

LONDON
SCHOOL of
HYGIENE
& TROPICAL
MEDICINE



LSHTM Research Online

McGowan, CR; (2012) Frustration of purpose: public health and the future of death investigation in England & Wales. PhD thesis, London School of Hygiene & Tropical Medicine. DOI: <https://doi.org/10.17037/PUBS.04651218>

Downloaded from: <http://researchonline.lshtm.ac.uk/4653923/>

DOI: <https://doi.org/10.17037/PUBS.04651218>

Usage Guidelines:

Please refer to usage guidelines at <https://researchonline.lshtm.ac.uk/policies.html> or alternatively contact researchonline@lshtm.ac.uk.

Available under license: Copyright the author(s)

<https://researchonline.lshtm.ac.uk>

Frustration of Purpose:
Public health and the future of death
investigation in England & Wales

Catherine R. McGowan

LONDON
SCHOOL *of*
HYGIENE
& TROPICAL
MEDICINE



Thesis submitted to the Faculty of Public Health and Policy
London School of Hygiene & Tropical Medicine
University of London
for the degree of Doctor of Philosophy

London, 2012

Frustration of Purpose:

Public health and the future of death investigation in
England & Wales

Catherine R. McGowan

SUPERVISORS

Professor Tony Barnett

London School of Economics and Political Science
London School of Hygiene & Tropical Medicine

Professor Gill Walt

London School of Hygiene & Tropical Medicine

EXAMINERS

The Right Honourable Lady Justice Smith

Professor Martin McKee

London School of Hygiene & Tropical Medicine

Professor David Hunter

Durham University

DECLARATION

I, Catherine Ruth McGowan, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Catherine R. McGowan

ABSTRACT

Coroners have existed since the 12th century when they were created to support itinerant judges and, thus, facilitate the levying of fines on people living in England and (following the Edwardian Conquest) those in Wales. Over the centuries, the medieval coroner lost this function and his descendants have, in spite of a long-standing lack of central guidance, been forced to reinvent the coronial identity and to discover a modern purpose. The coroner operates in the space between law and medicine. Consequently, the coroner has been forced to adapt to the development of medical science, the normalisation and codification of human rights, and the development of the theory and practice of public health. Recent scandals - most notably the inquiry into the crimes of Harold Shipman - have highlighted the shortcomings of the office and have resulted in calls for reform. Though there is clearly a case for change, and many have made specific suggestions as to how the office should be modernised, few have considered that what underlies many of the problems of the coroner system/office, and its anachronistic and atavistic nature is a fundamental lack of a responsible and logical purpose.

The study attempts to describe the problems encountered by the coroner in recent years, to provide a background to outline the coroner's evolution from the 12th century, and to pose the question: what, ultimately, is the purpose of the coroner? This study is based on a) qualitative interviews with coroners in England and Wales, b) qualitative interviews with professionals who encounter coroners through their work, c) observation of coroners during inquests, and d) a written submission to coroners requesting inquest data. Coroners were asked to state and describe their purpose - there was no consensus. Coroners described their purpose in one of six ways: to 'give families closure', to protect public health and safety, to discover homicide, to enforce Article 2 of the European Convention on Human Rights, to provide public reassurance, and to investigate the military. One coroner believed the question of purpose not to be germane. This study considers each response and attempts to come to an evidence-based, normative conclusion as to the purpose of the coroner. Some have suggested that the coroner's role is both complex and multifarious and should necessarily include several distinct purposes; however, in practice, these purposes often undermine and contradict each other. This study argues for a single, overriding purpose for the coroner. In addition, the work considers changes which might render the office capable of pursuing the normative purpose in a contemporary context in which our understanding of public health is more developed.

CONTENTS

FIGURES.....	viii
TABLES.....	viii
ABBREVIATIONS.....	ix
ACKNOWLEDGEMENTS.....	x
Chapter I: INTRODUCTION.....	1
THE CORONER SYSTEM IN ENGLAND AND WALES.....	5
THE PURPOSE OF THE INQUEST.....	7
THE LEGAL FRAMEWORK.....	8
SOCIAL RULES AND CONVENTIONS.....	10
WHAT IS GUIDING CORONIAL PRACTICE?.....	10
OTHER CORONER SYSTEMS.....	11
The Republic of Ireland.....	11
Australia.....	12
New Zealand.....	13
United States.....	14
Canada.....	15
RESEARCH APPROACH.....	17
STRUCTURE OF THESIS.....	17
FRUSTRATION OF PURPOSE.....	19
Chapter II: CREATION OF THE OFFICE OF THE CORONER.....	20
Norman Britain.....	22
The Third Crusade.....	23
Richard goes to jail.....	23
Itinerant judges and the coroner.....	24
Investigation of deaths.....	25
Lex murdrorum.....	25
The deodand.....	25
Trials by fire and water, approaching the bier, outlawries and abjurations.....	26
Chapter III: THE DECLINE OF THE IMPORTANCE OF THE CORONER.....	27
The justices of the peace and the escheator.....	29
The Coroners Act 1509.....	30
The Coroners Act 1751.....	31
Chapter IV: THE ADVENT OF MEDICO-LEGAL DEATH INVESTIGATION.....	33
The Victorian coroner.....	36

The Coroners Act 1887.....	41
The Coroners' Committee Report of 1910	41
The Coroners (Amendment) Act 1926.....	43
The Wright Report.....	43
The Coroners Rules 1953 and the Coroners Act 1954.....	46
Chapter V: THE CHANGING UTILITY OF CAUSE OF DEATH.....	48
THE MODERN EVOLUTION OF THE CORONER.....	50
The modern system in the UK and the British Isles	50
The Brodrick Report	50
The Coroners Rules 1984	55
The Coroners Act 1988.....	58
Chapter VI: CASE LAW.....	61
The coroner's jurisdiction	62
The public good	64
Matters to be ascertained	66
The European Convention on Human Rights	67
Chapter VII: THE MODERN IDENTITY CRISIS	75
The Allitt Inquiry.....	76
The Bristol Royal Infirmary Inquiry and the Royal Liverpool Children's Inquiry	77
The Clarke Inquiry	79
The Luce Review and the Shipman Inquiry.....	80
Chapter VIII: THE CORONER TODAY.....	90
THE SUB-CLINICAL VCJD SURVEY AND THE IMPLICATIONS OF CORONIAL AUTONOMY.....	91
THE CORONER AND JUSTICE ACT 2009	95
The coroner reform draft Bill.....	95
Welcoming the scrutiny.....	97
The Coroners and Justice Act	100
'BONFIRE OF THE QUANGOS'.....	102
THE GUIDE TO CORONERS AND INQUESTS.....	104
THE PUBLIC BODIES BILL 2010.....	105
Chapter IX: AN EMPIRICAL STUDY OF CORONERS TODAY	107
STUDY DESIGN.....	108
Pilot.....	112
STUDY AREA	112

