;
  - the Registration Service, the Home Office and the Chief Medical Officers could give guidance on the use of autopsies in the light of our recommendations;
  - a new charter of standards for service to families could be produced and recommended on an advisory basis before the introduction of the new powers to give it statutory force;
  - training programmes for coroners' officers should be introduced with some support from central funds, and the development of new training arrangement for coroners themselves could be started;
  - informal piloting of death certification changes could be started;
  - the Coronial Council could be appointed on an informal basis and asked to oversee progress with the reforms.
7. All these changes could be made in advance of new legislation, and all would be very worthwhile. We hope there will be clear progress on all of them within a year of the publication of our report.
8. The first quotation in our report was from material we received during our Review from Victims' Voice, an organisation speaking for users. We give the last word to the organisation representing some of the people with the responsibility for trying to make obsolete systems work to the satisfaction of a modern public:

*"The present service has for far too long been inadequately resourced and been compromised in what it can do. Outmoded laws and regulations, insufficient staff, lack of resources and poor training have all contributed to the need for reform. It will be most important for there to be a full commitment to any proposed changes that are recommended and implemented, including proper funding, to ensure that the objectives of the system are achieved."*

<sup>1</sup> Submission to the Review from The Coroners' Society of England and Wales, November 2001.

## **CHAPTER 21 - SUMMARY OF RECOMMENDATIONS**

**The changes we recommend are broadly summarised in chapter 3, paragraph 2. The objectives and values we recommend for the new service are summarised in chapter 3, paragraph 3. There is an overview of the new service structure in paragraphs 89 -99 of chapter 15. In this chapter we list the main individual recommendations.**

### **Chapter 4: Reporting Deaths to the Coroner**

1. The identification of the categories of deaths which should be reported to the coroner should cease to be legally centred on the registration process. The Coronial Council should issue statutory guidance on the types of death which should be reported to coroners. Suggested categories of deaths to be reported are in chapter 4 paragraph 18.
2. The doctor providing care during the final illness, or the police who attend the scene of a traumatic or sudden death, should normally report deaths to the coroner, but the range of people with a power to do so should include other professional health care personnel, and members of the care inspectorates, fire service personnel and funeral staffs.
3. Families and others who have continuing concerns should be able to report a death directly to the coroners' office.
4. A doctor or member of the police reporting a death to the coroner should be obliged to take all reasonable steps promptly to inform the family that the death has been reported.

### **Chapter 5: Death Certification Support and Supervision**

5. The legislation governing death certification in England and Wales and Northern Ireland should be amended to allow for adaptation of the certification system, for the piloting of change, and for differences of approach in different settings where this would be desirable.
6. To provide support for doctors in death certification, to audit the death certification process and create links between death certification and the death investigations performed through the coroner service, there should be a new post of Statutory Medical Assessor created in each coroner area, to be filled by doctors working alongside the coroner.

7. The General Medical Council and the Royal Colleges should acknowledge the importance of death certification in the initial training and continuing professional education of medical students and doctors.

## Chapter 6: Verifying and Certifying Deaths

8. All deaths should be subject to professional verification that the life has ended. This verification should be made after the body has been viewed. Verifying that a death has occurred should be statutorily defined as a step distinct from certifying the cause of death. Verification of death may be performed by a doctor (whether or not the doctor who also certifies the cause of death), or by other suitably qualified personnel. There should be, in England and Wales and Northern Ireland respectively, national protocols agreed with representatives of the police, the medical and other healthcare professions and the funeral services industry, governing the circumstances in which verification should occur, the information that should be recorded, the groups of personnel able to perform the function and the training they should have.
9. The existing cremation certification process should not be continued. There should be a common certification process for all deaths not reported to the coroner, whether the body is to be buried or cremated, and that process should in each case bring two professional opinions to bear before disposal of the body is authorised.
10. The Statutory Medical Assessor in each coroner area should appoint a panel of doctors to provide all community second certifications.
11. There should be no general requirement that all bodies should be viewed by the certifying doctor before certification.
12. For deaths in hospital there should be in principle the same two-tier certification process in which the Statutory Medical Assessor would appoint and support doctors to perform second certification. He should also approve each hospital's policy for referring deaths for second certification.
13. All certification should be done by fully registered doctors, and second certifiers in hospitals should be of consultant status.
14. Authorisation to dispose of the body should be given by the second certifier at the time he completes the second certification, and should not wait on the process of registering the death.

## Chapter 21 - Summary of Recommendations

15. Any doctor in a general practice looking after a patient if available and willing to certify the patient's death should be able to act as first certifier.
16. The maximum interval between the death and the preceding visit or attendance by the certifying doctor or his practice partner should be 28 days.
17. The family representative should provide or confirm full personal details of the person who has died, should have a right to be informed of the cause of death given by the first certifier, and a right to talk to the second certifier.
18. Copies of the new certification material should be sent to and retained by the area coroner's office so that the Statutory Medical Assessor can perform the audit function on the basis of full information.
19. The costs of the new certification system should be met from the funds of the new death certification and coroner service that we recommend. This would lead to a saving to families choosing cremation of £100.

## **CHAPTER 7: GENERAL DEATH INVESTIGATION ISSUES**

20. When the new structure is introduced, legal qualification and experience of practice as a barrister or solicitor should be required for coroners and deputy coroners in England and Wales (as is already the case in Northern Ireland).
21. The coroner, the Statutory Medical Assessor and their staffs should be under duties to comply with statutory guidance and practice directions issued by the head of the jurisdiction or the Coronial Council.
22. The coroner should be given explicit powers to determine the scale and scope of his investigation; to obtain any document necessary to his investigation; and to enter premises.
23. The coroner should be given explicit powers to investigate any death on his own initiative whether or not it had been formally reported to him; and to investigate any group of deaths which have already been certified if, in retrospect, there are grounds to think there might have been common factors not previously identified.
24. The coroner should be able to require for any specified time that all deaths occurring in particular facilities or locations should be reported to him, even if they would not normally fall within reportable categories.

25. Families should, by right, be able to meet the person conducting the investigation – the coroner, or the Statutory Medical Assessor, or a member of their investigating staff.
26. Families should have a right to a copy of the investigation report, and of any reports on which it has relied, unless, exceptionally, giving them any of this material would prejudice any criminal or other proceedings.
27. Death investigations should so far as is necessary find the identity, time and place of death and medical cause of death; and examine the immediate circumstances in which the death was discovered, the events immediately leading up to the death, relevant circumstances and history of the deceased, the actions of other individuals where relevant, any management or regulatory systems relevant to the protection of the deceased, and the role of any relevant emergency services.
28. Public inquests should be held into the deaths of people in custody or compulsorily detained under mental health powers, at the hands of law and order services, traumatic work place deaths, deaths occurring in public transport crashes or commercial vessel sinkings or collisions, and some deaths of children. In other cases they should be held where there is a need for public judicial examination to resolve conflicts of evidence, or where the public interest would be served by an inquest. Other cases would be investigated administratively.
29. Deaths reported to the coroner's office which are found to be from natural disease should be treated as though they had been certified by the general practitioner or hospital doctor in the normal way. In these cases, therefore, the medical cause of death would not be accessible to the general public.

### **Chapter 8 Inquests: Their Outcomes and Scope**

30. The outcome of the inquest should be primarily a factual account of the cause and circumstances of the death and an analysis of whether there were systemic failings which had they not existed might have prevented it, and of how the activities of individuals bore upon the death. The analysis should in suitable cases examine whether there was a real and immediate risk to life and whether the authorities took, or failed to take, reasonable steps to prevent it.
31. The analysis should include the regulatory or safety regimes designed to protect people from risk in the circumstances of the death, and whether or not they were properly observed or were, so far as the evidence shows, adequate.

## *Chapter 21 - Summary of Recommendations*

32. Since researchers and statisticians have a legitimate and important interest in inquest outcomes, there should continue to be some classification of each inquested death, but it should be in terms of type and not in terms implying criminal or other liability or its absence. Existing short form verdicts should not be used.
33. In place of the present Rule 42 of the England and Wales Coroners' Rules, the statute governing coroners' inquests should simply state that their outcomes do not determine civil or criminal liability. A corresponding change should be made to the Rules in Northern Ireland.
34. Coroners should send promptly to any public or other body a clear and succinct account of any inquest or investigation finding relevant to the body's services, activities or products and to the safety of its users, customers or staff. The responsibility for acting on, or deciding not to act on, such reports lies with the recipient bodies. The main responsibility for pursuing matters with the recipient body should lie with the regulator, inspectorate or auditor, but the coroner should be informed within six months of the recipient's decision on the report or as soon as possible thereafter if the decision has not by then been made. The coroner should inform the family of the response that he has received.
35. The regulatory bodies or inspectorates should in their own annual or periodic reports describe any coroners' recommendations or findings of significance and say whether they are satisfied with the responses.
36. Decisions on the scope of the inquest should be taken by the coroner in the light of the circumstances of the case, after considering any submissions from the family or other participants. Long-term or speculative issues should be excluded as should any issue possibly relevant to other proceedings but not to the purpose of the inquest.

## **Chapter 9: The Handling of Inquests**

37. The sixty or so new coroner areas which we recommend to replace the present 136 coroner districts in England and Wales should not be self-standing geographical jurisdictions in their own right, but components within a single England and Wales jurisdiction.
38. Regional Co-ordinating Coroners should be able to allocate cases as between the areas in their regions, and the Chief Coroner should be able to allocate cases within the national jurisdiction. There should be a comparable arrangement for the Northern Ireland jurisdiction.



39. A small number of exceptionally complex or contentious inquests should be taken by suitably trained Circuit Judges, and a yet smaller number of still more complex inquests should be heard by suitably prepared High Court Judges, each sitting as Coroner.
40. In inquests of exceptional length and complexity the Coroner should appoint a lawyer to act as Counsel to the Inquest.
41. In both the England and Wales and Northern Ireland coroner jurisdictions there should be standing Rules Committees to establish the detailed rules of procedure for the conduct of judicial inquests, and keep them under regular review. Before new rules are adopted they should, in draft, be the subject of consultation with representatives of lay users and with other statutory investigative services likely to be affected.
42. In complex inquests or inquests where seriously contentious issues may arise, public pre-inquest hearings should always be considered.
43. The new Rules Committees should devise a set of rules on disclosure which reflect a presumption in its favour but contain such safeguards or limitations as can be shown to be necessary for the effectiveness of other essential investigations and legal processes such as prosecutions.
44. The Rules Committees should look sympathetically at a provision which would allow the coroner to permit participants to make an "address as to the facts".
45. The present right to refuse to answer questions at an inquest which might lead to self-incrimination should be replaced by a procedure requiring all questions to be answered in return for an undertaking that the testimony will not be used against the witness in any criminal trial.
46. Juries should be empanelled in cases where someone compulsorily in the care of the state has died in unclear circumstances, or where a death may have been caused by agents of the state and in others which fall within Article 2 of the European Convention on Human Rights but not in other cases.
47. The coroner should have a power to forbid the publication of detailed material or evidence given in an inquest if he is satisfied that to do so would be in the interests of the privacy and well-being of the bereaved, and that there is no overriding public interest in access to the material.
48. Where there is an inquest which is to be in public the coroner should regularly and without exception follow the practice of the Courts Service in making publicly available the details of time and place.

## Chapter 10: Inquests, Inquiries and Other Investigations

49. The England and Wales practice of opening and then adjourning inquests into violent deaths pending police investigations and any criminal trial and then resuming the coroner's investigation if it would serve a purpose should continue. A similar process for opening and adjourning inquests should be implemented in Northern Ireland.
50. When the new national coroner jurisdictions are set up investigation of workplace deaths should be regarded as a specialist function on which expertise would be concentrated in one coroner in each of the new coroner areas or perhaps even one coroner in each region. A similar specialisation should be encouraged in a small number of coroner's officers.
51. The Health and Safety Executive and the other enforcement agencies should consider how they might follow the practice of the CPS, in cases involving a death, and offer bereaved families an opportunity to give a view of whether they should prosecute, and explain their decisions to families.
52. Following disasters leading to multiple deaths the inquest should normally be held by or at the level of the head of the coronial jurisdiction, or the inquest scope and arrangements should be settled after application to him.
53. There should be as soon as reasonably practicable after such an event a pre-inquest hearing at which all interests should be represented to hear information from all the technical and other investigatory bodies with responsibility to follow-up the event. They would explain the nature and scope of the investigations they intend to carry out and their likely timescale.
54. The judge sitting as coroner would reach decisions on the timing and scope of the inquest in the light of the information elicited by the pre-inquest hearing.
55. The inquest would hear representations from the leaders of the statutory technical investigations and examine them on the general scope and method of their investigations but subject to that the details of their investigations would not normally be subject to scrutiny or re-investigation by the inquest.
56. In cases engaging Article 2 of the European Convention on Human Rights the inquest should in principle be the main forum for the investigation, in conjunction as appropriate with other investigative processes for which the State is responsible.

**Chapter 11: Some Special Cases: Deaths of Children, Hospital Deaths, Deaths in Care Homes, and Deaths Abroad**

57. In all coroner areas there should be standing protocols between the coroner and the various children's services and child protection agencies setting out how the children's agencies should be involved in death investigations and how the coroner and his staff should work with them. These should include the National Care Standards Commission and its successor bodies.
58. In each coroner area there should be at least one coroner's officer with some specialisation in handling children's deaths.
59. All autopsies on children should be done by a paediatric pathologist or a pathologist with specialist paediatric experience. In appropriate cases he should work jointly with a forensic pathologist.
60. These recommendations should in principle be adopted for Wales and Northern Ireland, with suitable adaptations for differences of structure.
61. Under existing arrangements, deaths in care homes should be verified as promptly as is practicable by the general practitioner or emergency service doctor. Under the new proposed contractual arrangements for primary health care, primary care trusts should arrange for suitably qualified and trained nurses independent of the home to attend to verify death.
62. Statutory Medical Assessors should identify, support and monitor care home death certification by first and second certifiers as a distinct sub-group of certification by doctors and practices.
63. The National Care Standards Commission followed by the Commission for Social Care and Inspection should be able to raise any anxieties about an individual death with the coroner.
64. The Commission should be given on a confidential basis any information from individual death investigations that would be relevant to its inspectorial and regulatory functions. The Commission should have reciprocal arrangements with the coroner and the Statutory Medical Assessor, and for its part should make available to them relevant material from its inspections and regulatory work.
65. Deaths by suicide should not be routinely be inquested in public. The outcome of an investigation, or an inquest, into such deaths should be narrative and analytical as for other deaths. They should be classified as "death from a deliberate act of self-harm or injury".

## Chapter 21 - Summary of Recommendations

66. There should be discretion, to be exercised on reasonable grounds, over whether to hold a public inquest when a UK resident dies abroad and the body is repatriated into England or Wales, and the circumstances of the death are unclear or otherwise needing explanation. The circumstances most likely to justify public inquests are (a) where there are issues about the precautions taken or the plans made by the domestic organisers of collective trips abroad, particularly for children and young people and (b) there are mass disasters abroad with significant loss of British lives.

## Chapter 12: The Response to Families

67. It should be an obligation on the coroner's office to make contact as quickly as possible with the nearest relative of the person who has died and inform them of the location of the body, the arrangements for viewing it, any autopsy or other investigation proposed, the likely timescale and details of the investigation and the probable release timing of the body.
68. All coroner areas should regularly audit their inquest and investigation timings, with an analysis of the reasons for the cases in the longer interval categories. The results of these audits should be published.
69. All coroner areas should make arrangements to provide families with practical support to guide them through the inquest process, either by using their own staffs or through voluntary bodies.
70. The Coronial Council should issue a Family Charter which all coroner areas would be obliged to follow to the maximum extent practicable. It should cover the provision of essential and timely information to families, their rights of access to key people and material, the processes for obtaining bereavement help, the likely timing of developments in their case, and the arrangements for giving some practical help at the inquest where this is necessary.
71. The inquest should so far as possible be conducted in a style that is accessible to unrepresented lay people, and the current criteria for awarding legal aid at inquests are broadly satisfactory. However, there should be a more liberal interpretation of the criteria in cases where a public authority is represented.
72. The arrangements for legal aid in Northern Ireland should be such as to have the same effect as our recommendations for England and Wales.

### **Chapter 13: Scientific and Pathology Investigations for the Coroner**

73. The Coronial Council should issue statutory guidance on autopsy arrangements so as to achieve consistent standards and practices in England and Wales.
74. In each coroner area there should be an open process of application and appointment for coroners' pathology work. Appointments should be to a panel and the selection of applicants for entry to the panel should be made by a small appointment committee chaired by the coroner or the Statutory Medical Assessor. Pathologists should have formal service contracts with coroners.
75. The statutory requirements governing the conduct of autopsies should require all coroners' autopsies to be done by or under the supervision of fully trained and accredited pathologists.
76. Work done by consultant pathologists for coroners should be covered in the general appraisal of their work.
77. The Commission for Health Audit and Inspection should periodically undertake thematic inspections of pathology done for coroners.
78. Tissues or organs should never be retained for any purpose not directly stemming from the justification for a coroner' autopsy, and in particular for teaching or research purposes, without the full and informed prior consent of the family.
79. Families should be informed in advance of the autopsy of any tissue or organ retention which may be predictable. Where tissues or organs are retained for any essential diagnostic or medico-legal purpose there should be one or more specific reasons for the retention in each case and the reason should be recorded in the post-mortem report as should the quantity and type of material retained. Whether or not the family choose to see the autopsy report they should be informed of the retention and its likely duration, so that they can decide whether or not to delay the funeral until the material has been restored.
80. The arrangements for seeking and obtaining family consent in cases where it is required and the machinery for supervising and enforcing the consent arrangements should be the same as, or as close as possible to, those which emerge from the work of the Retained Organs Commission and the work being done by the Health Departments in preparation for new Human Tissue legislation.

## Chapter 21 - Summary of Recommendations

81. The Coronial Council's statutory Charter for Families should cover the family's normal rights to information about the autopsy or any other investigation intended, covering their rights to review of a decision to have, or not to have, an autopsy, their rights to information on timing and representation at the autopsy, issues of organ and tissue retention including their rights to give or withhold consent to the retention of any organs or tissues for research or teaching purposes and to be told of retention for diagnostic or medico-legal purposes, their right to see the autopsy report if they wish to do so, or to have it sent to the general practitioner, and to be told of any autopsy findings relevant to the health of family members.
82. Where appropriate autopsy and medical investigation reports should be sent to the hospital consultant or general practitioner responsible for treating the patient at the time of the death unless there are legal grounds for withholding them, or the family requests otherwise.
83. Statutory Medical Assessors should periodically review all autopsy and investigation reports in their area and send to healthcare, public health and other interested agencies in their areas information on trends and findings that would be of interest to them.
84. Any medical investigation ordered by the coroner or Statutory Medical Assessor, whether autopsy or other test, should be to clarify a defined uncertainty or range of uncertainties about the death and should be at the lowest level of invasiveness likely to resolve the uncertainty. Referrals for autopsy or other technical investigations should never be routine or automatic. This may apply equally after traumatic deaths though when forensic autopsies are required for criminal investigations they should be carried out.
85. Where possible before any significant technical investigation is ordered, the medical records should have been scrutinised, the doctors and others who had attended the patient should be contacted as well as the family.
86. In cases where the family object to an autopsy it should not be proceeded with unless there is positive indication of the need to investigate a possible crime or lack of medical or other care, or a public health risk that requires the cause of the individual death to be established, in order to prevent similar fatalities.
87. The Coronial Council should set in hand research and survey work to establish a proper evidence base from which good practice and sound policy in the selection of cases for medical investigations can be derived. That evidence base should include, in due course, the outcome of the project already initiated by the Department of Health into less invasive forms of investigation.

## **Chapter 14: Responsibilities in Government**

88. Policy responsibility for death certification in England and Wales should transfer from the Home Office to the Department of Health and, for Wales, to the Assembly's Ministry for Health and Social Services.
89. When the new national coroner jurisdiction for England and Wales is introduced, the general responsibility for supporting and financing the service within central government should transfer to the Lord Chancellor's Department, and all responsibilities for the appointment and discipline of coroners should be brought together in that Department.
90. There should be a statutory Coronial Council with powers to monitor the general performance of the new structures in death certification and investigation, and to give statutory guidance on issues of policy and process. The Council should be appointed by the Lord Chancellor after consultation with other Ministers. Its membership would include members chosen by Ministers for their insight into the experiences of bereaved families, as well as the head of the new coronial jurisdiction, the Chief Medical Officers and the Registrar General.
91. If those responsible in Northern Ireland for death certification and the coroner service wish to participate in the Council's work the membership should be extended. Otherwise there should be a comparable body for Northern Ireland.
92. There should be a small Coroner Service Inspectorate to monitor standards of interaction with families and the standards of the service's physical environment. The Inspectorate should make its reports to the coroners of each area and to the head of the jurisdiction. They should be published. The inspectorate would also examine complaints from members of the public not resolved locally.
93. The new coroner service and each coroner area should have a high and proactive public profile. It should aim to inform the general public about its role and purposes and make use of accepted means of contact and communication such as websites.

## **Chapter 15: Structures for Delivering the Services**

94. The coroner services should be remodelled into national coroner jurisdictions covering England and Wales, and Northern Ireland, respectively.

## *Chapter 21 - Summary of Recommendations*

95. The responsibility for appointing and supporting coroners in England and Wales should pass from local authorities to the Lord Chancellor who broadly speaking should exercise the same responsibility for the judicial aspects of coroners' work as he has for the mainstream judiciary.
96. Each of the new coronial jurisdictions should be headed by a member of the permanent judiciary, and should include arrangements for enabling exceptionally complex inquests to be heard at higher judicial levels.
97. Each jurisdiction should have appeal arrangements, suitable to the jurisdiction, enabling appeals against coroners' decisions to be made without recourse to judicial review.
98. In England and Wales responsibility for provision, management and financing of coroners' officers should be transferred from the police service and local authorities (in those places where the local authority have assumed the responsibility) to the Court or Tribunal Service, depending on which is chosen as the new base for the coroner service.
99. In Northern Ireland a coroners' officer service should be created independent of the police and responsibility for its development and management should be vested in the Northern Ireland Court Service.
100. Consideration should be given to appointing some coroners' officers in each of the new areas as statutory registrars of deaths.
101. Each national coroner jurisdiction should be led by a full-time Chief Coroner, perhaps at Circuit Judge level in England and Wales.
102. Each area coroner should be full-time. The area coroners should be supplemented by part-time coroners as case-loads and local circumstances require.
103. In England and Wales the present coroner districts should be reduced from the present 136 to a structure broadly and flexibly aligned with Police Authorities (in London with the 6 MPS areas). The needs of rural areas and others with large geographical boundaries should be taken into account in settling the details of the new structure.
104. The Chief Coroner should designate some area coroners as regional co-ordinating coroners.
105. Review and appeals processes should be introduced in England and Wales - of administrative decisions by the Statutory Medical Assessor, review by the coroner; of decisions by the coroner, review by the Regional Co-ordinating Coroner; of such decisions by the Regional Co-ordinating Coroner, review by the Chief or Presiding Coroner or such other coroner



as he may designate for the purpose. Appeals against judicial decisions by the coroner would go to the Chief Coroner, or a High Court Judge authorised to hold inquests.

106. In Northern Ireland the judicial authorities should give effect to broadly similar review and appeals processes through the means most suitable in their jurisdiction.
107. In order to maintain their role in the world of healthcare and public health practice and development Statutory Medical Assessors should be employed by or in contract with either NHS Strategic Health Authorities, or, through the Regional Director of Public Health, with Government Offices in the Regions. They should be seconded to the Coroner's Office.

## Chapter 16: Appointments and Training

108. In England and Wales as already in Northern Ireland the Lord Chancellor should appoint coroners and deputy coroners after considering the recommendations of an appointment committee. Vacancies should be publicly advertised. The appointment committees should include a member nominated by local government in the area of appointment. The appointment criteria should include suitability to work with bereaved families.
109. Coroners should have tenure until 65, though there should be provision for review at five yearly intervals, and opportunities for moving to other judicial work should be explored in suitable cases.
110. Deputy coroners should have renewable five-year appointments. Financial terms for coroners and deputy coroners should be settled following review by the Senior Salaries' Review Body.
110. Existing medically qualified coroners (and deputy and assistant deputy coroners) within the present structure should be able to apply for coroner and deputy coroner posts in the new structure, alongside those with legal qualifications and experience.
112. The development of nationally agreed job descriptions and structured training models for coroners' officers should be a priority task in the preparation of coroner service reform.
113. All coroners, Statutory Medical Assessors, and coroners' officers should have mandatory training on first appointment, and should be expected and enabled to pursue approved continuing professional education and development annually thereafter. Such training should also be available to pathologists working with coroners.

## Chapter 21 - Summary of Recommendations

114. The Coronial Council should be responsible for determining the new service's training strategies, but there will be continuing important roles for the Judicial Studies Boards in both jurisdictions, and there may be a role in relation to coroners' officer training for the Community Justice National Training Organisation.
115. Human rights, bereavement and diversity issues should be core training components.

## Chapter 17: Northern Ireland

116. In Northern Ireland the criteria for holding public inquests should be the same as we recommend for England and Wales. Public inquests would become mandatory for certain kinds of death including those apparently at the hands of law and order services.
117. In all cases of apparent homicide the England and Wales practice of opening and then adjourning inquests pending police investigations and any criminal trial and then resuming the coroner's investigations if it would serve a purpose should be systematically implemented in Northern Ireland.
118. The new arrangements for the scope, handling and outcomes of inquests, including inquests in cases engaging Article 2, outlined in Chapters 7-10 of this report should apply also to Northern Ireland.
119. The Northern Ireland Court Service should publish each year a summary of the number of outstanding reported cases in Northern Ireland, with an analysis of the reasons for delay and a statement of the measures they intend to take to deal with any continuing backlog and to ensure that bereaved families receive prompter service in future.
120. The State Pathologist's Department should publish annually figures for the number of autopsies it does for coroners, the average time taken between the completion of the autopsy and the delivery of the report to the coroner, and the range of times for delivering reports.
121. Coroners' officers should be created in Northern Ireland along the same lines as in England and Wales. They should be independent of the police and employed by the Court Service. They should support the Statutory Medical Assessor as well as the judicial coroner, and their professional backgrounds and training should be developed as we recommend for England and Wales.

122. When suitable legislative opportunity occurs the legality of investigative support to coroners by the Northern Ireland Police Ombudsman should be put beyond doubt.

### **Chapter 18: The Coroners' Inquest and Treasure**

123. The provisions in section 30 of the Coroners Act 1988 which give the coroner jurisdiction in respect of treasure should be repealed.



# **ANNEXES**



# ANNEXES

- Annex A: Reference Group Members
- Annex B: Lists of People seen by the Review and of people who sent written responses to the Consultation Paper
- Annex C: Summary of Review Activity
- Annex D: Previous Inquiries
- Annex E: Death Investigation in Some Other Countries

**Members of the Reference Group for England and Wales**

Mr Tom Beldon

Mr Tony and Mrs Yvonne Brown

John O'Hare – Chairman  
Pity II Bereaved  
Parents Support Group  
Executive Committee

David Frei  
London Beth Din  
and Office of the Chief Rabbi

Eileen Dallaglio  
Marchioness Contact Group

Eleanor Platt QC  
The Board of Deputies of British Jews

Margaret Lockwood-Croft  
Marchioness Action Group  
& Victims Voice

Barbara Davis  
Marchioness Contact Group

Rose Dixon  
SAMM (National)

Graeme Skidmore  
Funeral Standards Council

Joyce Epstein  
The Foundation for the Study  
Of Infant Deaths

Pauline Fielding  
RoadPeace North West

Pip Finucane  
Victims Voice Trustee  
& Member of RoadPeace

John Flanagan  
Training & Information Officer  
Merseyside Asbestos Victims Support

Billy Gorman  
Marchioness Contact Group

Lorraine Gwinnutt  
Association of Personal Injury Lawyers

Christabel Hilliard  
Welfare Advisor  
CRUSE Bereavement Care

Graeme Peart  
The Compassionate Friends

John Mellor  
Councillor  
Wolverhampton City Council

Ibrahim Ahmed Jasat  
Muslim Council of Britain / Muslim  
Burial Council of Leicestershire



Erin Pizzey

Dr Gordon Pledger  
Medical Referee

John Sandwell - Chairman  
SAMM (Liverpool)

Helen Shaw & Deborah Coles  
INQUEST

Zoe Stowe – Chair  
RoadPeace

Michael Summers – Trustee  
The Patients Association

Mary Teesdale  
National Schizophrenia Fellowship

Lucy Thorpe – Policy Advisor  
NSPCC

The Cremation Society of Great  
Britain

Michaela Willis  
NACOR

Lynne Lovelock  
SAMM (South Wales)

Mr Phil Hammond  
Hillsborough Families Support  
Group

Vanessa Eden-Evans  
The Samaritans (General Office)

## Members of the Reference Group for Northern Ireland

Paul O'Connor  
The Pat Finucane Centre

Michael Gallagher  
The Omagh Support and Self Help  
Group

Sandra Peake – Director  
The WAVE Trauma Centre

Paul Mageean  
Committee on the Administration of  
Justice

Dr David Stevens – General Secretary  
Irish Council of Churches

Ian Elliot  
NSPCC

William Frazer  
Outreach and Development Worker  
Families Acting for Innocent Relatives  
(FAIR)

Vanessa Eden-Evans  
The Samaritans

Alan Wardle  
Shankhill Stress Centre

**ANNEX B****List of People the Review have seen in England and Wales**

Acland, Dr	Home Office Pathologist
Adey, Giles	Kent County Council
Adler, Solomon	Jewish Community Worker, Manchester
Akhtar, Salim	Confederation of Sunni Mosques, Midlands
Aldridge, Pauline	North Wales
Allan, Mr & Mrs	Bristol
Allen, Patrick	Association of Personal Injury Lawyers
Anderson, Shirley	Registrar (Cornwall)
Anns, Sarah	Campaign Against Drink Driving
Anthony, Lionel	National Care Standards Commission (Nottinghamshire Area Office)
Appleby, Professor Louis	National Director for Mental Health
Arber, Roger N.	The Cremation Society of Great Britain
Arlett, Dr. Peter	Medicines Control Agency
Ashworth, Peter	H.M. Coroner for Derby & South Derbyshire District
Aspinall, Peter	Neville Funeral Service
Atkinson, RD	H.M. Coroner for West Lincolnshire District
Attia, Mrs	Surrey
Aubrey QC, David	(Treasurer) Wales and Chester Circuit
Austin, Trevor	National Council for Metal Detecting
Bacon, Dr Chris	Royal College of Paediatrics and Child Health
Baker, Detective Chief Superintendent	West Midlands Police
Baker, Judy	Victim Support
Balen, Paul	Personal Injury Solicitor
Barber, Paul	Bevan Ashford Solicitors
Barker, Julie	Victim Support
Barrett, Frank	R. Pepperdine & Sons
Baxter, Dr Chris	The North London Hospice
Bearcroft, Dr Phillip	Addenbrooke's Hospital, Cambridge
Bedford, Peter	H.M. Coroner for Bracknell Forest, Slough, Windsor, Maidenhead & Wokingham
Beesley-Murray, Caroline	H.M. Coroner for Essex, Southend & Thurrock
Beldam, Rt. Hon. Sir Roy	Retired Lord Justice of Appeal
Beldon, Tom	Hertfordshire
Belson, Ginny	Department of Health
Benbow, Dr E W	Department of Histology, Manchester Royal Infirmary
Bendle, Ann	Kent County Council
Bergman, David	Centre for Corporate Accountability
Berkowitz, Robert	London Union of Hebrew Orthodox Congregation
Bernstein, Judith	Lord Chancellor's Department
Berry, Professor Geri	Royal College of Pathologists

## Annex B

Best, Dr David	Researcher, Police Complaints Authority (PCA)
Betts, Paul	NHS Litigation Authority
Bhatt, Raju	Bhatt Murphy Solicitors
Biddell, Ivan	St Albans
Bishop, Sandy	Road Safety Division, Department for Transport
Blackshaw, Tony	Bedford Hospital
Blake QC, Nick	Matrix Chambers
Bland, Dr Roger	Treasure and Portable Antiquities Scheme, British Museum
Bloxom, Bill	West Midlands Police
Bodenham, Dr	Transplant Partnership (BMA)
Bond, James	Royal British Legion
Bonner, Alan	Chester
Bowen, David	H.M. Coroner for Gwent
Bowler, David	Gillingham Local Medical Committee
Bowler, Dr Colene	Paediatric Pathologist, John Radcliffe Hospital, Oxford
Brazier, Margaret	Chair, Retained Organs Commission
Brearley, Sally	Railway Safety
Brown, Anna	PAPYRUS (Prevention of Young Suicide)
Brown, The Rt. Hon. Sir Simon	Lord Justice of Appeal
Brown, Tony and Yvonne	Flackwell Heath
Bundy, Ruth	Harrison Bundy & Co
Burgess, Michael	H.M. Coroner for Surrey and the Royal Household, Secretary, The Coroners Society
Burke, Geraldine	St Luke's Hospice
Burke, Margaret	National Confidential Enquiry into Perioperative Deaths (NCEPOD) Steering Group and Royal College of Pathologists representative
Burnett, Dr Rodney	Royal Institute of Public Health
Burrows, John	Norwich
Burton, Mrs	South Wales
Bye, Joan and Derek	Dorset
Byone, Ian	Police Complaints Authority (PCA)
Cadden, Mr and Mrs	Chester
Calvert-Smith QC, Sir David	Director of Public Prosecutions for England and Wales
Campbell, Dr Fiona	Royal Liverpool Hospital
Carey, Dr Nat	Home Office Pathologist
Carlyon, Dr Emma	H.M. Coroner for East Cornwall District
Carlyon, Edward	Former H.M. Coroner for West Cornwall District
Carney, Terence	H.M. Coroner for Gateshead and South Tyneside District
Cartlidge, Dr P H	Royal College of Paediatrics and Child Health
Carver, Gary	Gillingham Local Medical Committee
Catling, Steve	Retained Organs Commission
CEART Families	