Selection of the Study Area	113
Interviews	114
Coroner interviews.....	115
Non-coroner interviews	117
Inquests.....	118
Data request.....	119
DATA ANALYSIS	119
Triangulation.....	119
Framework analysis.....	119
Legal and jurisprudential content.....	121
REFLEXIVITY	121
LIMITATIONS OF THE RESEARCH METHOD.....	124
Scope of study	124
Representativeness and generalisability.....	125
Bias	126
ETHICAL ISSUES	127
Confidentiality	128
Anonymity.....	128
Chapter X: RESULTS	129
CORONER INTERVIEWS	130
Gender and Length of Service	130
Region.....	130
Full-time versus part-time.....	130
Qualification.....	131
Number of cases and inquests	131
PURPOSE	131
Families.....	133
Public health & safety.....	135
Detect homicide	137
Article 2	137
Public reassurance.....	138
Other.....	138
Investigating the military.....	138
No purpose	139

Negative statement of purpose	139
NON-CORONER INTERVIEWS	140
INQUESTS	141
DATA REQUEST	143
Open Verdicts.....	144
Narrative Verdicts.....	145
Chapter XI: DISCUSSION	147
CORONERS AND THEIR UNDERSTANDING OF PURPOSE	148
Providing a service to families.....	148
Public health and safety.....	154
Ruling out homicide.....	174
Article 2 of the ECHR.....	180
Public reassurance	184
Other	185
Military	185
Coroners need not have a purpose.....	186
LIMITATIONS OF THE PRESENT STUDY	186
Media attention.....	186
Changing policy environment	187
Difficulty in accessing information.....	187
Chapter XII: CONCLUSIONS	189
FRUSTRATION OF PURPOSE.....	190
Public health as a defining purpose	194
Chapter XIII: RECOMMENDATIONS.....	195
PUBLIC HEALTH AND THE FUTURE OF DEATH INVESTIGATION IN ENGLAND & WALES.....	196
Incorporate the coroner system into one of the branches of government	196
Formalise the purpose of the coroner as a facilitator of public health	198
Modify or implement specific practices to support a public health orientation	208
Establish an oversight council.....	215
Eliminate unjustified investigation of cases and submission of fees	216
Enforce Section 36(2) of the Coroners Rules 1984	217
Clarify the coronial status.....	217
Empower the bereaved	222
REFERENCES.....	224

FIGURES

Figure 1: Section from the Coroners Act 1509 describing the “inconvenience” and “great [an]noyance” caused by unburied bodies.....	30
Figure 2: Preamble to <i>A Bill for the Better Ordering of the Office of the Coroner</i> 1747-1749 which describes the decline of the office and the problem of remuneration of fees for coroners.	31
Figure 3: An inquest into the death of a young girl chaired by Coroner Wakley on 26 February 1844 at University College Hospital, London.	38
Figure 4: Coroner districts in England and Wales (2007). Reprinted from the Resilience Research Branch: London.....	116
Figure 5: The estimated average time taken to process an inquest (2004-2010). Reprinted from: <i>Coroners Statistics 2010</i> , Ministry of Justice Statistics Bulletin, 2011.....	164
Figure 6: Number of narrative verdicts: by year of death registration, 2001-2009. Reprinted from: Hill C, Cook L. <i>Narrative verdicts and their impact on mortality statistics in England and Wales</i> . Health Stat Q. 2011 Spring(49):81-100.	208

TABLES

Table 1: Percentage response by first or only stated purpose	132
Table 2: Percentage response by coroners by stated purpose	133

ABBREVIATIONS

BCC: Bristol City Council
 BCCS: British Columbia Coroners Service (Can)
 BMA: British Medical Association (UK)
 BRI: Bristol Royal Infirmary (Eng)
 CID: Criminal Investigation Department (UK)
 CMO: The Chief Medical Officer (UK)
 COD: Cause of death
 CSEW: The Coroners' Society of England and Wales
 DCA: Department for Constitutional Affairs (UK)
 DoH: The Department of Health (Eng)
 DsPH: Directors of Public Health (Eng)
 DTES: Downtown Eastside of Vancouver (Can)
 ECHR: European Convention on Human Rights
 FOI: Freedom of information
 GRO: General Register Office (Eng/Wales)
 HMP: Her Majesty's Prison (Eng/Wales)
 HPA: The Health Protection Agency (UK)
 ICD: International Classification of Diseases
 IRA: Irish Republican Army (NI)
 LSHTM: London School of Hygiene & Tropical Medicine (UK)
 MCCD: Medical certificate of cause of death
 MoJ: The Ministry of Justice (UK)
 NAO: The National Audit Office (UK)
 NCIS: The National Coroners Information System (Aus)
 NCEPOD: National Confidential Enquiry into Patient Outcome and Death (UK)
 NGO: Non-governmental organisation
 NHS: National Health Service (UK)
 NHSBT: NHS Blood and Transplant Authority (UK)
 NHSCR: National Health Service Central Register
 OCCO: Office of the Chief Coroner for Ontario (Can)
 ONS: The Office for National Statistics (UK)
 PCT: NHS Primary Care Trust (UK)
 QUANGO: Quasi-autonomous non-governmental organisation
 PHE: Public Health England (Eng)
 RUC: Royal Ulster Constabulary (NI)
 SADS: Sudden arrhythmic death syndrome
 SAS: Special Air Service (UK)
 SEAC: Spongiform Encephalopathy Advisory Committee (UK)
 vCJD: Variant Creutzfeldt-Jakob disease

ACKNOWLEDGEMENTS

First, and foremost, I would like to thank Professor Tony Barnett whose tutelage is, without any measure of doubt, the best thing that could ever happen to a PhD student. My eternal thanks Tony - I could not have done this without you. You inspire....everyone.

I am also greatly indebted to Professor Gill Walt for her guidance and support. Thank you so much. *Baie Dankiel!*

I will never forget how much I have been helped by Alistair Tait and Elaine Williamson in IT Training. You have both made more of a difference than you know. Thank you...

To Adrian Viens and his boundless intellect I thank you of course. You have been incredibly supportive and I am most grateful.

No PhD would ever be written in the Faculty of Public Health & Policy without the generous support of Arnab Acharya, Ben Armstrong, and - perhaps most of all - Susan Quarrell.

I would like to extend my thanks to those who took the time to talk with me. Many thanks to those at: Scotland Yard, the Health Protection Agency, the Department of Health, the Office for National Statistics, the Ministry of Justice, the Coroners Society of England and Wales, and the Coroners Officers Society.

Also to the incredible Dame Janet Smith and Mr. Tom Luce; I admire your vision, your probity and your devotion to making things better.

And, of course, much is owed to: Patricia Kingori for being simply extraordinary; Erin Minor for being eternally positive; Ben Brandon for his generous nature; Triantafyllos, Landon, Greg, René, Edith, Andrew, Anna and Altynay for offering vicarious genius; to José for his password; Sloan for coming to visit; Ursula for being eternally wise; Erling for knowing important things; and Major Leslie Kelly for making sense of it all.

To Primo Levi for surviving to give us all some much needed perspective.

To the coroners themselves who were so extraordinarily kind, patient and temperate in the face of difficult questions. It is not easy to do what you do....I know this.

I was so very fortunate to be awarded a scholarship from the Canadian Centennial Scholarship Fund. To those on the committee, I am most honoured....

And, of course, to mum...

Catherine R. McGowan
London
11 November 2011

Chapter I: INTRODUCTION

It is doubtless of absolute Necessity for the [coroner] to have some Knowledge in the Nature and Theory of his Duty, previous to the Practice of it; as the Practice, without the Theory, is but a partial and imperfect Use, leading rather into Error and Confusion, than a due and just discharge of the Care. Error begets Error, and it is certainly owing to a defective, unintelligible Practice, that the Office is now so meanly and contemptibly looked upon, and that its antient State and Dignity is now lost, by Inattention or Misconduct.^{1, p. v-vi}

Edward Umfreville, London, 1761

Death investigation systems (*e.g.* coroner, medical examiner and procurator fiscal systems) are responsible for collecting information about deaths for the purpose of determining the cause and/or circumstances of death on behalf of the state. They are often responsible for the certification of the cause of death and have jurisdiction over post-mortem material. Thus, medico-legal death investigation provides important data which often form an essential part of mortality studies (and, occasionally, morbidity studies).

The coroner system in England and Wales has evolved over centuries. The system was created during the reign of Richard I (1189-1199) in response to dwindling financial resources which were the inevitable result of Richard's incessant warmongering, first on the Third Crusade, and later against Phillip II of France. The coroner's original purpose was to facilitate the levying of fines upon the people by local judges and the investigation of death was undertaken almost exclusively for this purpose. Although the power and influence of the coroner has waxed and waned over the centuries the office still exists, despite the fact that the original purpose of providing financially for the Crown has long since disappeared. The coroner is still with us, and is still carrying out some of the tasks with which he was originally charged back in the 12th century; however, in modern times little consideration has been given to establishing the coroner's purpose.

The fact that the office of the coroner has not kept pace with the times and may not be providing a valuable service, has been pointed out by every formal review of the system.²⁻⁵ On 1 February 2000 the Secretary of State for Health in the UK announced that an independent inquiry would take place to consider the extent of the crimes of Harold Shipman who had, on 31 January 2000, been convicted on 15 counts of murder - a fraction of the nearly 215 murders that he was thought to have committed between 1975 and 1998.⁶ Additionally the Shipman Inquiry was to consider the actions and performance of

organisations intended to investigate deaths. The Third Report of the Shipman Inquiry titled *Death Certification and the Investigation of Deaths by Coroners* considered the role of coroners in England, Wales and Northern Ireland and concluded that the death certification and investigation system, "...does not contribute, to the extent that it should, to the improvement of public health and safety".^{5, p. v} Dame Janet Smith, the chairperson of the Inquiry, would ultimately conclude that the coroner system was in need of "radical reform", reform which required a "complete break with the past, as to organisation, philosophy, sense of purpose and mode of operation".^{5, p. 25}

In July 2001 the Home Office announced it would be conducting its own review of the death certification and investigation systems in England, Wales and Northern Ireland. This review, commonly termed *The Luce Review*, was published in 2003 and identified 15 "critical defects" of the death investigation and certification systems including the fact that: "there is no clear modern legal base for the conduct of most death investigations", "there are no mechanisms encouraging the systems to adapt and to develop in accordance with emerging needs", and "there are no agreed objectives or priorities".^{4, p. 18} The Luce Review suggested six major changes to the system, the third of which states that an improved system should, "...work effectively across the full range of public health and public safety".^{4, p. 22}

Despite these very public acknowledgements that the coroner's role in no small part involves the protection of public health, coroners in England and Wales continue to struggle to identify with this mandate. In July 2007 the Chief Medical Officer, Sir Liam Donaldson, requested participation by coroners in a nation-wide public health measure to determine the sub-clinical level of variant Creutzfeldt-Jakob (vCJD) in England and Wales. The coroners declined to participate in this study claiming that it was beyond their remit and, in so doing, not only failed to support a public health initiative but, in effect, acted as an obstruction to it.⁷⁻¹²

In addition, there has been recent criticism of coroners who do not render verdicts of suicide, preferring instead to conclude a suicide inquest, where it appears highly likely that a person has deliberately taken their own life, with an open verdict^{4, 13, 14} or by documenting the circumstances of the death in the form of a vague and inconclusive narrative verdict.¹⁵
¹⁶ It has been suggested that this practice is an attempt to spare families the shame and stigma of a suicide verdict^{4, 14, 17}; however, this practice is clearly contradictory to, and undermining of, public health as it obscures suicide data and possible contributory factors

which, if considered in aggregate, might indicate areas for further investigation with respect to matters of public health.

[The Office for National Statistics (ONS)] estimates that if all deaths from hanging and poisoning given narrative verdicts by coroners and coded as accidents by ONS were, in fact, suicides, the 2009 suicide rate would have been underestimated by 6% - a difference equivalent to almost a third of the National Suicide Prevention Strategy's 20% reduction target. This may be a conservative assessment because the ONS's analysis did not include other common methods of suicide, such as drowning and jumping.^{16, p. 2}

In spite of the fact that coroners do render open or narrative verdicts in cases in which the death was patently the result of suicide, it may still be possible for researches to collect information on such deaths from coroners' files; however, there is a great deal of variation in the data collected by coroners, and they are under no obligation to share information they have collected for the purpose of holding an inquest.¹⁷