Chadwick, Rachel	National Care Standards Authority (Nottinghamshire Area Office)
Chapman, Dr Nigel	H.M. Coroner for Nottinghamshire and Nottingham City
Charteris, Steven	Coroners Unit and Support Services (Hertfordshire)
Chatham, Mrs	RoadPeace
Chaudhary, Brigitte	RoadPeace
Chen, Dr Klaus	Home Office Pathologist
Chivers, Kit	Magistrates Court Service Inspectorate
Christian, Louise	Christian Fisher Khan Solicitors
Christie, Dr John	Pathologist
Christy, Andrew & Sheila	Dorset
Clarke, Mr	Cyclist Touring Club
Clayson, Dr Helen	St Mary of Furness Hospice
Clayton, Sylvia	Stockport
Cleary, John	Survivors of Bereavement by Suicide (SOBS)
Clement-Evans, Cenric	Association of Personal Injury Lawyers
Clifford, Robert	Home Office
Cloke, David	British Medical Association (BMA)
Cobb, Rebecca	H.M. Coroner for North East Kent
Cobley, Trevor	Home Office
Cockburn, Jocelyn	Christian Fisher Khan Solicitors
Coles, Deborah	INQUEST
Colin, Carr	Addenbrooke's Hospital, Cambridge
Colin, Dale	Care Home Specialist Group, Royal College of Nursing
Collins, Professor Peter	Addenbrooke's Hospital, Cambridge
Connerty, Angela	Support After Murder and Manslaughter (SAMM)
Connon, William	Department of Health
Cooksley QC, Nigel	Old Square Chambers
Cooper, Dr Nigel	Home Office Pathologist
"Coopey, John	Coroner's Officers' Association
Copeman, Dennis	Retained Organs Commission
Corner, Rodney	H.M. Coroner for Milton Keynes
Cottam, Bernie	Royal College of Nursing
Cotter, Aidan	H.M. Coroner for Birmingham District
Coverdale, William	H.M. Coroner for the County of York
Cox, Alison	Cardiac Risk in the Young (CRY)
Cox, Dr Phillip	Birmingham Women's Hospital
Craze, Alan	H.M. Coroner for East Sussex
Creer, Graeme	Legal Services, Barnet Borough Council
Creighton, Susan	NSPCC
Crowe, Belinda	Lord Chancellor's Department
Crowther, Dr	Public Health Office (Oxford)
Cuneen, Mary	Liberty
Dafis, Rhys	Welsh Language Board
Dale, Linda	Sheffield Medico-Legal Centre

## Annex B

Dallaglio, Eileen	Marchioness Contact Group
Davies, Krista	Guildford
Davies, Robert	Impairment and Sanctions Branch, Department for Transport
Davis, Barbara	Marchioness Contact Group
Davis, Detective Chief Superintendent	Nottinghamshire Police
Day, Keith	Addenbrooke's Hospital, Cambridge
Dean, Nick	Department of Health
Dean, Peter	H.M. Coroner Ipswich District
Dearden, Andrew	General Practitioners Committee (South Wales)
Deri-Bowen, Ann	Royal College of Paediatrics and Child Health
Desai, Sehra	Tuckers Solicitors
Dixon, Rose	Support After Murder and Manslaughter (SAMM)
Dolman, Dr William	H.M. Coroner for Northern London District
Donaldson, Sir Liam	Chief Medical Officer, Department of Health
Donnelly, Malcolm	H.M. Coroner for Hartlepool
Dorries, Chris	H.M. Coroner for South Yorkshire (Western District)
Downey, Judy	Relatives and Residents Association
Doyle, Dr Peter	Department of Health
Dring, Sarah	Consular Division, Foreign and Commonwealth Office
Drury, Peter	Department of Health
Drysdale, Ian	Kent County Constabulary
Dunn, Peter	Victim Support
Dunne, Adrian	Coroners' Officer (Cornwall)
Earl, David	Coroner's Officer (Birmingham)
Ebsworth, Professor	Council for the Registration of Forensic Practitioners
Eden-Evans, Vanessa	The Samaritans
Edey, Roy	Folkestone
Edgar, Elaine	Department of Health
Edmonds, Rebecca	Lion Court Chambers
Ellicot, Mrs	Wrexham
Enser, Briony	Department of Health
Epstein, Joyce	Foundation for the Study of Infant Deaths (FSID)
Esiri, Professor M	Radcliffe Infirmary, Oxford
Evans, Dr Chris	Royal College of Physicians
Evans, Dr Philip R	Royal College of General Practitioners
Everson, Jane	Campaign Against Drink Driving
Eyre, Dr Anne	Trauma Training
Facer, Duncan	Cumbria Bureau of Investigation
Fahy, Peter	Association of Chief Police Officers (ACPO)
Fairley, Mr and Mrs	York
Families from the Tameside Support Group	Relatives of Victims, or Alleged Victims, of Family Shipman
Farnan, Turlough	H.M. Deputy Coroner for Derby & South Derbyshire District

Feamey, George	British Medical Association (BMA)
Feehan, Deirdre	Department of Health
Fell, Geoffrey	Acting H.M. Coroner for North Yorkshire (West District)
Ferguson, Ann Louise	Welsh Health, Legal Advisor
Fielding, Pauline	RoadPeace
Finucane, Pip	Victims Voice and RoadPeace
Flanagan, John	Merseyside Asbestos Victim Support Group
Fleming, Professor	Royal College of Paediatrics and Child Health
Forest, Detective Chief Inspector	West Midlands Police
Forest, Paul	H.M. Coroner of Bath & NE Somerset, Bristol City, North Somerset, & South Gloucestershire
Foster, Keith	Department of Health
Foster, Simon	MIND (The Mental Health Charity)
Fountain, Colin	The Benefits Agency
Fox, Dr John	General Registry Office
Franklin, Peter	Association of Police Surgeons
Fraser, Douglas	H.M. Deputy Coroner for Liverpool District
Free, Chief Inspector Mick	Emergency Procedures Committee (Metropolitan Police)
Frei, David	London Beth Din
Friedman, Danny	Matrix Chambers
Fry, Marcia	Department of Health
Gallon, Charles	H.M. Coroner for South Northumberland and North Tyneside
Gardiner, Nicholas	H.M. Coroner for Oxfordshire
Ghosh, Helen	Cabinet Office
Gibbons, David	H.M. Coroner for Gloucester District
Gibbons, John	Judicial Studies Board
Ginger, Margaret	Suicide Support Group, CRUSE
Goddard, Eileen	Office for National Statistics
Goldblatt, Peter	Office for National Statistics
Goldup, Ian	H.M. Deputy Coroner for North East Kent
Gonda, Dr Peter	Southampton General Hospital
Goodwing, Jenny	Birmingham Coroner's Office
Gorman, Billy	Marchioness Contact Group
Gorodkin, Leonard	H.M. Coroner for Manchester
Goss, Roger	Patient Concern
Gould, Dr Steve	Royal College of Paediatrics and Child Health
Gray, Dr Anthony	National Confidential Enquiry into Perioperative Deaths (NCEPOD)
Greenwood, Jill	Consular Division, Foreign and Commonwealth Office
Gregory, Mick	East Midlands Ambulance Service
Grenter, Andy	Road Policing, Bramshill Police College
Grey, Eleanor	Bar Law Reform Group
Griffiths, Dr Sian	Royal College of Physicians
Griffiths, Jane	Transplant Partnership (BMA)

## Annex B

Gwinnutt, Lorraine	Association of Personal Injury Lawyers
Gwynne, Michael	H.M. Coroner for The Wrekin
Hale, Peter	Coroner's Officer (Birmingham)
Hall, Avril	National Association of Funeral Directors (Cornwall)
Halpern, David	H.M. Coroner for Herefordshire
Halstead, Gary	Coroner's Officer (Teesside)
Hamblin, Richard	Commission for Health Improvement (CHI)
Hamilton, Dr Patricia	Royal College of Paediatrics and Child Health
Hamilton-Deeley, Veronica	H.M. Coroner for Brighton & Hove
Hammond, Phil	Hillsborough Family Support Group
Hannah, Jane	Epilepsy Bereaved
Hargraves, Christobel	National Confidential Enquiry into Perioperative Deaths (NCEPOD)
Harper-Reekie, Kamila	Middlesex
Harrison, Ruth	Traumatic Loss Consultant and Advisor, University of Exeter
Harvey, Mark	Association of Personal Injury Lawyers
Hasleton, Professor Philip	Retained Organs Commission
Hatch, Roger	H.M. Coroner for North West Kent District
Hawkyard, Tom	Coroners Unit (Hertfordshire)
Haywood, Mr and Mrs	Stockport
Healey, Mr	Cyclist Touring Club
Helliwell, Dr Tim	Royal Liverpool Hospital
Helsby, Andrew	Proprietary Crematorium Association
Hendry, Patricia	Wolverhampton
Herald, Winston	London Union of Hebrew Orthodox Congregation
Herrington, Professor Simon	Royal Liverpool Hospital
Hetherington, Gordon	H.M. Deputy Coroner for Teesside and Hartlepool
Hill, Suzanne	Consular Division, Foreign and Commonwealth Office
Hilliard, Christabel	CRUSE
Hilliard, Vicky	Goodmans Solicitors
Hinchliff, David	H.M. Coroner for West Yorkshire (Eastern District)
Hobbs, Dr Chris	Consultant Community Paediatrician (Leeds)
Hoile, Ron	National Confidential Enquiry into Perioperative Deaths (NCEPOD)
Holcroft, Mrs Pauline	Herefordshire
Holden, Peter	British Medical Association (BMA)
Hopkins, Linda	Association of Welsh Community Councils
Horne, Amanda	Medical Research Council
Horstead, Sean	Mitre House Chambers
Horton, Steve	Maritime & Coastguard Agency
Howells, Michael	H.M. Coroner for Pembrokeshire District
Hughes, John	H.M. Coroner for North East Wales District
Hunt, Elizabeth	Addenbrooke's Hospital, Cambridge
Hurst, Chris	Coroner's Officers' Association
Hutchinson, Susan	Derby



Hutt, Jane	Minister for Health & Social Services, Welsh Assembly
Imperato, Michael INQUEST Families Forum	Association of Personal Injury Lawyers
Iqbal, Mr	Minority Community Leader (Birmingham)
Isaacs, Elaine	Manchester
James, Dr Ryk	Pathologist
James, Kate	Department of Health
Jasat, Ibrahim	Muslim Council of Britain / Muslim Burial Council of Leicestershire
Jawed, Mr	Confederation of Sunni Mosques, Midlands
Jeffries, Roy	Swindon
Jeffer, Jane	Association of Welsh Community Health Councils
Johnson, Christopher	H.M. Coroner for Wirral District
Johnson, Dr Jane	Consultant Histopathologist
Johnston, Michael	H.M. Coroner for Dorset (Western District)
Jones, Ann	Centre for Corporate Accountability
Jones, Doreen	Liverpool
Jones, Dr	General Practitioners Committee (North Wales)
Jones, Dr Hefin	Welsh Medical Committee
Jones, Gwyn	Railtrack (Manchester)
Jordan, Billy	National Council for Metal Detecting
Joynsen, Pat	Liverpool
Judd, Reverend Dr Peter	The Cremation Society of Great Britain
Keavney, Dr P	Nottingham Prison
Kemp, Linda	Bereavement Officer, Royal Cornwall Hospital
Kennedy, Damian	The Benefits Agency
Kennedy, Dr Angus	Consultant Neurologist
Khan, Mr	Afro Caribbean & Asian Forum
Khan, Sadiq	Christian Fisher Khan Solicitors
Kieve, Milly	Adverse Psychiatric Reactions Information Link (APRIL)
King, Derek	The Benefits Agency
Knapman, Dr Paul	H.M. Coroner for Inner West London District
Knight, Dr Michael	Association of Police Surgeons
Knott, William	RoadPeace
"Kokai, Dr George	Alder Hey Hospital, Liverpool
Kondratowicz, Dr George	Pathologist
Kopetzki, Wendy	Survivors of Bereavement by Suicide (SOBS)
Kramer, Susan	Hove
Lambert, Carole	The Cremation Society of Great Britain
Landy, Anette	Bereavement Counsellor, Arthur Rank House
Langdon, Mike	Merseyside Police
Langrich, Brian	Alder Hey Hospital, Liverpool
Large, Debbie	Teesside University
Laurie, Jessie	Adult Offenders and Rehabilitation Unit, The Home Office
Lawrence, Soraya	Eight Kings Bench Walk Chambers
Lawson, Alan	H.M. Coroner for Hertford District

## Annex B

Leadbeatter, Dr Stephen Lee, Kathleen Leech, Dr Philip Leeming, Jennifer	Wales Institute of Forensic Medicine Coventry Department of Health H.M. Coroner for Greater Manchester (West District)
Leishman, Dr Ralph Lennox, Anni Leppard, Peter Lester, John Lewis, Detective Chief Superintendent John Lewis, Jim Lewy, Mrs L H Lillyman, Professor J Limerick, Countess Sylvia Lindley, Dr Roger Lingwood, Detective Chief Inspector John Litherland, Andrew Lloyd, Ceinwen Lloyd, Deputy Chief Constable	Forensic Pathology Review The Benefits Agency Railtrack (Swindon) Coroner's Officer (Hertford) Dyfed Powys Police Coroner's Officer (Liverpool) London and R.A.I.D Royal College of Pathologists Foundation for the Study of Infant Deaths (FSID) Medway Maritime Hospital, Kent Northumbria Police Force Railtrack (London) General Registry Office Cambridgeshire Police
Lockwood-Croft, Margaret Lockyer, Mr C Frank Lovell, Peter Lovelock, Lynne Lowe, Kathleen Lucas, Professor S	Marchioness Action Group & Victims Voice Salisbury The Court Service Support After Murder and Manslaughter (SAMM) The Law Society National Confidential Enquiry into Perioperative Deaths (NCEPOD)
Lymn-Rose, Nigel Lynch, Selena Lyons QC, His Honour Judge Shaun	AW Lymn Limited H.M. Coroner for Inner South London District Council of H.M. Circuit Judges
MacDonald Davies, Isobel MacDonald, Diane Maddrell, Alan Mahony, Kieran Makin, Robin Mann, John Mansfield QC, Mike Magrs, Alf Marsden, Graham Maton-Howarth, Dr Bill Matthews, Paul McCann, Michael	General Registry Office South Wales H.M. Coroner for Cheltenham District Office for National Statistics E Rex Makin and Son Solicitors Department of Health Tooks Court Chambers Teesside University Coroner's Officer (South Yorkshire) Department of Health H.M. Deputy Coroner for City of London H.M. Coroner for Preston and South West Lancashire
McCartney, Dr McCourt, Marie McCrae, Margaret	Inspector of Mortuaries Support After Murder and Manslaughter (SAMM) West Yorkshire

McCreath, Ian	H.M. Coroner for North Northumberland District
McGale, Barry	Suicide Awareness Coordinator, Western Health Board
McGinty, Superintendent	West Midlands Police
McHale, Bernard	The Federation of British Cremation Authorities
McIntosh, Professor Neil	Royal College of Paediatrics and Child Health
McKay, Stephen	Railway Safety
McMahon, Kate	Road Safety Division, Department for Transport
McNeil, Chief Supt Ian	Association of Chief Police Officers, Homicide Group (ACPO)
Meach, Steven	Gillingham Local Medical Committee
Metcalfe, David	Coroner's Officer (Bedford)
Metters, Dr Jeremy	H.M. Inspector of Anatomy, Department of Health
Milewski, Dr Yvonne	Medical Examiner, The Bronx, N.Y.
Mistry, Daksha	Forensic Pathology Review
Mitchell, Reverend Robert	The College of Healthcare Chaplaincy
Mitford, David	H.M. Coroner for Newcastle-Upon-Tyne District
Moore, Jeremy	Police Liaison Officer, Road Safety Division, Department for Transport
Moore, Judith	RoadPeace
Moore, Wendy	Royal Institute of Public Health
Morgan, Dr Anthony	Nottingham NHS Trust Hospital
Morgan, Roger	Child Rights Director, National Care Standards Commission
Morris, Bob	Former Assistant Under Secretary, Home Office
Morris, David	H.M. Coroner for Bedfordshire, Luton, South & West Cambridgeshire District
Morris, Richard	Consular Division, Foreign and Commonwealth Office
Morris, William	H.M. Coroner for North & East Cambridgeshire District
Morton, Ian	H.M. Coroner for Cumbria (North Eastern District)
Mowatt, Allan	Hill Dickinson Solicitors
Mundy, Gilly	INQUEST
Munyard, Terry	2 Garden Court Chambers
Mussgrave, Jim	Association of Personal Injury Lawyers
Naseem, Dr	Chairman of the Birmingham Mosque
Nelson, Linda	Legal Services (NHS Trust), West Midlands
Newton, Rt. Hon. Lord	Chair, Council on Tribunals
Nicol, Colin	RoadPeace
Noah, Mrs	Cleveland
Norridge, Detective Sergeant Dermott	Thames Valley Police
Noyes, Phillip	NSPCC
O'Connor QC, Patrick	Doughty Street Chambers
Oakley, Michael	H.M. Coroner for North Yorkshire (Eastern District)
O'Brien, Joseph	Broad Chare Chambers
Ofer, Nogah	Hickman and Rose