According to the Coroners Rules 1984, coroners are forbidden from expressing any opinion about an inquest beyond the matters to be ascertained at inquest (namely, the identity of the deceased and how, when and where the deceased came by his/her death^{18, section 36}); however, it is not uncommon for coroners to make statements regarding inherently political matters of public health and safety.¹⁹⁻²² These statements rarely reflect or make reference to the evidence-base²³, may mis-construe causation²⁴⁻²⁶, are often based on exceptional cases²³, and are arguably always beyond the expertise of the coroner to comment on accurately.^{23, 27} Coroners have also expressed their own subjective opinions about the circumstances of particular deaths.^{25, 28} Additionally, the coroners' power to determine what is a 'natural' and 'unnatural' death can be socially pernicious and stigmatising as was clearly the case in the mid-1990s when it was the practice of the then coroner for Exeter to consider all HIV deaths to be natural, unless they were the consequence of anal sex or needle sharing, in which case it was his practice to deem them 'unnatural' and, in doing so, assume jurisdiction (necessitating an investigation representing a considerable invasion of privacy followed by a potentially humiliating public inquest).²⁹

Coroners have long argued that they are underfunded, a fact confirmed by both the Shipman Inquiry and the Luce Review. Regardless, the system as it now operates represents a considerable expense to the local authorities and, to a lesser extent, the police

authorities, which assume financial responsibility for coroner's officers in many jurisdictions. Neither the Ministry of Justice nor the Coroners' Society of England and Wales (CSEW) collect data nationally on the cost of the coroner system. Though I have made repeated requests to the Secretary of the CSEW to disclose the operating costs for his region, he would not provide them claiming that he did not have access to the figures and that funding for coroners is complex and diverse. It is thus not possible to detail the cost of the system either in whole or in part.

The coroner system in England and Wales has recently undergone limited reform which has been carried out partly in response to the failings of the system discovered by the Luce Review and the Shipman Inquiry. Both the Review and the Inquiry acknowledged the public health role of coroners, in addition to proposing that the system be reformed in such a way as to strengthen the capacity of coroners to support public health; however, the system as defined in the new Coroners and Justice Act 2009 still does not make formal reference to this fact and conspicuously lacks any provisions for public health oversight.³⁰ The extent of the reforms as detailed in the Coroners and Justice Act 2009 are minimal, do not address the bulk of the recommendations put forth in the Luce review and the Shipman Inquiry and, on the whole, are unlikely to be effective in promoting any substantive change. Though there is a compelling public health case for extensively modernising the coroner system in England and Wales, the global economic crisis has muted much of the political will to do so.

THE CORONER SYSTEM IN ENGLAND AND WALES

Coroners are self-described as independent judicial officers^{31,32} (though the Constitutional Reform Act 2005³³ makes no mention of coroners) who have jurisdiction within the region to which they are appointed. Coroners are hired and funded by the local authority but are linked to central government through the Ministry of Justice* which has no authority to direct coroners in the exercise of their statutory duties. Under exceptional circumstances coroners may be removed from their position by the Lord Chancellor as per Section 3(4) of the Coroners Act 1988.³⁴ There is currently no system of oversight and accountability, no leadership, and no mechanism for quality assurance within the coronial system. There is no code of ethics for coroners and no system of censure. Coroners are required to be solicitors, barristers or they may be medically qualified. The majority of coroners are legally

* In 2005 the Department for Constitutional Affairs (DCA) assumed responsibility for coroners from the Home Office. In 2007 the DCA was expanded and renamed the Ministry of Justice.

qualified; of the few who hold a medical degree most are dually qualified. Once the Coroners and Justice Act 2009 is implemented all subsequently appointed coroners will be required to have a legal qualification.

Though coroners do decide which witnesses are to be called to court, they do not generally collect evidence themselves (this is the responsibility of the police and/or the coroner's officer). Coroners very rarely attend scenes of death, and many coroners have never done so. Neither do the majority of jurisdictions require that the coroner's officer visit the scene. Of the 33 coroners interviewed for this thesis only two required that their officers attend scenes of death. It is usually the case that all of the information collected at scenes of death is collected by the attending police officer(s).

In England and Wales all deaths must be registered by the Registrar of Births, Deaths and Marriages. In order to register a death, the Registrar requires a medical certificate of cause of death (MCCD). The MCCD can only be completed by a physician or a coroner. In many cases the coroner need not be notified of a death as the physician may complete the MCCD if s/he cared for the deceased during his/her last illness[†], or if the physician viewed the body after death and was satisfied as to the cause of death. In 2010 physician certified deaths completed without contacting the coroner represented 53% of the total number of registered deaths.³⁵ The remaining 46.8% (N=230, 595[‡]) of deaths are referred to the coroner either because they do not meet the above criteria or because the death is believed to have been the result of a cause which the coroner is mandated to investigate (including all violent, unnatural[§], sudden deaths and all deaths that occur in custody). Of the 46.8% of registered deaths referred to the coroner in 2010, 54.3% (N=125, 265) were certified following advice on certification from the coroner without formal action by him/her^{**}, or following a cursory investigation by the coroner who then issued a Form 100A indicating that the death was registered by the physician "after formal reference to the coroner".^{4, p. 12}

In 2010 a total of 101, 943 post-mortems were held in England and Wales.³⁵ Section 19 of the Coroners Act 1988 states that, upon being notified of a sudden death for which the cause is unknown, the coroner may order a post-mortem if, in his or her opinion, the information gathered at the post-mortem may prove an inquest to be unnecessary.³⁴ In 2010 inquests were dispensed with in 32.3% (N=74, 542) of all referred cases following

[†] Provided the physician had seen the deceased at some point during the 14 days prior to his/her death.

[‡] These data are from 2010.³⁵

[§] There is no statutory definition of 'unnatural' deaths.

^{**} In most cases it is the coroner's officer 'advising' on certification.

post-mortem examination.³⁵ In such cases the coroner then completes a Form 100B so that the death can be certified. In the remaining cases the coroner will hold an inquest. In 2010 inquests were held on 13.4% (N=30, 788) of the total number of cases referred to the coroner. In the majority of inquest cases (89.0%) a post-mortem was held.

Under the Coroners Act 1988³⁴ as well as the Coroners Rules 1984¹⁸ the coroner is to hold an inquest (*i.e.* a formal inquisitorial hearing) in cases where someone has died a “violent or unnatural death”, a “sudden death of which the cause is unknown” or has died in prison.³⁴

Section 8(1) Coroners are also required to hold an inquest with a jury when the death has occurred in custody, when the death was “caused by an accident, poisoning or disease notice of which is required to be given under any Act to government”^{34, Section 8(3)(c)}, or when “the death occurred in circumstances the continuance or possible recurrence of which is prejudicial to the health or safety of the public or any section of the public”.^{34, Section 8(3)(d)}

The inquest is intended to offer a public means through which to answer the questions pertaining to the death as per the Coroners Act 1988: those questions include establishing the identity of the deceased, and determining when, where and how the deceased came to be dead. Rule 36 of the Coroners Rules 1984 expressly forbids either the coroner or the jury from offering any opinion on any other matters. The inquest is intended to be a solely inquisitorial (*i.e.* not adversarial) undertaking although this is not always the case in practice. Once the inquest is complete, the coroner can complete the MCCD. All inquests, regardless of circumstances, are open to the public - this includes the media. Information regarding the deceased and the deceased’s medical history is often read out in court. The extent to which information is made public during the inquest is at the discretion of the coroner. Though the relevant legislation (*i.e.* the Coroners Act 1988 and the Coroners Rules 1984) define what is to be determined at an inquest, neither piece of legislation defines the purpose of establishing these facts.

THE PURPOSE OF THE INQUEST

In a 1913 article published in *The Lancet*, Dr. William Brend, speculated that the lack of uniformity of practice among coroners had arisen in, “...the absence of any clear indication as to the fundamental purpose for which a coroner holds an inquest”.^{36, p. 1404} Dr. Brend further stated that, “...it is literally impossible to answer the question, *Why does a coroner inquire into a death?*”.^{36, p. 1404} By 2003 - nearly a century later and after two major reviews and five significant legislative changes to coronial law - the question had still not been answered, a fact noted by Dame Janet Smith in the Shipman Inquiry:

It is possible to infer from [the Coroners Act 1988] and from [the Coroners Rules 1984] that the function of an inquest is to discover, in the case of a violent or unnatural death, a sudden death of which the cause is unknown or a death in prison, who the deceased was and how, when and where s/he came by his/her death. The inquest will also seek to establish the particulars required for the registration of the death. However, these provisions throw little light on why it is thought desirable to discover these facts...^{5, p. 213}

That both Dr. Brend and Dame Janet Smith were specifically addressing the lack of formal purpose of the *coroner's inquest* might give the impression that carrying out inquests is the coroner's sole function; however, as inquests are held in a relatively small number of the total referred cases, it is perhaps unhelpful to limit the mandate of the coroner solely to this aspect of his/her work. In fact, the Explanatory Notes accompanying the Coroners and Justice Act 2009 acknowledge that the preceding act, the Coroners Act 1988, was drafted "almost exclusively in terms of inquests to refer to coroners' work" and that this did not recognise that, "a significant amount of work goes on which does not lead to court proceedings".^{37, section 5}

Though inquest proceedings may demand a disproportionate amount of the coroner's time relative to those cases in which an inquest is not held, this should not imply that defining a purpose for the inquest alone is sufficient, as there must be a comprehensive defining purpose for the coroner and the inquest should be seen as merely one of many means through which the coroner achieves that purpose. A more meaningful inquiry would be to explore the question of what precisely is *the purpose of the coroner*. This question is perhaps complicated by the coroner's atavistic duties including holding inquests on treasure trove. It would be impossible, for example, to make a blanket statement about the coroner's duty to support public health as determination of treasure trove renders such statements problematic.

THE LEGAL FRAMEWORK

Lord Widgery noted in his ruling on *R v Bristol Coroner ex p Kerr (1974)*³⁸ that it is not possible to ascertain the powers and duties of a Coroner by simply looking at a statute or statutory instrument - a fact which Lord Justice Clarke deemed, "...profoundly unsatisfactory, especially since the common law is in some respects far from clear".^{39, p. 119} Case law is not only deficient in terms of outlining the coroner's powers and duties, but has

also been remiss in defining a foundational purpose for the office. This problem of lack of formally legislated purpose is not unique to the coroner system; in fact, this reluctance to codify a purpose in law is indicative of other governmental organisations which exist in the common law system. For example, Lord Carrington recently raised precisely this issue with regard to the purpose of the House of Lords:

One of the problems about reform of the House of Lords has always been, in my view, that people start from the wrong end. They always start about how should it be composed and they never ask themselves what they want it to do. And, it seems to me, that you should start by saying what you want a second chamber to do, then compose it in the best possible way, to perform that task. We've never really done that - we've gone on and on about the hereditary system and life-peers and all the rest of it and never asked what you wanted it to do. It's quite wrong...⁴⁰

It may well be a feature of these ancient British institutions^{††} that, having lost their original purpose, they still remain, in perpetuity, without any guiding purpose owing to the lack of pressure to codify such principles. As coroners do not exist in Europe outside of the British Isles there has been no impetus for European Union law to define a coronial purpose; in fact, European Union law does not regulate death investigation at all.^{‡‡}

The current legislation and legislative instruments - though arguably enabling of a public health purpose - do not make any prescriptive claim to a purpose of the coroner. Common law has decreed that the coroner's inquest is a sufficiently independent inquiry to meet the provisions of Article 2 (*i.e.* the Right to Life) protection to the right to life) of the European Convention on Human Rights; however, as these Article 2 cases represent a fraction of the total number of cases, the vast majority of a coroner's duties remain without formal declaration of purpose.

The primary statutes and statutory instruments governing coroners in England and Wales include: the Births and Deaths Registration Act 1953⁴², the Coroners Act 1988³⁴, the

^{††} Incidentally, the coroner system is considerably older than the House of Lords which wasn't formally distinguished from the Commons until 1341, or formally referred to as the House of Lords until 1544.⁴¹

^{‡‡} There is no explicit mention of death investigation in EU law. However, the right to life provision of Article 2 of the European Convention on Human Rights which, though it does not specify that an effective death investigation be in place to investigate violations of Article 2, does provide the foundation for the common law interpretation of this provision as conferring a positive obligation to have in place an effective system for the investigation of deaths at the hands of state agents. Thus, EU law enables this interpretation, but does not explicitly call for it.

Coroners and Justice Act^{§§} 2009⁴³, the Cremation act 1902⁴⁶, and the Treasure Act 1996⁴⁷. The primary statutory instruments governing coroners in England and Wales include: the Registration of Births and Deaths Regulations 1987⁴⁸, the Coroners Rules 1984¹⁸ and the Cremation Regulations 1930⁴⁹. Though many of the duties of the coroner are laid out in the legislation, no explicit purpose is indicated.

The principles of equity do not help to establish a purpose for the coroner and, though there is a body of common law, no purpose has been made explicit in case law beyond the ruling that the coroner's investigation, in part, meets the positive obligation (on member states of the Council of Europe) to have in place a system which is able to effectively investigate deaths resulting from the use of force (*i.e.* perpetrated by an agent of the state).⁵⁰

Ultimately, the current legal framework does not explicitly define the purpose of coroners. Michael Burgess, the coroner for Surrey, while giving evidence to the Constitutional Affairs Committee in 2006 stated that, "...it is necessary to understand what the coroner's function is and currently in statute that is not clear. All we have got is that we are to hold inquests and those inquests are expected to find certain things as proved or not as the case may be".^{51, ev 1} Though the legislation is, arguably, enabling (in that it does not identify and prohibit any principles of action, and it is sufficiently vague as to allow the coroner a certain latitude in terms of practice) it does not offer any guidance to coroners, or the general public, as to what purpose coroners are meant to serve.