## Annex B

O'Hare, John	Parents who have Interred Their Young Twice, (Pity II)
O'Herne, David	Crime Reduction Unit, Welsh Assembly
Olley, Grace	National Schizophrenia Fellowship
Omerjee, Mr	Jamia Mosque (Leicester)
Oppenheim, Andrew	Gateshead Jewish Community
Osborne, Susan	National Patient Safety Agency
Osborne, Tom	Osborne and Morris Solicitors
Owen QC, Tim	Matrix Chambers
Owen, Jane	Birmingham Women's Hospital
Owen, Wendy	Hill Dickinson Solicitors
Oyefeso, Dr	St. Georges Hospital, London
Page, Sylvia	Registrar (Bedford)
Painter, Elaine	Consultant, British Museum
Paisley, Heather	Department of Health
Palmer, Dr Roy	H.M. Coroner for Southern London District
Parker, David	Coroners' Officer (Cornwall)
Parker, Dr Alistair	Department of Health
Parkinson, Stephen	Attorney General's Office
Parry, Anne	PAPYRUS (Prevention of Young Suicide)
Parry, Elaine	Coroners' Officer (Cornwall)
Patel, Dr	Emergency Medical Services (Nottingham)
Patel, Dr	Gillingham Local Medical Committee
Pearce, Brian	Inter Faith Network
Pearce, Gemma	Department of Health
Peart, Graeme	Compassionate Friends
Peers, Mr and Mrs	North Wales
Penny, Russell	Metropolitan Police
Pepperell, Derrick	H.M. Coroner for the Isles of Scilly
Philips, Marie	Support After Murder and Manslaughter (SAMM)
Phillips, Dr Barbara	Alder Hey Hospital, Liverpool
Phippard, Sonia	Cabinet Office
Piera, Elisade	Amnesty
Pinter, Rabbi Avron	London Union of Hebrew Orthodox Congregation
Piper, Brian	John Radcliffe Hospital, Oxford
Pizzey, Erin	National Schizophrenia Fellowship
Plant, Mr	Registrar (West Midlands)
Platt QC, Eleanor	The Board of Deputies of British Jews
Pledger, Dr Gordon	Crematorium Referee
Pollard, John	H.M. Coroner for Manchester (South District)
Pollard, Mike	St. Georges Hospital, London
Pounder, Professor Derrick	University of Dundee
Price, Dr Jean	Royal College of Paediatrics and Child Health
Prickett, Thomas	H.M. Coroner for Cumbria (Southern District)
Pritchard, D	H.M. Coroner for North West Wales District
"Prtak, Mr	Mental Health Act Commission
Pygott, Elizabeth	H.M. Deputy Coroner for West London
Quadus, Abdul	Muslim Community Representative (Dudley)

Qureshi, Dr Jaffar	Muslim Council of Britain / Muslim Doctors and Dentists Association
Risdon, Professor R A	Great Ormond Street Hospital, London
Rangecroft, Laurence	British Association of Paediatric Surgeons
Ransford, John	Local Government Association
Ratcliffe, Dr Jan	Alder Hey Hospital, Liverpool
Rebello, Andre	H.M. Coroner for Liverpool
Redfern, Gordon	Liverpool Local Authority
Redman, Rachel	H.M. Coroner for Central and South East Kent
Reicher, Professor Harry	Agudath Israel World Organisation, New York
Reubinstein, Dan	Imran Khan and Partners
Reynolds, Christopher	Hertfordshire
Reynolds, Teressa	Victim Support
Rickard, Helen	Royal College of Pathology Lay Committee & NACOR
Rimmer, Dr David	Bedford Hospital
Roads, Dr Peter	Crematorium Referee
RoadPeace Lawyers Group	
Robertson, Bruce	Christian Conscience
Robertson, Lesley	Nursing Home Inspectors, National Care Standards Authority (Nottingham Area Office)
Robertson-Jones, Hedy	Victim Support
Robinson, Bill	Railway Safety
Robinson, Jan	Parents who have Interred Their Young Twice (Pity II)
Robinson, Wendy	Zito Trust
Robson, Michael	H.M. Deputy Coroner for Cumbria (North Eastern District)
Roche, Lin	Foundation for the Study of Infant Deaths (FSID)
Rooney, Dr Cleo	Office for National Statistics
Rosenberg, Joshua	The Daily Telegraph
Rosentiel, Joy	CRUSE (Cambridge)
Ross, David	Forensic Pathology Review
Rostock, Chris	Local Authority Representative (Cornwall)
Round, Vic	H.M. Coroner for Dudley District
Rowell, The Right Revd Dr Geoffrey	Bishop of Gibraltar
Rutherford, Dr	Consultant Forensic Pathologist
Rutty, Professor Guy and Lisa	University of Leicester
Ryall, Gordon	H.M. Coroner for Peterborough & Stamford District
Sale, Allan	NSPCC
Sampson, John	H.M. Deputy Coroner for South London
Samuels QC, His Honour Judge John	Council of H.M. Circuit Judges
Sandwell, John	Support After Murder and Manslaughter (SAMM)
Sarginson, David	H.M. Coroner for the West Midlands (Coventry District)

## Annex B

Saul, Geoffrey	H.M. Coroner for Hull and East Riding
Scheimberg, Dr Irene	Paediatric and Perinatal Pathologist
Schifano, Dr	St. Georges Hospital, London
Schlechte, Doreen	Patients' Forum
Scott, Dr Ken	Royal College of Pathologists
Scott, John	Department of Health
Scott, Mark	Bhatt Murphy Solicitors
Scott, Mr & Mrs	Solihull
Sedley, The Right Hon Sir Stephen	Lord Justice of Appeal
Selby, Dr Andrew	Alder Hey Hospital, Liverpool
Sharman, Dr	Stanley Medical Centre (Liverpool)
Sharpe, Brian	Medway Maritime Hospital, Kent
Sharpe, Mrs	Derby
Shaw, Christine	Help the Hospices
Shaw, Helen	INQUEST
Shaw, Martin	H.M. Coroner for Sunderland District
Sheath, John	Brachers Solicitors
Sheffield, Michael	H.M Coroner for the counties of Middlesbrough, Redcar, Cleveland and Stockton on Tees
Shellan, Tessa	Wales Public Law and Human Rights Association
Shelton, Melissa	'Our Children' Support Group
Shepherd, Dr R	St. Georges Hospital, London
Sherwood, Mr and Mrs	Hartlepool
Sherwood, Anthea	British Medical Association (BMA)
Silk, Lt Col Robbie	Army Boards of Inquiry Section
Simmons, Tom	Metropolitan Police
Simons, Barry	General Registry Office
Simpson, Detective Superintendent Debbie	Bedfordshire Police
Sinitsky, Sidney	London Union of Hebrew Orthodox Congregation
Skidmore, Graeme	Funeral Standards Commission
Skone, John	Crematorium Referee (Wales)
Slatter, Anna	Special Advisor on Health, Welsh Assembly
Smart, Captain Jeremy	Maritime & Coastguard Agency
Smart, Ken	Air Accident Investigation Branch
Smith, Annette	Ipswich
Smith, Brenda	John Radcliffe Hospital, Oxford
Smith, Ian	H.M. Coroner for Cumbria (Furness District)
Smith, Tracey	Coroners' Officer (Cambridge)
Speakstone, Julian	Gillingham Local Medical Committee
Spittles, Graham	Association of British Insurers
Stark, Margaret	Association of Police Surgeons
Starkey, Bernadette	London
Stearns, Dr Elizabeth	H.M. Coroner for Eastern London District
Steele, Gordon	Metropolitan Police
Stevenson, Nick	Addenbrooke's Hospital, Cambridge
Stewart, Terry	CEART (Irish Deaths in Custody Support Group)
Stiles, Jenny	Help the Aged

Stone, Roger	H.M. Coroner West Sussex
Stowe, Zoe	RoadPeace
Stutt, Colin	Legal Services Commission
Sullivan, Brenda	Victims Voice
Sullivan, Sandra	Victim's Voice
Summers, Michael	Patients Association
Sumner, Christopher	H.M. Coroner for Merseyside, Knowsley, St Helens and Sefton District
Surplice, Andy	Family Liaison Officer (Metropolitan Police)
Sweeney, Eve	Reading
Sykes, Roger	H.M. Coroner for Mid Kent & Medway District
Symington, James	H.M. Coroner for Leicester City & South Leicestershire District
Tait, Dr Nancy	Occupational & Environmental Diseases Association
Tait, Dr Theresa	Marie Curie Cancer Care
Talbot, Maureen	Coroner's Officer (Dudley)
Taylor, Ann	Blackburn
Taylor, Bob	Coroner's Officer (Worcester)
Taylor, David	Local Health Authority
Taylor, June	British Medical Association (BMA)
Taylor, Lincoln	Christian Conscience
Taylor, Stuart	Christian Conscience
Teasdale, Mary	National Schizophrenia Fellowship
Terry, John	West Sussex
The Bristol Families	
Thomas, Liz	Action for Victims of Medical Accidents (AVMA)
Thomas, Peter	Railway Safety Division, Department for Transport
Thompson, Alison	H.M. Coroner for Western London District
Thornton-Jones, Helen	University of Hull
Thorpe, Elaine	Birmingham Women's Hospital
Thorpe, Lucy	NSPCC
Tippell, Steve	Home Office
Tobutt, Clive	National Treatment Agency
Touche, Peter	London
Towel, Inspector Paul	Association of Chief Police Officers, Homicide Group (ACPO)
Turner, Hamish	H.M. Coroner for Torbay and South Devon District
Tweddle, Andrew	H.M. Coroner for Northern District of Durham
Tyler, Janette	General Registry Office
Underwood, Professor J	Royal College of Pathologists
Van Oppen, Richard	H.M. Coroner for Exeter & Greater Devon District
Venables, Penny	Birmingham Women's Hospital
Vernal, Kim	Bhatt Murphy Solicitors
Wadham, John	Liberty
Walden, David	Barrister
Walker, Timothy	Health and Safety Executive
Walsh, Richard	Association of British Insurers

## Annex B

Wallace, Gordon	Coroners' Officer (Cambridge)
Webb, Sandra	Royston
Welby-Everard, Colonel Hugh	Army Boards of Inquiry Section
Weller, Sam	Association of Burial Authorities
Wells, Brian	Lord Chancellor's Department
Welsh, Jo-Anne	Sussex Beacon Hospice
Wesseley, Professor Simon	Kings College, London
Whalley, Robert	National Council for Metal Detecting
Whent, Peter	HWZ Solicitors
White, Stephen	The Cremation Society of Great Britain
Whittal, Hugh	Department of Health
Whittington, Richard	H.M. Assistant Deputy Coroner for Oxfordshire
Whitwell, Professor Helen	Sheffield Medico-Legal Centre
Wickett, Margaret	Registrar (Oxfordshire)
Wilkie, Dr Patricia	Royal College of Pathology Lay Committee
Wilkinson, Rosie	Royal College of Nursing
Wilks, Michael	Transplant Partnership (BMA)
Williams, Professor Geraint	Pathologist
Willis, Michaela	National Committee relating to Organ Retention (NACOR)
Wilson, Austin	Former Assistant Under Secretary, Home Office
Wilson, Dr	Forensic Science Service
Wilson, Sarah	Nottingham Health Authority
Wing OBE, Heather	National Care Standards Commission
Winter, Jane	British Irish Rights Watch
Wood, Martin	Worcestershire County Council
Woodford, Dr Noel	Sheffield Medico-Legal Centre
Wright, Janet	Registrar (West Midlands)
Wright, Marion	Registrar (Liverpool)
Wyllie, Professor Andrew	Addenbrooke's Hospital, Cambridge
Wynne, Dr Jane	Consultant Community Paediatrician (Leeds)
Yeoman, Chris	Review of Forensic Science Services
Zilli, Livio	Amnesty



## List of People the Review have seen in Northern Ireland

Bailie, John	Law Society of Northern Ireland
Bain, Douglas	Northern Ireland Prison Service
Bloomfield, Sir Kenneth	Former Head of the Northern Ireland Civil Service
Broderick, Nigel	Human Rights Committee, Northern Ireland Law Society
Broderick, Siobhan	Northern Ireland Court Service
Campbell, Dr Etta	Chief Medical Officer, Department of Health (Northern Ireland)
Campbell, Stanley	Registrar
Carswell, Rt. Hon. Sir Robert	Lord Chief Justice (Northern Ireland)
Clotworthy, Alan	State Pathology Administration Office
Coates, Eddie	Funeral Director
Colhoun, Angela	Former Coroner
Craig, Alan	Northern Ireland Prison Service
Crane, Professor Jack	State Pathology Department (Northern Ireland)
Crookes, Mr S	Belfast
Darragh, Dr Paul	Department of Health (Northern Ireland)
Dickson, Professor Brice	Human Rights Commission (Northern Ireland)
Dixon, Jim	Families Acting for Innocent Relatives (FAIR)
Dougal, Hugh	Funeral Director
Duffy, Gerard	Former Deputy Coroner
Elliot, Ian	NSPCC (Northern Ireland)
Feeney, Brian	Political Columnist, Irish News
Ferris, Ken	Funeral Director
Frazer, William	Families Acting for Innocent Relatives (FAIR)
Gallagher, Michael	Omagh Support & Self Help Group
Garland, Brendan	Northern Ireland Bar Council
Gilchase, Annette	Registrar
Gowdy, Clive	Department of Health (Northern Ireland)
Greer, Professor Desmond	Queens University, Belfast
Hadden, Professor Tom	Human Rights Commission (Northern Ireland)
Hanna, Sharon	Victim Support (Northern Ireland)
Healey, Margaret	Funeral Director
Hunter, David	H.M. Coroner for North Antrim
Ingram, Brian	State Pathology Administration, Northern Ireland Office
James Summers & Sons	Funeral Director
Keatley, George	Northern Ireland Court Service
Kerr, The Hon. Mr. Justice Brian	High Court Judge (Northern Ireland)
Kincade, James	Northern Ireland Coroners Society (Chair)
King, George	General Registry Office (Northern Ireland)
Lavery, David	Northern Ireland Court Service
Leake, Rev Charlie	Church of Ireland
Leckey, John	H.M. Coroner for Greater Belfast

Annex B

Livingston, Professor Stephen	Committee on the Administration of Justice (CAJ)
Mageean, Paul	Committee on the Administration of Justice (CAJ)
Malcolm, Deborah	H.M. Deputy Coroner for Greater Belfast
Matthews, Derek	Community Relations Council
McAlpine, Lorraine	Northern Ireland Court Service
McBratney, Barry	Funeral Director
Mitchell, Wesley	Families Acting for Innocent Relatives (FAIR)
Napier, Sir Oliver	Human Rights Committee (sub committee), Northern Ireland Law Society
O'Brien, Martin	Committee on the Administration of Justice (CAJ)
O'Brien, Peter	Northern Ireland Law Society
O'Connor, Maggie	Human Rights Commission (Northern Ireland)
O'Connor, Paul	Pat Finucane Centre
O'Curry, Shane	Pat Finucane Centre
O'Doherty, Ronnie	H.M. Coroner for Derry
O'Farrell, John	Former Editor of Fortnight Magazine
O'Loan, Nuala	Police Ombudsman for Northern Ireland
O'Reilly, Claire	Relatives for Justice
Parkinson, Maurice	Belfast City Council
Peake, Sandra	Widows Against Violence (WAVE)
Reed, Colin	NSPCC (Northern Ireland)
Ritchie, Angela	Madden & Finucane Solicitors
Scott, Dr Maureen	The Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) (Northern Ireland)
Spence, Terry	Northern Ireland Police Federation
Stephens, Dr David	Irish Council for Churches
Strain, Eric	Northern Ireland Court Service
Thompson, Daniel	H.M. Coroner for South Down
Thompson, Mark	Relatives for Justice
Thornton, Chris	Political Columnist, Belfast Telegraph
Wade, Hugh	Funeral Director
Webb, Stephen	Criminal Justice Implementation Team, Northern Ireland Office
Wilkinson, William	Families Acting for Innocent Relatives (FAIR)

**List of People the Review have seen in Scotland and the Republic of Ireland**

Bruce, Denise	High Court Unit, Crown Office, Edinburgh
Burns, Susan	Policy Group, Crown Office, Edinburgh
Cusack, Professor Denis	University College, Dublin
Farrell, Dr Brian	Coroner, Republic of Ireland
Galbraith, Amber	Policy Group, Crown Office, Edinburgh
Gilchrist, William	Deputy Crown Agent, Crown Office, Edinburgh
Haskins, John	Department of Justice & Equality and Law Reform, Republic of Ireland
Littlejohn, Jim	Fife Constabulary
Mellor, David	Fife Constabulary
Nicholson QC, C G B	Sheriff Principal, Edinburgh Sheriff Court
Normand, Andrew	Crown Agent, Crown Office, Edinburgh
Norris, Paul	Coroner, Republic of Ireland
Parr, Paul	General Registry Office, Edinburgh
Paton, Liz	Deaths Unit, Procurator Fiscal Service, Edinburgh
Service, John	Deaths Unit, Procurator Fiscal's Office, Glasgow
Sineron, Dr Paul	Forensic pathologist, Procurator Fiscal's Office, Edinburgh
Watt, Geri	Policy Group, Crown Office, Edinburgh

**List of People the Review have seen in Canada,  
Australia and New Zealand**

Abernethy, John	State Coroner, New South Wales
Always, Sergeant Geoff	Victoria Police, Australia
Anderson, Kelvin	Correctional Services Commissioner, Victoria, Australia
Berger, Dr Yossi	Coroners Occupational / Industrial Disease Committee, Victoria, Australia
Bibby, Neil	Country Fire Authority, Victoria, Australia
Brown, Stuart	Medical Referee, Auckland, New Zealand
Byrne, Phillip	Coroner for Victoria, Australia
Cairns, Dr James	Deputy Chief Coroner for Ontario, Canada
Chittenden, Gary	Police Officer, Auckland, New Zealand
Clark, Mike	Police Officer, Auckland, New Zealand
Cordner, Professor Stephen	Victorian Institute of Forensic Medicine, Victoria, Australia
Dennis, Senior Sergeant Huri	Police Maori Responsiveness Advisor, Auckland, New Zealand
Eden, Dr B	Toronto, Canada
Esplin, Bruce	Emergency Services Commissioner, Victoria, Australia
Ferris, Dr James	Pathologist, Auckland, New Zealand
Heffey, Jacinta	Coroner in Victoria, Australia
Hender, Frank	Coroner in Victoria, Australia
Hilton, Professor John	Department of Forensic Medicine, New South Wales, Australia
Howard, Eric	Road Safety, Vic Roads, Victoria, Australia
Ibrahim, Dr Joseph	Clinical Liaison Service, State Coroner's Office, Victoria, Australia
Jamieson, Murray	Coroner for Auckland, New Zealand
Johnstone, Graeme	State Coroner, Victoria, Australia
Kenafacke, Graham	WorkSafe Victoria, Australia
Kianidis, Jim	WorkSafe Victoria, Australia
Koelmeyer, Professor Tim	Pathologist, Auckland, New Zealand
Kohlmann, Senior Constable Wayne	State Coroner's Investigation Unit, Victoria Police, Australia
Leibel, Norm	Deputy Chief Coroner of British Columbia, Canada
Little, Michael	Work-Related Deaths Strategy and Programmes Division, WorkSafe, Victoria, Australia
Matthews, Peter	Coroner's Officer, New South Wales, Australia
Martin, Trevor	WorkSafe Victoria, Australia
McLellan, Dr B	Trauma Registry, Toronto, Canada
Merrick, John	State Coroner's Office, New South Wales, Australia
Nicholson, David	Metropolitan Fire and Emergency Services Board, Victoria, Australia
Noonan, Bill	Transport Workers Union, Victoria, Australia

O'Brien, Dr Adam	Clinical Liaison Service, State Coroner's Office, Victoria, Australia
Ozanne-Smith, Professor Joan	Injury Prevention, Accident Research Centre, Monash University, Victoria, Australia
Palegeo, Gina	Counsellor, Coroner Service, New South Wales, Australia
Pollard, Sergeant Ed	State Coroner's Investigation Unit, Victoria Police, Australia
Ranson, Professor David	Victorian Institute of Forensic Medicine, Victoria, Australia
Rivers, Bruce	Children's Aid Society, Toronto, Canada
Robinson, Peter	Victorian Transport Association, Australia
Russell, John	Mortuary Manager, Auckland, New Zealand
Smith, Commander Keith	Legal Services Division, Victoria Police, Australia
Starkman, Bernard	Federal Lawyer, Ottawa, Canada
Synek, Dr Beth	Neuropathologist, Auckland, New Zealand
Vuletic, Dr Jane	Pathologist, Auckland
West, Virginia	Deputy Minister, Toronto, Canada
West, Ian	Deputy State Coroner for Victoria, Australia
Wisdom, Philippa	Office of Correctional Services Commissioner, Victoria, Australia
Young, Dr James	Chief Coroner, Ontario, Canada

**List of People who submitted a Written Response  
to the Consultation Paper**

Adams, ES	The Executive Director, Judicial Studies Board
Albiston, CCK	Police Service of Northern Ireland
Aldred, Graham	Cheshire
Alford, Martin	Head of Registration and Coroners, Kent County Council
Allen, Margaret	Registry Office (Chippenham)
Allen, Richard	H.M. Coroner for Wolverhampton
Appleby, Professor Louis	National Director for Mental Health
Appleby, Michael	Thompsons Solicitors
Arber, Roger N.	The Cremation Society of Great Britain
Ashworth, Peter	H.M. Coroner for Derby & South Derbyshire District
Atkinson, Roger	H.M. Coroner for West Lincolnshire District
Austin, Trevor	Secretary, National Council for Metal Detecting
Baker, Dr Maureen	Royal College of General Practitioners
Balmain, Robin	H.M. Coroner for Sandwell District
Bangs, Martin	Managing Director - Government & Public Sector, Smith Bernal Wordwave
Beasley-Murray, Caroline	H.M. Coroner for The Counties of Essex, Southend & Thurrock, Essex No. 1 District (including Thurrock)
Beldon, Tom	Hertfordshire
Bell, Professor Jeanne E	Western General Hospital, Edinburgh
Belson, Ginny	Department of Health
Ben, John	Institute of Anatomical Sciences
Best, Dr David	Researcher, Police Complaints Authority (PCA)
Bingham, Dr Paul	Director of Public Health, NHS (Isle of Wight)
Bisset, Rob	Radiologist
Blair, Alison	London
Bolton, David	National Health Service
Bond, Julie	British Association of Forensic Science
Booth, Sallie	Irwin Mitchell Solicitors
Brace, A	Pontypridd & Rhondda National Health Service
Brooks-Johnson, Carole	Pannone & Partners, Solicitors
Brown, Anna	PAPYRUS (Prevention of Young Suicide)
Brown, Tony and Yvonne	Flackwell Heath
Browning, Roger	Surrey
Bryce, Sue	National Committee Relating to Organ Retention (NACOR)
Burgess, Michael	H.M. Coroner for Surrey and the Royal Household, Secretary, The Coroners Society
Burns, Georgina	Velindre NHS Trust (Wales)
Burton, Dr J D K	Crematorium Referee

Bush, Ruth	Christian Science
Butcher, David	West Sussex
Buxton, Teresa	
Bynoe, Ian	Police Complaints Authority (PCA)
Cadden, Aiden	Chester
Calascione, Jay	Bosham
Carlyon, Edward	Former H.M. Coroner for West Cornwall District
Carson, Dr Ian	Deputy Chief Medical Examiner
Carter, Dr Naomi	Home Office Pathologist
Chaber, Lois	London
Chappell, Margaret	Consultant Cellular Pathologist
Charteris, Steven	Head of Coroners Unit and Support Services, Hertfordshire
Chughtai, Haroona	SEAC (Spongiform Encephalopathy Advisory Committee)
Cochrane, Hugh	Consultant Histopathologist, Sunderland
Coles, Deborah	INQUEST
Connah, Ben	Legal Services Division, Lord Chancellor's Department
Connell, C.A.	Department of the Director of Public Prosecutions
Conroy, Joseph	County Durham
Copeman, Dennis	Retained Organs Commission
Corkery, John	Surrey
Coroner's Society of England and Wales	
Cox, Alison	Cardiac Risk in the Young (CRY)
Coyle, Peter	Health and Safety Manager, Electricity Association
Crean, Marie	Human Organs Enquiry Line
Crow, Bob	Secretary of the National Union of Rail, Maritime & Transport Workers
Dale, Linda	Sheffield Medico-Legal Centre
Dalton, AJP	Writer and researcher
Davies, C	Deputy Assistant Coroner for Manchester North
Derrick, Peter	Senior Mortuary Technician, Wrexham Maelor Hospital
Dickson, Professor Brice	Northern Ireland Human Rights Commission
Dixon, Rose	Survivors After Murder and Manslaughter (SAMM)
Dobbs, Julie	North West Lincolnshire Community Health Council
Donnellon, Linda	Sheffield
Dorries, Chris	H.M. Coroner for South Yorkshire (Western District)
Dowd, Carmen	The Legal Secretariat To The Law Officers, Attorney General's Chambers
Ennis, David	Royal College of Paediatrics and Child Health
Epstein, Joyce	Foundation for the Study of Infant Deaths (FSID)
Eyre, Dr Anne	Trauma Training
Fenton, Theo	Mayday University Hospital

## Annex B

Field-Smith, Mary	Volatile Substance Abuse Mortality Register, St George's Hospital, London
Forest, Paul	H.M. Coroner of Bath & NE Somerset, Bristol City, North Somerset, & South Gloucestershire
Foster, Simon	MIND (The Mental Health Charity)
Frei, David	London Beth Din
Gaspar, Kathryn	National Care Standards Commission
Goldblatt, Peter	Office for National Statistics
Gwinnutt, Lorraine	Association of Personal Injury Lawyers
Gwynne, Michael	H.M. Coroner for Telford & Wrekin
Haigh, Andrew	H.M. Coroner for Staffordshire
Halpern, M	Salford
Hamilton, Dr Patricia	Royal College of Paediatrics and Child Health
Hamilton-Deeley, V	H.M. Coroner for The Counties of Brighton & Hove
Hannah, Jane	Epilepsy Bereaved
Hargraves, Christobel	The National Confidential Enquiry into Perioperative Deaths (NCEPOD)
Harrett, DP	Senior Manager, NHS, CYRUS, Wales
Harvey, Heather	Foreign and Commonwealth Office
Hayes, C	Nursing Director, Pembrokeshire and Derwen NHS Trust
Healy, Becky	Head of Children's Nursing, NHS Cardiff
Healy, Dr David	North Wales NHS Trust
Heathcock, Dr Rachel	Communicable Disease Control Group
Helliwell, Dr Tim	Royal Liverpool Hospital
Hempsall, Grace	Royal Brompton and Harefield NHS trust
Hendry, Patricia M	Wolverhampton
Hetherington, Gordon	H.M. Deputy Coroner for Teesside and Hartlepool
Hopkins, Linda	Research Officer, Association of Welsh Community Health Councils
Horton, Dr LWL	Consultant Histopathologist
Houston, John	Contingency Plans Association
Howells, Michael	H.M. Coroner for Pembrokeshire District
Hull, Lisa	Voluntary Euthanasia Society
Hurcombe, Linda	Shropshire
Ingrams, Dr Grant J	West Midlands Regional Local Medical Committee
Ironside, James W.	Professor of Clinical Neuropathology, Director of The National CJD Surveillance Unit, The University of Edinburgh
Isaacs, Elaine	Manchester
Jackson, Mr D P M	Hope Valley
Jaffa, Pip	The Relatives Reference Group, The Human Organs Inquiry, Northern Ireland
Jarmulowicz, Dr Michael	Consultant Histopathologist, Department of Histopathology, The Royal Free Hospital
Jeremiah, Deborah	Hampstead
Johnson, Ann	Beven Ashford Solicitors
	Staffordshire



Jolly, Anne	Sudden Adult Death Trust (SADS UK)
Jones, Anne	Simon Jones Memorial Campaign
Jones, Beverley Anne	Gwynedd, North Wales
Jones, Rick	Coroner's Officer (Essex)
Jones, Sue	Welsh Local Government Association
Kafetz, Kalman	Whipps Cross University
Kembrey, Sue	Telfrod & Wrekin Council
Kershaw, Alan	Council for the Registration of Forensic Practitioners
Kershaw, G R D	Conwy & Denbighshire NHS
Kirkland, Neil	Head of Resources, West Sussex County Council
Knapman, Dr Paul	H.M. Coroner for Inner West London
Knapton, Karen	Society of Registration Officers
Kramer, Susan	Hove
Lamb, Mrs Sally	Hampshire
Langan, Anthony	The Samaritans
Leadbeatter, Dr Stephen	Director, Wales Institute of Forensic Medicine
Leckey, John	Coroners' Association of Northern Ireland
Lee, JCA	Court Support Services, Merseyside Police
Lee, Kathleen	Coventry
Levine, Sir Montague B.	Retired Coroner
Lewy, Mrs L H	London and R.A.I.D
Leyton, Dr E	Crematorium Referee
Linnane, Jon	Kent
Lockwood-Croft, Margaret	Marchioness Action Group & Victims Voice
Lockyer, C Frank	Salisbury
Lowe, Kathleen	The Law Society
Lynch, Selena	H.M. Coroner for Inner South London District
Macaulay, Fiona	The Board of Deputies of British Jews
MacDonald Davies, Isobel	Deputy Registrar General for England and Wales
Mackay, Dr EH	Consultant Histopathologist, University Hospitals of Leicester
Maddrell, Alan	H.M. Coroner for Cheltenham District
Mageean, Paul	Committee on the Administration of Justice (CAJ)
Malone, Beverly	Royal College of Nursing
Margill, Bernadette	County Antrim
Marriot, Dr John	The Government Chemist, LGC Limited
Matthews, John	H.M. Coroner for Isle of Wight
McCarthy, Dr John	Consultant Pathologist (Gloucestershire)
McCarthy, John	Home Office Pathologist
McCarthy, Keith	Consultant Histopathologist
McClellan, John	Regional Health and Safety Officer, GMB London Region
McFarlane, Gary	Veale Wasbrough's Clinical Negligence Team
McLoughlin, J C	Mater Hospital
McMullan, Eunan	Office of the Police Ombudsman for Northern Ireland
Meadows, Nigel	H.M. Coroner for the County of Devon
Mills, Stephen	Pathologist (Wigan)

## Annex B

Mitford, David	H.M. Coroner for Newcastle-Upon-Tyne District
Moore, Sue	The Churches Funeral Group
Morgan, Dr I	Crematorium Referee
Morgan, Jeffrey	Coroner's Officer (Cheltenham)
Morris, Bill	Transport and General Workers Union
Morris, R. M.	Retired civil servant
Mulley, Kate	Policy Manager, Victim Support
Mumford, Robert	Registrar
Munday, Dr S	Assistant Deputy Coroner
Murphy, Dr John K	West Wales General Hospital
Muslim Council of Britain / Muslim Burial Council of Leicestershire	
Nadat, M	Walsall Muslim Burial Committee
Nash, Lesley J	Hampshire County Council
Nesbitt, Mary-Lou	Medical Defence Union
Newman, Raymond	Northern Ireland Health and Social Services Councils
Nicholls, Mrs Anne	Registrar (Gloucestershire)
Oakley, Michael	H.M. Coroner for North Yorkshire (Eastern District)
O'Driscoll, Christina	The Newspaper Society - Society of Editors Wiltshire
Osborne, John	Consultant Histopathologist
Otter, Dr Mark	Peterborough Hip Fracture Project
Parker, Martyn	Southall Black Sisters
Patel, Meena	H.M. Coroner for the Isles of Scilly
Pepperell, Derrick	Swansea NHS
Perrin, Jane	North Glamorgan NHS
Phillips, Ian	Consultant Histopathologist
Pitcher, Robert	Crematorium Referee
Pledger, Dr Gordon	Medical Law Group
Pollock, Evelyn	Dudley Borough Council
Polychronakis, John	Director - Health Services Policy & Development Division, Welsh Assembly Government
Ponton, Mike	Education & Social Policy Division, Local Government Association
Power, Susan	Chairman, Asworth Prison Officers' Association
Preece, David	Swansea NHS
Price, David	PAPYRUS (Prevention of Young Suicide)
Price, Dr Erika	Chief Executive, Rethink
Prior, Cliff	Senior Coroner's Officer (Bradford)
Pritchard, Alan	Coroner's Officer (Essex)
Quinton, Kazi	Medicines Control Agency
Raine, Dr June	Department for Trade and Industry
Raine, Dr Phil	Society of Editors
Rasaiah, Santha	Devon
Rea, K	H.M. Coroner for Central and Southeast Kent
Redman, Rachel	Manchester
Reich, Leslie	

Reynolds, Chris	Hertfordshire
Robbins, Cheryl	
Robbins, Dr Justin	General Practitioner (Plymouth)
Roberts, Dr Ian	Consultant Pathologist, John Radcliffe Hospital, Oxford
Robinson, Bill	Railway Safety
Robinson, Jo	Project Manager, National Confidential Enquiry
Rose, Michael	H.M. Coroner for West Somersetshire
Round, Vic	H.M. Coroner for Dudley District Royal Liverpool Children's NHS Trust
Royde, Dr C.A.	Salford
Ryder, Melissa	Bevan Ashford Solicitors
Samboski, Susanna	Buckinghamshire
Sarginson, David	H.M. Coroner for the West Midlands (Coventry District)
Saunders, John	Consultant Physician, Nevill Hall Hospital, Abergavenny
Scraton, Professor Phil	Director of Studies in Crime & Social Justice, Edge Hill University College
Sealy, Kim	Railtrack
Sheffield, Michael	H.M. Coroner for the counties of Middlesbrough, Redcar, Cleveland and Stockton on Tees
Shepherd, Professor Neil	Gloucestershire Royal Hospital
Sherwood, Dr Anthea	Histopathologist, Derriford Hospital
Sherwood, EJ	Hartlepool
Siddiqui, Hannana	Southall Black Sisters
Simpson, Dr C G B	Bronglais General Hospital, Aberystwyth
Sitch, Phil	Coroner's Officer (Essex)
Skone, J.F.	Medical Referee, Thornhill Crematorium, Cardiff
Slann, N H J	Surrey
Slatter, Anna	Special Advisor on Health, Welsh Assembly
Smith, Dr M E F	Consultant Histopathologist, Plymouth Hospitals
Smith, Ian	H.M. Coroner for Cumbria (Furness District)
Smith, Mrs R.E.	London
Smith, Professor Peter	SEAC (Spongiform Encephalopathy Advisory Committee)
Smith, Wendy	Royal College of General Practitioners
Squier, Dr Waney	Pathologist, John Radcliffe Hospital, Oxford
Stanley, Pat	Coroner's Officer
Start, Roger	Consultant histopathologist
Stern, Anya	The Association of Community Health Councils for England and Wales (ACHCEW)
Stewart, Dr David	Director of Public Health, Eastern Health and Social Services Board, Belfast
Stretton, Dr Christopher	Medical Referee
Stutt, Colin	Head of Funding Policy, Legal Services Commission
Summers, Michael	The Patients Association
Sunley, Kim	GMB Trade Union

## Annex B

Surplice, Detective Inspector Andy Sutcliffe, Andrea Sweeney, Eve Sykes, Roger Symes, Christine	Family Liaison Officer (Metropolitan Police)
Tait, Dr Nancy	National Institute for Clinical Excellence School of Psychology, University of Reading H.M. Coroner for Mid Kent & Medway District Head of Transport Safety & Crime Branch, Department for Transport Occupational & Environmental Diseases Association Blackburn
Taylor, Ann Taylor, Bob Taylor, Stuart Thewlis, David J & Mrs R Thomas, Leslie Thomas, Liz Thompson, Alison Thorpe, Lucy Tomkins, Mrs D Tonkin, Mike	Coroner's Officer (Worcester) Christian Conscience Liverpool 2 Garden Court Chambers Action for Victims of Medical Accidents (AVMA) H.M. Coroner for Western London District NSPCC London Office of the Chief Nursing Officer - The National Assembly for Wales
Trendall, Philip Trotter, Stephanie Tudor, Owen Turner, Bridget Turner, Martin Tweedle, Andrew Underwood, Professor J Varachhia, Abdul Viney, Anne Wacks, Arran Wagstaff, Mr P. S. Walker, Timothy Wallis, Alan Walter, Tony Warner, Mrs Ali Watson, Sally Weekes, Gareth Wells, Christine Wertheimer, Alison West, Ken West, Lindsay White, Dr Donald Whittaker, Roger Whittingham, Carole	British Transport Police C O - Gas Safety Trade Union Congress Head of Policy, Diabetes UK Gwent Healthcare NHS Trust H.M. Coroner for the North District of Durham President, Royal College of Pathologists Walsall Chief Executive, CRUSE Lawyer Cheshire Health and Safety Executive Staffordshire County Council University of Reading Coroner's Officers Association British Medical Association (BMA) Bournemouth The Compassionate Friends Academic Bereavement Services Manager Health and Safety Executive Home Office Pathologist H.M. Coroner for West Yorkshire Founder of S.C.A.R.D. (Support & Care After Road Death & Injury)
Whittington, Richard Whomersley, Chris Wilkinson, Professor John	H.M. Assistant Deputy Coroner for Oxfordshire Foreign and Commonwealth Office Chair of Public Health Observatories

Wilks, Dr Michael	Transplant Partnership, British Medical Association (BMA)
Wilson, Austin	Former Home Office Civil Servant
Wing OBE, Heather	National Care Standards Commission
Winston J. Held	Union of Orthodox Hebrew Congregation
Winter, Jane	British Irish Rights Watch
Wood, Martin	Worcestershire County Council
Woolf, The Rt. Hon. Lord	Lord Chief Justice of England and Wales

### Summary of Review Activity

Between September 2001 and April 2003 Review Group members met with 56 coroners individually, of which 14 were whole-time and 42 were part-time. The Review also participated in a number of group meetings with coroner societies during the programme of regional visits.