SOCIAL RULES AND CONVENTIONS

Though not legally binding, social rules and conventions can guide practice insofar as they are shared and followed. Even though a conventional purpose might not be binding in law, it can effectively define both principles and practice; however, this presupposes a shared and concurred understanding of such principles and practices. As this thesis will show, there is no shared understanding of the coronial purpose among coroners, thus, no conventional purpose can be said to exist.

WHAT IS GUIDING CORONIAL PRACTICE?

What then is guiding coronial practice? It is perhaps unsurprising that in the absence of some formative statement of purpose there is no consistent understanding among coroners

^{§§} The Coroners and Justice Act 2009⁴³ is to be implemented gradually as per the Ministry of Justice implementation schedule.⁴⁴ The implementation of the section of the Act relating to coroners has been problematic owing to the abolishing of certain components of the Act by the Public Bodies Bill.⁴⁵

as to their purpose. Nor, as has been repeatedly pointed out, is there a uniformity of practice^{4,5} as the Chair of the Bristol Royal Infirmary Report noted: “[c]oroners in effect, operate fiefdoms. They exercise considerable discretion and display little uniformity of practice....”^{52, p. 18} When asked to comment on their purpose coroners indicate that they are meant to: provide a pastoral service to the bereaved, investigate cases of potential violations of the European Convention on Human Rights, rule out homicide, to provide public reassurance or, finally, to protect public health and safety. There is no consensus among coroners as to purpose and no clear indication of an association between: qualification (medical or legal), years of practice, gender, status (in terms of part-time/full-time), region, or the number of cases/inquests the coroner performs and their putative purpose.

OTHER CORONER SYSTEMS

There is no precedent from which to establish what the coroner’s purpose is, as the system in England and Wales was the first coroner system and has long pre-dated systems elsewhere. In fact, all modern coroner and medical examiner systems are descendent, and in that sense, derivative of, the system in England and Wales. Coroner systems currently exist in: the Republic of Ireland, the United States (in some jurisdictions), Canada (in some jurisdictions), Australia, New Zealand, Nigeria, Papua New Guinea, Fiji, Vanuatu, India (in some jurisdictions), Hong Kong, Singapore and Malaysia. By way of comparison, some of these other systems demonstrate explicit commitments to supporting public health.

The Republic of Ireland

The coroner system in the Republic of Ireland has long resembled that of England and Wales. The statute currently governing Irish coroners is the Coroners Act (Ireland) 1962.⁵³ The first, and only, comprehensive review of the system occurred in 2000; the Department of Justice, Equality and Law Reform Working Group concluded that, “...radical reforms are indicated” and that “unattended historical evolution” would have to give way to the creation of a modern system.^{54, p. i} The Working Group emphasised that “... it is critical to focus on the fact that the coroner system is a service for the living”.^{54, p. i} In response to the Report the government drafted the Coroners Bill 2007⁵⁵ which outlined legislation for the creation of an integrated service, the *tSeirbhís Chróinéara* (the Coroner Service), with an extended statutory remit which would better enable the new service to serve the public.⁵⁵

The Bill includes a formal declaration of the purposes of the new service; the purposes of the coroner are, in part, to:

- provide a national service for coroners' investigations and inquests,
- liaise efficiently and sympathetically with bereaved families and interested persons involved in an investigation or inquest,
- where relevant to a reportable death, liaise with any statutory body involved in the investigation of accidents, incident or diseases,
- contribute to the enhancement of public health and safety^{55, section 9}

The bill lapsed as a consequence of the change in government in 2011, though there has recently been pressure to reintroduce the bill to Parliament for consideration by the current government.⁵⁶

Australia

The Coroner system in Australia is similar, in many respects, to that of England and Wales in terms of the judicial status of the coroner and the procedure for executing death investigations. Each state/territory operates a distinct coroner system regulated by local legislation.

Between 1 January 1980 and 31 May 1989 there were 99 deaths involving Aboriginals in prison, police or juvenile detention institutions in Australia.⁵⁷ In October 1987 a Royal Commission was established in response to widespread concern that a number of these deaths may have been the consequence of foul-play. In 1991 the findings of the Royal Commission into Aboriginal Deaths in Custody were published and included 339 recommendations.⁵⁸ One such recommendation was that the Coroner's Offices in all States and Territories, "...establish and maintain a uniform database to record details of Aboriginal and Non-aboriginal deaths in custody" and that the Offices liaise with "others as may be authorised to compile and maintain records..."^{58, r. 40} In 1991 the Australian Coroners' Society was formed and in 1993 the Society proposed the creation of a national database which not only addressed the recommendation of the Royal Commission but included within its purview all deaths in Australia and not just deaths in custody.⁵⁹ Following a lengthy period of consultation the National Coroners Information System (NCIS) was established in 1997 and was officially launched in July of 2000 with support from: the State and Territory Departments of Justice, a number of Commonwealth government agencies, Monash University, the Victorian Institute of Forensic Medicine, the

National Injury Surveillance Unit, the Australian Institute of Health and Welfare, and the Australian Coroners' Society.⁵⁹ Coroners in the State of Victoria are supported by the Coroners Prevention Unit⁶⁰ comprised of a multidisciplinary team, "trained in medicine, law, public health and the social sciences that assists coroners with their prevention role".^{61, p. 7}

A 2011 article by Bugeja *et al* aimed to examine the nature of coroners' recommendations in the State of Victoria, and to consider whether or not these recommendations were consistent with public health principles of injury causation and prevention (*i.e* were they based on a scientific assessment of population burden, risk factors, countermeasures, and programme implementation).⁶¹ The study, which the authors describe as "the first to quantify and examine the nature of coroners' recommendations from a public health perspective" found that "overall coroners' recommendations were not systematically consistent with public health principles."^{61, p. 6} In addition, coroners recommendations most often include the following elements: 'countermeasures', 'level of intervention', and 'strategy for implementation'; however, the means through which these elements were addressed "were at the lower end of the recognised spectrum of effective injury prevention strategies, relying on repeated human interpretation and application".^{61, p. 6} Further, the authors claim that, as coroners are not qualified or trained in public health they may not appreciate the value in recommending targeted interventions and those which identify risk or contributory factors.