The Review Group held 42 meetings and 3 weekend residential away-days.

Review Group members participated in a total of 416 meetings with professional groups and members of the public for consultation purposes.

### List of Regional Visits to the English Regions, Wales, Northern Ireland and Other Countries

During the Review process Review Group members undertook a number of regional visits for consultation purposes. The details of these visits are listed below :

DATE	LOCATION	GROUPS / INDIVIDUALS MET
2nd October - 4th October 2001	Belfast	Victims Liaison Unit, Northern Ireland Office Criminal Justice Review Team State Pathologist Department Northern Ireland Court Service Crime Administration Branch Northern Ireland Police Ombudsman Northern Ireland Human Rights Commission CRUSE H.M. Coroner for Greater Belfast The Lord Chief Justice of Northern Ireland The Northern Ireland Bar Council Northern Ireland Law Society
16th October - 18th October 2001	Liverpool	Clinical staff at Alder Hey Hospital Hill Dickinson Solicitors Makin & Son Solicitors General Registry Office H.M. Coroner for Liverpool H.M. Deputy Coroner for Liverpool Head of administration, coroners office, Liverpool Merseyside Asbestos Victims Support H.M. Coroner for Knowsley, St Helens and Sefton

		H.M. Coroner for the Wirral District Support After Murder and Manslaughter Pity II Goodmans Solicitors Stanley Medical Centre Clinical staff at the Royal Liverpool Hospital RoadPeace Merseyside Police
7th November - 8th November 2001	Bedford  Wisbech  Hertford  Cambridge	Coroners' Officers, Bedford coroners office H.M. Coroner for Bedfordshire, Luton and South & West Cambridgeshire General Registry Office Nevilles Funeral Service Bedfordshire Police Clinical staff at Bedford Hospital  H.M. Coroner for North & East Cambridgeshire  Hertford Coroners Unit H.M. Coroner for Hertford District  Clinical staff at Addenbrooke's Hospital, Cambridge Cambridgeshire Police
13th December 2001	Manchester	Mrs Elaine Isaccs, member of the public
14th January - 15th January 2002	Edinburgh  Glasgow  Fife	Crown Office Procurator Fiscal's Office General Registry Office  Sheriff Court Procurator Fiscal's Office  ACPO (Scotland)
28th January - 30th January 2002	Belfast        Omagh  Derry	Committee on the Administration of Justice Coroners Association, Northern Ireland Northern Ireland Prison Service Relatives for Justice Western Health Board, Suicide Awareness Northern Ireland Department of Health Widows Against Violence General Registry Office  Omagh Support and Self Help Group Former H.M. Coroner for Omagh  Pat Finucane Centre H.M. Coroner for Derry/Londonderry

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<p>6th February - 8th February 2002</p>	<p>Oxford</p> <p>London</p> <p>Gillingham</p> <p>Croydon</p> <p>Brighton</p>	<p>Clinical staff at the Radcliffe Infirmary, Oxford H.M. Coroner for Oxfordshire H.M. Assistant Deputy Coroner for Oxfordshire General Registry Office Thames Valley Police Public Health Office Clinical staff and bereavement services at the John Radcliffe Hospital, Oxford</p> <p>South East Coroners Society</p> <p>RoadPeace H.M. Coroner for Mid Kent &amp; Medway Gillingham Local Medical Committee Kent County Constabulary Brachers Solicitors General Registry Office Kent County Council Clinical staff at Medway Maritime Hospital, Gillingham</p> <p>H.M. Coroner for Southern London</p> <p>H.M. Coroner for Brighton &amp; Hove</p>
<p>19th February - 22nd February 2002</p>	<p>Coventry</p> <p>Dudley</p> <p>Telford</p> <p>Birmingham</p>	<p>H.M. Coroner for Coventry Coroners Officers, Coventry office General Registry Office West Midlands Police Minority Community Leaders Legal Services, Walsgrave Hospital Home Office Pathologists Support After Murder and Manslaughter</p> <p>H.M. Coroner for Dudley and Worcester Coroners Officers, Dudley office Dr John Christie and Dr George Kondratowicz</p> <p>H.M. Coroner for the Wrekin</p> <p>Confederation of Sunni Mosques, Midlands Muslim Council of Britain H.M. Coroner for Birmingham Home Office Pathologists Principle administration assistant, coroner's office, Birmingham Coroner's Officers, Birmingham office Clinical staff at Birmingham Womens Hospital Bevan Ashford Solicitors Mr and Mrs Scott, members of the public Birmingham Central Mosque</p>



12th March - 15th March 2002	Wrexham  Newport  Cardiff	H.M. Coroner for Central North Wales and North East Wales General Practitioners Committee, North Wales H.M. Coroner for North West Wales Pathologist Open Meeting, North Wales  H.M. Coroner for Gwent  Representative for the Wales and Chester Circuit John Skone, Crematorium Referee Special Advisor for Health, Welsh Assembly Mrs Burton, member of the public Mrs MacDonald, member of the public Pathologist Open Meeting, South Wales Wales Public Law and Human Rights Association Welsh Language Board Association of Welsh Community Health Councils General Practitioners Committee, South Wales Crime Reduction Unit, Welsh Assembly Health and Social Services, Welsh Assembly Welsh Coroners Society Welsh Health Association of Public Injury Lawyers Dyfed Powys Police James Summers & Sons
9th April - 11th April 2002	Nottingham          Leicester       Lincoln	H.M. Coroner for Nottinghamshire and Nottingham City Nottingham Emergency Medical Services Dr Keavney, Nottingham Remand Prison AW Lymn Ltd Nottinghamshire, Leicestershire and Rutland Ambulance Service Nottingham Health Authority, Public Health Clinical staff at Nottingham City Hospital Nottinghamshire Police Paul Balen, personal injury lawyer National Care Standards Authority, Nottingham Area Office Afro Caribbean & Asian Forum  Muslim Burial Council of Leicestershire H.M. Coroner for Leicester City and South Leicestershire Jamia Mosque  H.M. Coroner for Lincoln
24th April - 26th April 2002	Belfast	Northern Ireland Court Service NSPCC Victim Support Funeral Standards Council CESDI Northern Ireland Community Relations Council Church of Ireland

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	Dublin	<p>Northern Ireland Police Federation          State Pathology Department          Belfast City Council          Northern Ireland Human Rights Commission          Fortnight Magazine</p> <p>Department of Justice &amp; Equality and Law Reform          Coroner for Dublin City          Review of Coroners Service Working Group          Coroners Association, Republic of Ireland</p>
7th May - 8th May 2002	Manchester	<p>H.M. Coroner for Manchester          NSPCC          Mrs Clayton, member of the public          Clinical staff at Manchester Royal Infirmary          Alexander Harris Solicitors          Families from the Tameside Family Support Group          H.M. Coroner for Manchester, West District          Dr Rutherford, Consultant Forensic Pathologist          Mr Bonner, member of the public          Association of Private Crematoria and Cemeteries          R Pepperdine &amp; Sons</p>
22nd May - 24th May 2002	<p>Bristol</p> <p>Truro</p> <p>Topsham</p>	<p>H.M. Coroner for Bath, North East Somerset,          Bristol City, North Somerset and South          Gloucestershire</p> <p>NACOR          The Bristol Families          Mr and Mrs Allan, members of the public          Bereavement Services, Royal Cornwall Hospital,          Bristol</p> <p>National Association of Funeral Directors          General Registry Office          Victim Support          H.M. Coroner for East Cornwall          H.M. Coroner for West Cornwall          H.M. Coroner for the Isles of Scilly          Cornwall Local Authority, Coroners Department          Coroners' Officers, Truro office</p> <p>H.M. Coroner for Exeter &amp; Greater Devon          H.M. Coroner for Torbay and South Devon</p>
30th May 2002	Derby	<p>H.M. Coroner for Derby and South Derbyshire          H.M. Deputy Coroner for Derby and South          Derbyshire          Mrs Sharpe, member of the public          Susan Hutchinson, member of the public</p>

11th June - 12th June 2002	Liverpool	Support After Murder and Manslaughter H.M. Coroner for Liverpool Hillsborough Family Support Group Patients Forum Mr and Mrs Cadden, members of the public Makin & Son Solicitors Pity II Merseyside Asbestos Victim Support
2nd July - 3rd July 2002	Newcastle	H.M. Coroner for Newcastle upon Tyne Tyneside Police Northern Coroners Society Mr and Mrs Sherwood, members of the public The Benefits Agency, Fraud Investigation Division Broad Chare Chambers Dr Cooper, Home Office Pathologist
	Blyth	H.M. Coroner for North Tyneside
	Middlesbrough	H.M. Coroner for Middlesbrough, Redcar, Cleveland and Stockton on Tees Coroners Officers, Middlesbrough office
9th July 2002	Liverpool	H.M. Coroner for Liverpool
10th July - 11th July 2002	Hull	H.M. Coroner for Hull and East Riding Survivors of Bereavement by Suicide
	York	Helen Thornton-Jones, University of Hull H.M. Coroner for York Mrs Fairley, member of the public Cyclist Touring Club Foundation for the Study of Infant Deaths and families
	Malton	H.M. Coroner for North Yorkshire, Eastern District
	Harrogate	H.M. Coroner for North Yorkshire, West District
	Leeds	Clinical staff at St James's University Hospital, Leeds
13th August 2002	Sheffield	H.M. Coroner for South Yorkshire, West District H.M. Coroner for West Yorkshire, Eastern District Pathology Department, Medico-Legal Centre Coroner Officers, Medico-Legal Centre

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25th October 2002	Salisbury	H.M. Coroner for Wiltshire and Swindon Coroners Officers, Salisbury office H.M. Coroner for Plymouth and South West Devon Pathology Department, Salisbury General Hospital General Registry Office RoadPeace Bournemouth Police Zito Trust
30th October - 31st October 2002	Liverpool	Merseyside Asbestos Victims Support Hillsborough Families Support Group Doreen Jones, member of the public Pat Joynsen, member of the public Pity II
4th November - 5th November 2002	Belfast	Widows Against Violence Families Acting for Innocent Relatives Irish Council of Churches Human Rights Committee, Northern Ireland Law Society Professor Desmond Greer Chris Thornton, Belfast Telegraph John O'Farrell, former editor of Fortnight Magazine Brian Feeney, Irish News NSPCC Committee on the Administration of Justice Northern Ireland Court Service Mr Crookes, member of the public
5th December 2002	Southampton	Retained Organs Commission, Public Meeting

### List of Countries and Jurisdictions Visited by Review Group Members

DATE	LOCATION	GROUPS / INDIVIDUALS MET
30th August 2002	Vancouver, Canada	Deputy Chief Coroner
30th September - 2nd October 2002	Toronto, Canada	Office of the Chief Coroner Centre of Forensic Science Children's Aid Society Toronto Police Ms. Virginia West, Deputy Minister Crown Attorney representative Trauma Registry Registrar General's Office Bereaved families
4th October 2002	Edmonton,	Office of the Medical Examiner Canada
7th January - 8th January 2003	Auckland, New Zealand	Coroner for Auckland Coroners Officers Mortuary staff Pathology Department Medical Referee Police Maori Responsiveness Advisor
9th January - 10th January 2003	Sydney, Australia	State Coroner for New South Wales Coroners Officers Information and Support Services Department of Forensic Medicine Counsellors
13th January - 15th January 2003	Melbourne, Australia	State Coroner for Victoria Institute of Forensic Medicine Researchers Counselling and Support Services Coroner's Investigation Unit WorkSafe Victoria Vic Roads Victoria Police Victorian Transport Association Correctional Services Emergency Services Commissioner Clinical Liaison Group Accident Research Centre, Monash University County Fire Authority Occupational / Industrial Disease Committee Transport Workers Union

## **Previous Inquiries**

1. In the last century and a half there have been five inquiries into or reviews of the coroner service:
  - two relatively brief Parliamentary Select Committee reports in 1860 and 1879<sup>1</sup>;
  - three departmental committees of inquiry which reported in 1910, 1936 and 1971 respectively<sup>2</sup>.

## **The Select Committee Reports**

2. The first, chaired by Robert Lowe M P, made recommendations on coroner remuneration (which should be by salary), election (through the Parliamentary franchise), and the method of summoning juries (from the county jury list)<sup>3</sup>.
3. The main concern of the Report was to resolve differences of view between coroners and magistrates who at the time met coroners' fees. The magistrates took the view that coroners should investigate only those deaths, referred by themselves or the police, where there seemed to be "some wilful act of the deceased, or of some other person, or...negligence". The coroners argued that they should be free to choose the cases which they investigated, and that these should also include "sudden death where the cause of death is unknown, and also where reasonable suspicion of criminality exists", and also "any prisoner dying from whatsoever cause".
4. The Select Committee sided with the coroners, observing that: "The coroner differs from all other judicial officers in this, that he initiates his own proceedings....the Committee are unwilling to deprive the coroner of the initiative".
5. The Select Committee which reported in 1879<sup>4</sup> took extensive evidence on the Scottish system for investigating deaths through Procurators Fiscal, assisted by pathologists or other doctors. They recommended that coroners should be:

<sup>1</sup> Also relevant are reports of the Parliamentary Select Committee on Death Certification (1894)

<sup>2</sup> There was also a Departmental Committee on Cremation, which reported in 1903.

<sup>3</sup> Report from the Select Committee on the Office of Coroner, Parliamentary Reports, 1860, xxii.257

<sup>4</sup> Special Report from the Select Committee on the Coroners Bill, Parliamentary Reports, 1879, ix. 433. The chair was Sir Matthew Ridley M P.

- legally qualified (there being at the time no statutory professional qualification for appointment);
  - supported in their work by one or two doctors appointed for the purpose, the role of the second being to conduct post-mortem examinations.
6. They addressed the problem of concurrent jurisdictions between coroners and magistrates, observing that “if a system of efficient salaried legal coroners were established it might be possible to confer upon them the powers of a stipendiary magistrate and thus obviate the evils referred to”.

### Twentieth Century Reports

7. The report made in 1910<sup>5</sup>, chaired by Sir Mackenzie Chalmers, was the first public examination of coroner issues since the Coroners’ Act 1887<sup>6</sup>, which consolidated all the main legislation affecting coroners and gave effect to some of the recommendations of the 1860 and 1879 Select Committees.

8. The Committee introduced its report by saying:

*“The law relating to coroners is antiquated. Much of it dates from the thirteenth century, and is of great historical interest, but it is not well suited to the changed conditions of modern life. On the whole we have been astonished at the good work done by coroners with out-of-date and imperfect machinery.....But we think that the performance of their duties would be made easier, and the system in general rendered more efficient, if the law relating to coroners was amended and brought more into line with modern requirements”.*

9. The recommendations included:
- new statutory powers obliging registrars to report some deaths to the coroner;
  - the progressive abolition of “franchise coroners” which certain institutions had a historic right to appoint<sup>7</sup>;

<sup>5</sup> Coroners’ Committee: Second Report of the Departmental Committee appointed to inquire into the Law Relating to Coroners and Coroners’ Inquests, and into the Practice in Coroners’ Courts. Cd 5004. The Committee’s first report was simply a note to cover the publication of its minutes of evidence. One committee member put in a minority report on some issues of detail.

<sup>6</sup> Also of importance was the Local Government Act 1888 which abolished the election of coroners by freeholders and provided that coroners should be appointed by local authorities.

<sup>7</sup> For example the University of Oxford appointed a coroner to investigate the deaths of “matriculated persons and their servants”. Powers for abolition were taken in the Coroners (Amendment) Act 1926. Franchise coronerships lapsed as their occupants retired. In 1936 when the Wright Committee reported there were still some 50, and a few remained during the 1960s when the Brodrick review took place.

## Annex D

- all coronerships to be salaried and pensionable;
- all coroner appointments to be filled by solicitors, barristers or “medical men”;
- coroners to be given a power to order post-mortems in cases where there was no inquest;
- strong backing for the use of police officers as coroners’ officers, whose “functions are extremely important though unknown to the law”;
- the provision of clerical support for coroners;
- a restriction of the circumstances in which coroners conducted Treasure inquests;
- viewing the body by inquest jurors to become discretionary;
- powers to conduct inquests into fires (at the time confined to the City of London coroner) to be made available to all coroners.

### 10. On the outcome and conduct of suicide inquests the Committee said:

*“We think that in cases of suicide the verdict should simply be that the deceased died by his own hand (stating how). But the jury should be at liberty to add to their verdict that there was no evidence to show the state of his mind, or that at the time of taking his life he was of unsound mind”.*

### 11. On the general question of whether death investigations should be by public inquest, they said:

*“In certain cases no doubt publicity is of great value.....On the other hand, there are many cases in which no public end is gained by reporting the proceedings at an inquest. The gratification of the public curiosity cannot be weighed for a moment against the intense pain caused to the relatives of the deceased by the disclosure of family matters, which may have nothing to do with the cause of death. The presence of the jury is a sufficient guarantee that the proceedings at the inquest are fair and above board. There is a good deal to be said for the Scottish system, under which deaths which would form the subject of an inquest in England are inquired into in private by the procurator fiscal, who in any case of doubt reports the facts to the Lord Advocate. A public inquest is required only in the case of industrial accidents, or in the case of a death in prison. However, the jury system is so deeply rooted in English life and history, that we do not see our way to advocate any change”.*



12. The 1936 report<sup>8</sup>, from a committee chaired by Lord Justice Wright, reviewed the system following the 1926 legislation which had introduced the requirement for legal or medical qualifications in coroners, allowed coroners to sit without juries in certain cases and to order autopsies without having to proceed to an inquest, and required them to adjourn a inquest when someone was charged with murder, manslaughter or infanticide of the deceased.
13. The committee identified a number of defects. These included the holding of many inquests which may be unnecessary, a tendency on the part of coroners to go beyond the mere investigation of the facts and to deal with questions of civil or criminal liability, and to "make animadversions on the character and conduct of individuals". It said that "the irresponsibility of coroners has been the subject of comment, there being no effective appellate tribunal or supervisory body" .It pointed to the absence of any general code of rules to fix the way in which inquests should be conducted, and said that the power of coroners to commit to trial for murder, manslaughter or infanticide was out of accord with the modern administration of the criminal law.
14. The recommendations included:
  - in suicide inquests a prohibition on the press from publishing an account of the proceedings. They should be able to publish only that an inquest has been held, the name and address of the deceased and the verdict that the deceased died by his own hand. No enquiry should be made into the state of mind of the deceased save in so far as it might throw light on the question whether he took his own life, and no reference should be made in the verdict to the state of mind of the deceased;
  - withdrawal of the power to commit for murder, manslaughter or infanticide, and a prohibition on dealing with questions of civil liability;
  - verdicts of censure or exoneration to be prohibited, but this prohibition should not extend to recommendations of a general character designed to prevent further fatalities;
  - introducing a discretion to dispense with inquests into deaths due to simple accidents, or to chronic alcoholism, and deaths under anaesthetic or during an operation;

<sup>8</sup> Report of the Departmental Committee on Coroners, Cmd 5070. One of the seven members declined to sign the report, and another signed it but put in a note of dissent on some issues.

## Annex D

- there should be better mortuaries;
  - a Rules Committee should be established to make rules for the conduct of inquests. It should consist of persons to represent the Lord Chancellor, the Home Secretary, the Coroners' Society, the Bar Council, the Law Society, the BMA and the general public;
  - a similarly constituted Disciplinary Committee should deal with complaints against coroners;
  - where juries are discretionary they should usually be dispensed with;
  - at jury inquests on the deaths of women, children or infants, the jury should include at least two women;
  - only solicitors or barristers should be appointed coroners;
  - deputy and assistant coroners should be appointed by local authorities after consultation with the coroner to whom the deputy is being appointed;
  - a coroner's officer should in all cases be a serving police officer.
15. The committee said that a whole-time service was "a goal to be aimed at", and recommended that the number of coroners should be reduced.
16. The 1971 report<sup>9</sup>, from a committee chaired by Mr Justice Brodrick, covered death certification as well as coroners. The Government had commissioned it in response to suggestions that causes of deaths were not being accurately certified and that the certification and coroner systems offered poor defences against occult homicide.
17. The Committee concluded:
- "...there is no requirement to strengthen the present machinery of death certification simply in order more efficiently to prevent or detect secret homicide.....Our task therefore has been to make sure that, in the future system of death certification, an autopsy will be performed in all cases in which there is any doubt about the medical cause of death or suspicion about the circumstances in which the death occurred."*<sup>10</sup>

18. The Committee made 114 detailed recommendations but a main

<sup>9</sup> Report of the Committee on Death Certification and Coroners.Cmnd.4810

<sup>10</sup> Chapter 4, paragraph 4.37. The proportion of all deaths in England and Wales subject to autopsy was at that time more than 25% - see paragraph 4.35 of the Report.

purpose was to engage the coroner more in the certification of deaths from disease in addition to those cases referred for circumstantial investigation. To achieve this they recommended an increase in the degree of certainty required for the certification of a death by a doctor, so that a higher proportion of cases would be reported to the coroner. The new and higher certainty level to be required of a certifying doctor was "he is confident on reasonable grounds that he can certify the medical cause of death with accuracy and precision".

19. Amongst the other recommendations on death certification were:
- certifying doctors should have seen the patient within 7 days of the death and should see the body after death;
  - the fact of death as well as its cause should be certified by a doctor;
  - regulations should prescribe categories of reportable deaths, and there should be a statutory responsibility on doctors to make such reports in cases they attend;
  - a new certificate of the fact and cause of death should cover a wider range of information about past medical treatment and accidents;
  - the new certification process should apply equally to burials and cremations, and the special cremation certification process should be discontinued.
20. For coroners the recommendations included:
- Only barristers or solicitors of at least five years' standing should be eligible for appointment;
  - Appointment of coroners by the Lord Chancellor in place of local authorities (though deputy and assistant deputies would be appointed by the coroner with the Lord Chancellor's approval);
  - A new responsibility on the Home Secretary to ensure and pay for the provision of staff and accommodation, though local authorities might retain agency responsibilities for the service;
  - Authorities should submit proposals for their coroner services for approval by the Home Secretary, on criteria implying preference for full-time coroner jurisdictions.
21. On inquests, the recommendations included:
- mandatory public inquests into deaths from suspected homicide, in legal (including mental health) custody, and of persons whose bodies are unidentified;

## Annex D

- in all other cases the coroner should have a complete discretion as to the form which his enquiries may take after a death has been reported to him;
- the duty to assess guilt and the obligation to commit suspects for trial should be abolished;
- "Verdicts" should be replaced with factual "findings";
- legal aid should be made available to interested parties for representation at an inquest.

### 22. Other recommendations were for:

- local rights of appeal, though access to judicial review should continue;
- coroners' officers no longer to be police officers but properly trained civilians, who should be employed by the coroner;
- coroners to be provided with secretaries;
- pathology for coroners to be done by the National Health Service;
- coroners to continue to enquire into treasure finds "until comprehensive legislation is introduced to deal with the whole question of the protection of antiquities".

### 23. The Report concluded by:

- recommending that consideration should be given to the appointment of an advisory committee to advise Ministers on the operation of procedures and the organisation of the system, to provide guidance to coroners, doctors and others about standards of good practice, and to keep under regular review the categories of death required by law to be reported to coroners;
- speculating that the future might bring a closer integration between the coroner and registration services, so that "the same officer might ultimately become responsible for the scrutiny of all medical certificates of the fact and cause of death, the detailed investigation ...of some deaths, the provision of a record of all deaths, and the provision of material for vital statistics".

**ANNEX E****DEATH INVESTIGATION IN SOME OTHER COUNTRIES****Introduction**

1. This annex provides an overview of information obtained during the Review on the approach of some other countries to death investigation.
2. Members of the Review paid short visits to the Republic of Ireland, Ontario, British Columbia and Alberta in Canada, New South Wales and Victoria in Australia, and New Zealand. These countries inherited the English common law coroner tradition, and have substantially developed and modernised it, or are considering proposals to do so. A short visit was also paid to Scotland.
3. Other sources of information have included material sent by the relevant authorities in some European countries in response to questions submitted through their embassies, material available on the web<sup>1</sup>, and some publications<sup>2</sup>.
4. The detailed notes made and the material collected will be available in the Review archive, to which reference is made in paragraph 17 of the Introduction of the main report.

**Types of Death Investigation System**

5. In nearly all countries examined the majority of deaths are registered and disposal of the body is authorised on the basis of a certificate of the cause of death completed by a doctor. This process is to varying degrees supplemented in some countries by further checks in cases where the body is to be cremated, and in some there are processes for auditing the certification system.
6. All countries have in addition methods of investigating unnatural and certain other deaths. They are broadly of three types:
  - the *generic criminal investigation and judicial system*, which examines deaths of suspect or uncertain cause through the same systems as are used to investigate suspected crime;

<sup>1</sup> Most of the coronial services in the countries visited have web-sites of their own. The Shipman Inquiry web-site includes the transcript of a seminar on international issues held in January 2003. Many United States coroner and Medical Examiner jurisdictions have their own sites.

<sup>2</sup> There is a valuable summary of approaches in other countries in chapter 22 of Jervis, *op. cit.* Also of interest on death certification is an EEC report "Comparability and Quality Improvement of European Causes of Death Statistics :Final Report 2001". (EDC DGV/F3 SOC 98 20108 – INSERM SC& Cepidc)

- the specialist *Medical Examiner* system found in some parts of North America , which provides a forensic pathology service to the police but investigates the causes of non-criminal deaths as well;
- the *coronial* system, which investigates causes and circumstances of deaths.

### Generic Criminal Investigation Systems

7. These systems – sometimes known as “civilian” systems - are predominant in most other European Union countries<sup>3</sup>. Deaths are investigated by the official with responsibility for investigating crime and bringing prosecutions – for example the *procureur* in France. Judicial involvement is from the examining magistracy which has in most such countries an inquisitorial role and takes responsibility for directing the investigation.
8. There are provisions in all such countries for the authorities to order un-consented autopsies though they are generally used only where there is suspicion of crime around the death. Such autopsies are carried out by forensic autopsy specialists, in some countries two doctors being required to participate in each case. In Germany, the law distinguishes between an external examination of the body, which is described as a “post-mortem” examination, and an internal examination, which is described as an “autopsy”. Medico-legal autopsies there require a court order and the consent of relatives is sought though there is power to proceed with the autopsy if the consent is not obtainable.
9. There are not generally in these countries public judicial hearings into deaths unless the investigations lead to criminal prosecutions, or there is a court challenge to a decision not to prosecute. They do not usually have special procedures around the deaths in prison or detention of other kinds. There would not normally be any public examinations of self-inflicted deaths, or traffic deaths unless the vehicle driver is prosecuted. These systems do not, characteristically, concern themselves with deaths that are considered to be natural but where the causative disease is not known, though at least in some countries there are powers to investigate and autopsy deaths from some defined communicable diseases.
10. In summary, systems of this kind:
  - concern themselves primarily with deaths that are suspicious in a criminal sense and not with a wider range of inquiry. They do not set out to cover deaths where the cause is natural but the specific disease is unknown;

<sup>3</sup> Also to be found, in central and north-east Europe, are approaches based on forensic pathology services as in Finland.

- have low rates of un-consented autopsy;
- involve public examinations mainly in cases where there are prosecutions.

### Medical Examiner Systems

11. The distinguishing characteristics of Medical Examiner systems are that they:
  - are led by forensic pathologists;
  - determine the causes of deaths but do not generally inquire into their circumstances;
  - usually provide forensic pathology services to the police and the criminal investigation services, in addition to their general death investigation work;
  - provide in-house autopsy and other scientific investigation services.
12. The concept originated around the end of the nineteenth century in some big United States cities which had high homicide rates and had come to regard the system of politically elected coroners as corrupt and lacking in technical expertise.
13. The position now is that in the U S A, where the responsibility for death investigation is with the individual states not the federal government and in many states is delegated to individual cities and counties, 22 states either have State Medical Examiners or have Medical Examiners in all their counties, 11 states have coroner systems, and in 18 states there is a mixture of the two. In Canada, there are Medical Examiner systems in four of the 12 provinces.
14. Medical Examiners are public officials appointed by the state, city or county within the framework of the state law, or city or county ordinance, governing the provision of the service. Their investigations are administrative not judicial but their decisions, like those of any other public official, may be challenged through the courts.
15. Many Medical Examiners employ specialist forensic investigators, not medically qualified but trained to degree standard, to handle cases and visit death scenes.
16. The state or county/city ordinances under which the service is provided may provide for, and in some cases circumscribe, the Medical Examiner's power to perform autopsies, and provide avenues of review or appeal in relation to such decisions.

17. The role of Medical Examiners is generally to find the cause or causes of death, whether by disease or injury. They consider the circumstances of the death in so far as relevant to such outcomes. They do not undertake further inquiries into the circumstances of individual deaths. Judicial inquests are held in some U S states but they are rare and the decision whether to hold one may be made by the District Attorney, the elected official of the city or county administration<sup>4</sup>. When inquests do occur they are presided by a judge from the state, city or county bench. Prisons and other public services may have their own inquiry processes. Otherwise there is civil litigation.
18. Medical Examiners may however make contributions to epidemiological and preventative literature. The web-site of the U S Federal Centers for Disease Control includes a Medical Examiner and Coroner Information Sharing Programme<sup>5</sup> which contains some examples. There is also a National Association of Medical Examiners<sup>6</sup> which runs an advisory and accreditation service.

### **The Coroner System and its Development**

19. The coroner system was exported with the early emigrants to most of the countries settled from England – those which are now within the Commonwealth, and the USA.
20. Within the USA coroners remain where not replaced by Medical Examiners, and are usually elected. Though there are doctors, nurses and lawyers acting as coroners the laws governing their election do not usually prescribe any qualification. Their inquiries into deaths are usually in private rather than through public inquest, though their outcomes, at least in traumatic cases, are usually published.
21. In Commonwealth countries the coroner system has retained the two characteristics which in combination make it distinctive - (a) it is a specialist investigation service concerned only with the investigation of deaths<sup>7</sup> and (b) as well as finding the medical or injury cause of individual deaths it undertakes judicial-style inquiries into their circumstances.
22. In all the Commonwealth countries on which we have information coroners are now appointed not elected. In most they must be either doctors or lawyers<sup>8</sup>.

<sup>4</sup> In the Canadian Medical Examiner jurisdictions inquests are held by the mainstream judiciary and are somewhat more frequent than in the USA - for the position in Alberta see paragraph 38 below.

<sup>5</sup> [www.cdc.gov/epo/dphs/mecisp](http://www.cdc.gov/epo/dphs/mecisp)

<sup>6</sup> [www.thename.org](http://www.thename.org)

<sup>7</sup> In Victoria and New South Wales, the coroner also investigates fires, and in England and Wales and in the Republic of Ireland he has a role in relation to Treasure.

<sup>8</sup> An exception is British Columbia where lay people may be appointed. In Quebec, the service uses doctors for much of its work but lawyers to conduct inquests.



23. In Australia death investigation is the responsibility of the individual states and in Canada of the provinces. In both countries there have been very substantial reforms of most systems in recent decades.
24. With many variations of detail the general direction of this change process has been away from independent locally appointed judicial-style city and county coroners holding a large number of public inquests towards the development of a *single coroner service* for the state or province with:
- objectives, procedures and standards set centrally for the service as a whole;
  - a chief coroner in charge, supported by a headquarters organisation and staff;
  - training and quality control processes;
  - in the very large majority of cases the investigation of a death is treated as a service to the deceased and to the family rather than as a public act and is a private and administrative rather than a public process;
  - public inquests are held on a much smaller scale than formerly and are deliberately restricted to certain mandatory categories including deaths in prison or detention and a small number of discretionary inquests chosen for their prospects of illuminating general risks or systems weaknesses and generating recommendations to improve public safety<sup>9</sup>.
25. Other features likely to be found in these reformed systems, depending on their date of reform and other circumstances, are statutory rights of family access to investigation outcomes and review of coroner decisions, and at the headquarters the incorporation of, or a very close association with, a salaried forensic pathology service which performs most of the autopsies and other scientific investigations for the coroner service at least in the provincial or state capital and its surrounding region and aims to set policies and standards for the whole service.
26. Particular features of interest include the statutory base and structure of these services, their processes for conducting administrative investigations, the criteria for choosing cases for public judicial inquests, and information and research resources.