New Zealand

In 1999 the Law Commission of New Zealand, prompted by concerns about the coroner service raised during consultation with the Māori for its Succession Law project, released a discussion paper proposing amendments to the existing Coroners Act (NZ) 1988.^{62, 63} In considering the purpose of coronial inquiries the Commission concluded that:

The underlying objective is to allow dangerous or negligent practices that have cost human lives to be identified and then modified or eliminated. These interrelated aims provide the foundations of twentieth century coronership.^{63, p. 1}

The Law Commission's Report advocated a significant reorientation of the system in New Zealand including the establishment of a National Coronial Surveillance System based on the Australian NCIS.⁶⁴ It was also suggested, by the Office of the Privacy Commissioner, that sensitive information in the possession of the coroner be restricted to those with a

“need to know, according to the purposes for which inquests are held”^{***} - health and safety research agencies are identified as parties with an appropriate “need to know”.^{64, p. 142} Subsequent legislation in the form of the Coroners Act (New Zealand) 2006⁶⁵ was based on the recommendations of the Law Commission report. The Act includes an explicit statement as to the coronial purpose which includes three interrelated purposes to: establish the facts pertaining to a death; to “make specified recommendations or comments that, in the coroner's opinion, may, if drawn to public attention, reduce the chances of the occurrence of other deaths”; and to “determine whether the public interest would be served by the death being investigated by other investigating authorities” and to “refer the death to them if satisfied that the public interest would be served by their investigating it”.^{65, section 4(2)}

It is not currently mandatory for agencies to respond to coroner recommendations though there has been recent pressure from Neil Maclean, the Chief Coroner for New Zealand, to do make responses obligatory under the law and to implement a policy of “naming and shaming” those who fail to do so.⁶⁶ On 15 May 2012 the New Zealand Law Foundation announced that Otago University researchers were working on a “major new study” to determine “the extent to which [coroners] recommendations are being taken up [and] if they're not why and what should be done about it”.⁶⁷ The results of the study are expected to be made public in late 2015.⁶⁷

United States

The position of coroner was exported to the colonies as a component of British common law and was well established (and some might add well corrupt) by the mid-19th century.⁶⁸ In 1877, in response to growing criticism with regard to the competence and integrity of coroners, Massachusetts passed legislation to create the office of the Medical Examiner which was to be staffed by physicians who would assume the medical functions of the coroner, while the district attorney would assume the coroner's legal duties. Several, municipal governments would soon follow suit with Cleveland (1914), New York City (1915), Chicago (1922) and Newark (1927) all instituting Medical Examiner systems to replace the existing coroners.⁶⁸ By 2007, 31% of counties in the United States were served by medical examiner systems.⁶⁹ Currently 8 states operate a coroner system, 22 a medical

^{***} The purpose for the inquest was identified by the Law Commission as, “[m]aking any recommendations or comments on the avoidance of circumstances similar to those in which the death occurred, or on the manner in which any persons should act in such circumstances, that, in the opinion of the coroner, may if drawn to public attention reduce the chances of the occurrence of other deaths in such circumstances”.^{64, p. 115}

examiner system, while 18 operate hybrid systems.⁷⁰ Reports released in 1928⁷¹ (by the National Research Council), 1954⁷² (by the National Conference of Commissioners on Uniform State Laws), and 2009⁷⁰ (by the National Academy of Sciences) all recommended that the office of the coroner be abolished and replaced with medical examiners. Despite a surge in conversions to medical examiner systems between 1960 and 1989, the trend slowed in the 1990's owing to, "...legislative, political, geographical, financial, population-based, and physician manpower distribution factors".^{69, p. 279}

In a recent Frontline documentary titled *Post Mortem: Death Investigation in America*, former San Antonio medical examiner, Dr. Vincent Dimao, stated that, "the major problem in this country is the coroner system".⁷³ Dr. Marcella Fierro, a former pathologist and member of the National Academy of Sciences Committee that recommended the coroner system be abolished⁷⁰, addressed the question of whether the coroner system was an appropriate means through which to investigate deaths stating, "I guess you have to ask yourself, do you want your cause of death, your manner of death to be decided by someone in medicine who has special competency to do that, or [do you want to] take your chances?".⁷³ Dr. Fierro went on to note, "I am not anti-coroner, I'm pro-competency".⁷³

Between 1986 and 2005 the US Centers for Disease Control and Injury Prevention operated a Medical Examiner and Coroner Information Sharing Program (MECISP) which was intended to, "...facilitate communication among death investigators, the public health community, federal agencies, and other interested groups".^{74, p. 531} In 2005 funding for the MECISP was withdrawn and the program discontinued.⁷⁰

Canada

In Canada death investigation is the purview of the provincial and territorial governments. Of the 13 provinces and territories, 4 provinces are served by medical examiner systems. Of the remaining 9 provincial/territorial coroner systems only 2 (Ontario and Prince Edward Island) require that coroners are qualified physicians. In Québec coroners are not required to be physicians, though most are. The remaining provinces operate lay services. In 2009, Dr. John Butt, the former Chief Medical Examiner for Alberta and Nova Scotia, recommended that British Columbia abandon the coroner system in favour of a medical examiner system.⁷⁵

In response to a series of serious breaches of justice regarding the handling of criminally suspicious paediatric deaths in Ontario the *Inquiry into Paediatric Forensic Pathology* (a.k.a. The

Goudge Inquiry) was formed and, in 2008, it produced four substantial reports.⁷⁶⁻⁷⁹ The reports were critical of the handling of paediatric cases by the Office for the Chief Coroner for Ontario (OCCO)^{†††} and recommended a series of changes intended to enhance oversight and accountability of the OCCO.⁷⁹ The OCCO has also produced a Code of Ethics for Coroners which reads:

Coroners shall accept their share of professional responsibility towards society in relation to matters of public health, health education and legislation affecting the health and well-being of the community.⁸⁰

Similarly, Section 9 of the *Code de déontologie des coroners* in Québec states:

Le coroner doit témoigner, dans l'exercice de ses fonctions, d'un constant souci du respect de ses devoirs de protection de la vie humaine.^{81†††}

In 2011 the British Columbia Coroners Service (BCCS) was the subject of an audit as mandated under the Auditor General Act 2003.⁸² The audit was intended to assess whether the system "...is meeting its mandate in an efficient, effective, timely, and independent manner".^{82, p. 3} The first of the Auditor General's eight recommendations was that the system, "develop a strategic plan, endorsed by ministry executive, that defines the service's role in preventing deaths and supporting public safety and includes strategies for fulfilling that role".^{82, p. 9} The report also recommended that the BCCS monitor the impact of its recommendations and public reports, particularly with respect to the benefits to public safety and the prevention of deaths. The BCCS has yet to make public a strategic plan for realising this recommendation. The BCCS continues to produce reports and public safety bulletins; however, it is difficult to determine the usefulness and effectiveness of such reports. The data that the BCCS produces is numerator data only and is not suitable for issuing recommendations. Though the BCCS is a supplier of data it is unclear who decides what data is released, to whom, and in what time-frame.^{§§§}

In 2010 Statistics Canada, the federal agency responsible for national statistics, established the Canadian Coroner and Medical Examiner Database (CCMED) in cooperation with all 13 provincial and territorial death investigation systems.⁸³ The data collected are extensive

††† The motto of the Office for the Chief Coroner for Ontario is "to speak for the dead to protect the living".
 †† In the performance of his duties, a coroner shall show constant concern to respect his duties toward the protection of human life.