<sup>9</sup> Information on reporting, autopsy and public inquest rates in the coroner jurisdictions, Alberta, and Scotland is in the Table facing paragraph 5 in chapter 2 of the Report.

## Statutes and Structures

27. In Ontario the service has been centrally organised since 1972. Present legislation is the Coroners Act 1990 with amendments since. The Act provides for the appointment of a Chief Coroner, Deputy Chief and Regional Coroners and territorial coroners, all of whom must be medically qualified.
28. The Chief Coroner is a statutory public service appointment whose duties include the administration of the Act and its regulations, the supervision and control of all coroners in Ontario, conducting programs for the instruction of coroners, bringing the findings and recommendations of coroners' juries to the attention of appropriate persons, and preparing, publishing and distributing a code of ethics for coroners.
29. The Act gives families – within defined degrees of affinity, including same sex partners – rights to see coroners' investigation reports including post-mortem reports, and other evidence, and to be represented at inquests (though it contains no public funding provision for their representation).
30. The service is part of the Ministry for the Solicitor General which also covers public safety and security, and the provincial fire, prisons and police services. The Chief Coroner ranks as the UK equivalent of a Deputy Secretary, and on a personal basis is also the Inspector of Anatomy.
31. At the Toronto headquarters the service employs about 50 full-time and 16 part-time staff. There are eight full-time regional coroners overseeing 320 part-time territorial coroners who are mainly family doctors in clinical practice but include some emergency care physicians as well.
32. In *British Columbia*, the legislation is from 1979 and the service is financed from the Attorney General's vote. Under the Chief Coroner there are 8 regional coroners supervising 21 full-time and 120 part-time coroners.
33. In *New South Wales*, the main powers are in the Coroners' Act 1980, as recently amended, but the present structure, which is led by a Chief Coroner and requires all coroners to be legally qualified, dates from 1998. The State Coroner is assisted by two full-time deputies. Coroners are drawn from the district (professional) magistracy and court clerks. All district magistrates are full-time and have the powers of a coroner *ex officio*. Those permanently assigned to coroner duties deal with the majority of reported deaths, the remainder being covered by magistrates sitting as part-time coroners.
34. In *Victoria*, under 1985 legislation, all coroners are legally qualified and part of the magistracy. As in New South Wales, the coroner service is an independent judicial service. Under the Chief Coroner there are 4-5 full-

time coroners. In the country areas there are 90 magistrates who act as part-time coroners. Some 6 of these are also regional co-ordinating coroners.

### Inquest Criteria

35. In all these jurisdictions some public judicial inquests are mandatory, but others may be held at the discretion of the service. The mandatory categories include:

- in *Ontario*, deaths of prisoners and of people detained under compulsory mental health powers, and deaths in the mining and construction industries;
- in *New South Wales*, unresolved homicides, deaths from anaesthesia, deaths in custody or during or as a result of police operations;
- in *Victoria*, deaths of unidentified people, and deaths “in care” (including children in care, deaths in prison, police custody, deaths of patients in approved mental health services, or in alcohol or drugs assessment or treatment centres);
- in *British Columbia*, deaths in a police prison or lockup or while in the actual custody of a police officer.

### Criteria and Process for Selecting Discretionary Inquests

36. In *Ontario*, the statute obliges the coroner to consider how far the basic factual questions about the death remain to be settled, and “..the desirability of the public being fully informed of the circumstances of the death through an inquest .. and the likelihood that the jury on an inquest might make useful recommendations directed to the avoidance of death in similar circumstances”. In *British Columbia*, the criteria that have evolved are “serious concerns of the public or next of kin, the refusal of a witness voluntarily to provide evidence in an enquiry, or agencies, institutions and interest groups legitimately pointing out concerns worthy of public focus”.

37. In *New South Wales* and *Victoria* the position is very similar with public interest grounds being a predominant criterion for deciding whether to hold inquests. In both cases the coroner has a wide discretion. The *Victoria* legislation provides that if a coroner is asked to hold an inquest he may refuse the request but if so he must give reasons in writing within a reasonable time, and that if he has not done so within three months an application can be made to the Supreme Court which if satisfied that it would be in the interests of justice may order an inquest to be held.

38. In *Alberta*, the inquests – known as public fatality inquiries - are held by the mainstream judiciary not the Medical Examiner service. A statutory Fatality Review Board recommends to the Minister and the Attorney General which cases should go to such inquiries. All deaths of certified patients under mental health legislation, children in the custody or guardianship of the government, and of people in custody or jail automatically go to Public Fatality Inquiry unless the death was due entirely to natural causes, was not preventable, and the Fatality Review Board feels that the public interest would not be served by an inquiry. The Board consists of a physician, a lawyer, a member of the public, and -in a non-voting capacity – the Chief Medical Examiner.

### Outcome of Inquests

39. Generally these jurisdictions have not retained the short-form “verdicts” of the England and Wales system. Deaths are classified by type into broad categories such as Accident/Homicide/Natural Causes/ Suicide and Unascertained. The main outcomes are a narrative and analytical account of the death, the events leading up to it, and the people and institutions or services involved. Incrimination and the establishment of liability are outside the scope of the inquest.
40. Preventative recommendations are seen as an important product of inquests. In *Ontario* there was in 1997-98 a succession of inquests into the deaths of children who had been receiving public care services. These led to a total of 428 recommendations aimed at improving the safety and quality of life for Ontario children. More recently there was a large inquest into the death of a young man from asthma, which went deep and wide into issues about the treatment of and public education on the disease, ambulance and emergency services and details of the Ministry of Health and Long-term Care’s budget allocations, making recommendations in all these areas as well as explaining the circumstances of the young man’s death. In all, the 63 inquests done in 1998 led to 805 recommendations. These are systematically followed up by the coroner service. It is expected that the responsible agencies should reply within a year.
41. In *Victoria*, the statute gives coroners wide powers of comment and recommendation which are regularly used. For example, the fire inquest following the 1999 Linton fire led to 55 recommendations. In *New South Wales*, an inquest into six deaths which occurred during the 1999 Sydney to Hobart yacht race made 14 recommendations.

## Investigations

42. A feature of these jurisdictions is the quality, scope and value to the family of the reports done by coroners following investigations. These are properly and, within each jurisdiction, uniformly, written- up reports of investigations done into cases where there is no public inquest.
43. In *Victoria* such reports are known as “chambers findings” and depending on the nature of the case may be between one and 20 pages in length. They will summarise the background, describe the circumstances of the death and any events relevant to it, give the injury or disease cause in the form required for a death certificate, summarise any autopsy or other reports, and give a narrative and analytical finding of the cause of death. These reports are publicly accessible.
44. In *Ontario* the coverage is similar, though the reports are more uniform in length. They are made in standard format distributed to all coroners through software prepared for the service. E-reporting is under consideration. The reports are made available to the family but are not accessible to the wider public.
45. In *British Columbia* the outcomes of investigations are recorded in a “Judgement of Inquiry” report. This will outline the factual circumstances relating to the death and determine the medical cause of death as well as classifying as natural, accidental, suicide, homicide or undetermined.
46. In *New South Wales* the family has access to the full investigation file, excluding any material needing protection for third-party reasons.<sup>10</sup>

## Research and Information

47. In some of these jurisdictions a significant effort goes into research to find patterns in the individual deaths so that general lessons may be drawn from them.
48. In *Victoria* the service has a small budget for such purposes and the service has three research officers, one financed by the Justice Department and one by the Health Department. Examples of work include a project done jointly with “Workcover” (the Health and Safety at work agency) on the top 10 causes of workplace deaths, and a study of commercial vessel fatalities in Victoria 1991-2001. Another was a study done jointly between the Chief Coroner’s Office and the Department of Human Services of “Unintentional Drowning: Toddlers in Dams in Victoria 1989-2001”.

<sup>10</sup> A considerable number of investigation and inquest reports from most of these jurisdictions and from New Zealand are in the Review archive.

49. In *Ontario* the service works with the Canadian Institute for Health Information in the preparation of an annual Ontario Trauma Registry report which analyses the sources of all major trauma injuries and deaths in the province. For deaths the analysis uses the coroner service's searchable data base of death investigation reports. The database is also the source of comprehensive figures published in each annual report of the Chief Coroner on the types, causes and circumstances of all deaths investigated by the service.
50. Of particular interest is the Australian *National Coroners Information System* a national internet-based data storage and retrieval system for coronial cases in Australia. It is set up and managed by the Monash University (Melbourne) Centre for Coronial Information<sup>11</sup>.
51. It covers all Australian coroner investigations since July 2000, giving details of the individual who has died, cause of death, the incident and circumstances of death and its classification, autopsy and toxicology reports and the coroner's findings. Its costs were met by funds from key public safety agencies in the states and Federal funding.
52. It is accessible to all Australian coroners, who can quickly find out whether there are other cases similar to cases they are investigating. It is also accessible to Australian Government agencies and research organisations with public health and safety interests. New Zealand coroners are also using the system.
53. Though not yet evaluated this system promises to be a major innovation in the provision of information to coroners and others on public health and safety risks.

## **New Zealand**

54. The New Zealand coroner system works within legislation last revised in 1988. There are two full-time coroners and over 60 part-time coroners. They are mainly lawyers though there is no statutory requirement that they should be.
55. Inquests must by law be held into apparent suicides, deaths in prison and police custody, or in care (for example in a psychiatric hospital or a children's home).
56. Inquests and administrative investigations result in largely narrative findings, and recommendations can be made to reduce the risks of comparable fatalities in future.

<sup>11</sup> [www.vifp.monash.edu.au/ncis](http://www.vifp.monash.edu.au/ncis)

57. Autopsies are culturally objectionable to many Maori and Islander people. The 1988 legislation requires coroners to take into account certain considerations when deciding whether or not to order an autopsy. These include the likelihood that an autopsy will provide information about the death, the involvement of others in the death, and the existence of any allegations or suspicions, any distress or offence which may be caused to people because of their ethnic background or spiritual beliefs, the wishes of the deceased person's immediate family, and whether the cause of death can be determined without an autopsy.
58. The New Zealand Law Commission reported on the coroner system in 2000<sup>12</sup>. The report identified problems of structure, procedure and perceptions of the system particularly in the Maori and Islander sections of the population. It drew attention particularly to lack of uniformity of coroner practice throughout New Zealand and the lack of a Chief Coroner with supporting staff.

### Republic of Ireland

59. The coroner service is based on 1962 legislation, with a number of largely part-time local jurisdictions. Inquests are required by law where a death may have been unnatural or caused by violence.
60. The system was the subject of a Government Working Group review in 2000<sup>13</sup>. The main recommendations were for the establishment of an independent centrally financed agency, and the introduction of appointment by the Ministry of Justice, Equality and Law Reform, to replace the present local appointment and support arrangements. Appointment would remain open to lawyers or doctors. The service would be organised regionally rather than locally. Coroners' officers independent of the Gardai would be introduced as would training for coroners and deputy coroners. The introduction of a Rules Committee was also recommended. Treasure trove should cease to be within the coroner's jurisdiction.
61. A Rules Committee has been established and a plan for the phased implementation of other changes is in preparation.

<sup>12</sup> [www.lawcom.govt.nz](http://www.lawcom.govt.nz)

<sup>13</sup> [www.justice.ie](http://www.justice.ie)

## Scotland

62. The death investigation arrangements in Scotland include some elements of the criminal investigation-based or “civilian” systems summarised in paragraphs 7-10 above.
63. The investigation of deaths is in the first instance the responsibility of the Procurator Fiscal who leads the investigation of crime including homicides and brings prosecutions.
64. However the range of deaths reported to and investigated by the Procurator Fiscal is considerably wider than would characteristically be handled by most of the other European systems and is comparable to the range handled in many coronial systems, at nearly 25% of all deaths.
65. The Procurator Fiscal investigates such reports in consultation with a pathologist or the police surgeon as necessary. In cases involving complex medical treatment issues the Fiscal may commission an independent review from a specialist. Witnesses may be interviewed and the family seen but the Procurator’s inquiry is not done in public.
66. At the end of the inquiry the Procurator Fiscal authorises the registration of the death, or makes a report to the Crown office where the Lord Advocate or one his deputies decide whether there should be criminal proceedings, a Fatal Accident Inquiry or no proceedings.
67. Fatal Accident Inquiries are held in the mainstream justice system by Sheriffs. They are statutorily required after deaths caused by accidents at work or the deaths of people in legal custody.
68. Otherwise they are at the discretion of the Lord Advocate who is guided by whether the case gives rise to serious public concern or it appears in the public interest to have a public judicial inquiry. The scale on which such inquiries are held is close to the scale of public inquests characteristic of most Canadian and Australian coronial jurisdictions.

## Role of Coroner Jurisdictions in Death and Cremation Certification

69. Generally speaking death investigation systems, whether coronial or Medical Examiner, have roles only in relation to deaths which are reported to them and have none in relation to deaths which are certified by doctors. Such scrutiny as there is of death certificates generally would be the province of the registration or statistical services.



70. However, it is of note that:
71. In *Ontario* and *Alberta* (which are both medically staffed services), information from all death certificates is sent periodically sent to the offices of the Chief Coroner and Chief Medical Examiner respectively where they are checked for apparent consistency and in particular to see whether they contain any evidence that the death should have been reported;
72. In those jurisdictions, the second certificates required before a body can be cremated are provided by the coroner/medical examiner service, rather than by any doctor of the first certifiers' choice.

AAIB	Air Accidents Investigation Branch
ACPO	Association of Chief Police Officers
AIDS	Acquired Immune Deficiency Syndrome
APIL	Association of Personal Injury Lawyers
APRIL	Adverse Psychiatric Reactions Information Link
AVMA	Action for Victims of Medical Accidents
BMA	British Medical Association
Brodrick Report	short for "The Report of the Committee on Death Certification and Coroners" which was chaired by Sir Norman Brodrick QC and which reported in November 1971
BSE	Bovine Spongiform Encephalopathy
CAJ	Committee on the Administration of Justice
CESDI	Confidential Enquiry into Stillbirths and Deaths in Infancy
CHAI	Commission for Health Audit and Improvement
CJD	Creutzfeldt Jacob Disease
CMO	Chief Medical Officer
CPS	Crown Prosecution Service
CRUSE	(not an acronym) name of a charity offering support to the bereaved
CRY	Cardiac Risk in the Young
Death Certificate	Copy which is given to the family of the unique entry in the register of deaths kept by the Registration Service (see also MCCD)
DH	Department of Health
DNA	Deoxyribonucleic Acid
DPP	Director of Public Prosecutions
ECHR	European Convention on Human Rights
FAIR	Families Acting For Innocent Relatives

Form 100A	Form issued to the Registrar by the Coroner to say that he does not consider it necessary to hold an inquest into a death that has been reported to him and the registration procedures may continue
Form 100B	Form issued to the Registrar by the Coroner to say that he does not intend to hold an inquest into a death but that a post mortem has been held and stating the cause of death as ascertained by that examination
FSID	Foundation for the Study of Infant Deaths
GOR	Government Offices in the Regions
GMC	General Medical Council
HSE	Health and Safety Executive
The Inquisition	The format prescribed in s.11 of the Coroners Act 1988 for recording the facts found by the inquest. It stipulates that these must be the name of the deceased; the cause of death; the place, time and circumstances of death; the coroner's conclusions; the particulars required by the registration legislation.
Juge d'Instruction	Term used in the French judicial system to describe 'the examining magistrate' who has fact-finding and investigatory powers to determine whether a criminal offence has taken place
LSHTM	The London School of Hygiene and Tropical Medicine
MAIB	Marine Accident Investigation Branch
MCCD	Medical Certificate of the Cause of Death. This is the form completed by the certifying doctor stating the cause of death and conveyed to the Registrar who uses it to complete the death certificate. The death certificate is the official and unique entry in the records kept by the Registration Service a copy of which is given to the family to keep.

## *Glossary*

ME	Medical Examiner
MPS	Metropolitan Police Service
MRI	Magnetic Resonance Imaging
NACOR	National Committee relating to Organ Retention
NCEPOD	National Confidential Enquiry into Peri-operative Deaths
NCSC	National Care Standards Committee
NHS	National Health Service
NICS	Northern Ireland Court Service
NIHRC	Northern Ireland Human Rights Commission
NISRA	Northern Ireland Statistics and Research Agency
NPSA	National Patient Safety Agency
NSPCC	National Society for the Prevention of Cruelty to Children
ONS	Office for National Statistics
PAPYRUS	Name of an organization founded by parents to prevent suicide amongst the young
PCA	Police Complaints Authority
PITY II	Parents who have Interred their Young Twice
Procurator Fiscal	The Procurator Fiscal Service is the sole public prosecuting authority in Scotland. There are 11 Area Procurator Fiscals and they conduct inquiries into all sudden deaths reported to them in their area.
Procureur	French judicial official who represents the interests of society as a whole in legal proceedings
QC	Queen's Counsel
RAID	Rigorous Analysis of Iatrogenic Death
Registrar General	Head of the Registration Service
RCN	Royal College of Nursing
RCP	Royal College of Pathologists
ROC	Retained Organs Commission
SAMM	Support After Murder and Manslaughter
SCARD	Support and Care After Road Death and Injury
SEAC	Spongeiform Encephalopathy Advisory Committee
SHA	Strategic Health Authority

SOBS	Survivors of Bereavement by Suicide
SPD	State Pathology Department
SSRB	Senior Salaries Review Body
WHO	World Health Organisation
Wright Committee	short for the "Report of the Departmental Committee on Coroners 1936" chaired by Lord Wright.

















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