§§§ I requested some very simple data from the BCCS on 2 February 2012 as per the directions for requesting data on the BCCS website. It has been four months and they have yet to respond in any manner despite repeated attempts to follow-up.

and include, “all deaths of Canadian residents and non-residents in Canada for which a coroner's or medical examiner's investigation was conducted”.⁸³ The first Annual Report was published on 9 February 2012 and includes national data from 2006 to 2008.⁸⁴ The report states that the information “...will be significant in the CCMED’s ultimate goal - the contribution to a decrease in preventable deaths in Canada”.^{84, p. 3}

RESEARCH APPROACH

Coroners disagree about nearly every aspect of their work and yet the nearest they come to a consensus is in their contention that the system does not operate as well as it should or for the benefit of society. There is broad consensus among coroners that the recent reform initiatives set out in the Coroners and Justice Act 2009 are a missed opportunity to modernise the system. There is evidence that the system is under-funded and under-resourced but without a clear idea of what the system should be funded to do there is little to motivate any changes to the current funding arrangements.

What follows is an empirical, predominantly descriptive, qualitative study based on semi-structured qualitative interviews, observation of coroners at inquests, and inquest data which, in effect, amounted to a survey insofar as it was intended to test the hypothesis that coroners do not cooperate when asked to produce information for public health purposes. Information was not only triangulated and contextualised using several types of data, but also by interviewing a purposive selection of individuals who work with coroners (or with the data they produce) including employees of the: Office for National Statistics, the Metropolitan Police, the Ministry of Justice, the Department of Health, the National Health Service, the Health Protection Agency, the Medical Research Council and the Coroner’s Officers Association. Two experienced barristers in private practice were consulted on various matters relating to public law, coronial law, human rights law and public health law - both barristers were also asked for comment because of their extensive experience acting as advocates for families at inquests. The study uses an inductive approach and is based upon framework analysis as described by Ritchie and Spencer (1994) in the context of applied policy research.⁸⁵

STRUCTURE OF THESIS

This thesis is structured to explain: what coroners believe their purpose to be, what factors may underlie the coroners’ understanding of their purpose, how coroners’ beliefs about their purpose are manifest, what is an appropriate purpose for the coroner, and how the

system could overcome the problems identified in the study in order to better support this purpose. Qualitative semi-structured interviews were carried out with the intent of establishing what coroners believe their purpose to be.

The extensive review of the history and background of the coroner in England and Wales provides context and establishes some of the historical, legal and social factors underlying coroners' understanding of their purpose. The following chapter presents the history of the coronial system from the 12th century to the mid-1900s. It describes the creation of the office of the coroner, its original purpose, and the subsequent and slow capitulation of the coroners' original duties. This chapter includes a summary of nearly 800 years of history and chronicles the growing debate about the purpose of the coronial system. The Background chapter begins with a description of the Brodrick Review, the first sizeable review of the system in recent times, and assesses its impact (or lack thereof) on the current legislation (the Coroners Act 1988 and the Coroners Rules 1984) governing coroners in England and Wales. The background includes a précis of several sweeping inquiries, each of which addressing various shortcomings of the coroner system, culminating in the Shipman Inquiry and the Luce Review both of which would expose the failings of the current system, and strenuously call for substantial reform. The chapter concludes with a description of the yet to be fully implemented Coroners and Justice Act 2009 and the debate surrounding this new Act.

The aims and objectives of this thesis (as well as a description of the methodological approach to understanding what coroners believe their purpose to be) follows, along with a description of the results.

A discussion of the legality, feasibility, and practicality of each of the coroners' stated purposes is presented as a means to come to a rational, rigorously considered conclusion about the most appropriate purpose for the modern coroner. This discussion addresses each of the purposes coroners claim to pursue in turn and describes how coroners' beliefs about their various purposes are manifest.

The Conclusions chapter answers the question, 'what is an appropriate purpose for the coroner', while the Recommendations chapter includes a series of policy recommendations which describe how the system could overcome the problems identified in the study in order to better support the coroner's primary and tenable purpose.

Several articles have been published as part of this research project. As the reform process was ongoing for the duration of this study, it was possible, and perhaps necessary, to enter the policy debate before the completion of this thesis. The four publications following the main body of the thesis address: the shortcomings of the Coroners and Justice Bill in terms of public health and safety³⁰; the role of death investigation systems in disease surveillance and the problematic notion of coronial independence¹¹; and the relationship between coroners and public health with specific reference to a failed national vCJD survey.¹² In addition, the published correspondence with Dr. Sebastian Lucas on the topic of the coroners' failure to participate in a national vCJD survey is included.⁸⁶

FRUSTRATION OF PURPOSE

Twelfth century coroners were tasked with protecting the financial interests of the Crown through the investigation of deaths and other sundry tasks. Various historical events have conspired to abolish the fiscal responsibilities of the coroner, to frustrate the original coronial purpose, and yet coroners are still responsible for investigating deaths in much the same fashion as they did 800 years ago.

Coroners play an important role in public health and safety; they are responsible for certifying a significant proportion of the total number of deaths, they act as gatekeepers and/or points of referral for post-mortem material and, in some circumstances, they may make recommendations intended to prevent future deaths. However, the system lacks a formal statement as to the purpose for being empowered to carry out these duties.

Regardless of the global movement to reorient the purpose of the coroner in order to emphasise public health and safety (and the various calls to eliminate the coroner system in the United States and Canada) the coroner system in England and Wales continues to operate in the absence of a clear statement of purpose. Coroners are left to come to a decision about what purpose they are to serve and are afforded a significant degree of discretion in the execution of their duties to tailor their practice to serve the purpose they have come to believe they are meant to pursue. This thesis will show how - in the absence of a common, legislated purpose: coroners in England and Wales differ in the interpretation of their purpose; how different purposes are realised by coroners; how the realisation of these purposes impacts public health; and how the system can reorient itself to serve the public interest through a modern purpose - one more consistent with the global shift toward public health and safety and a broader understanding of the nature of risk.

Chapter II: CREATION OF THE OFFICE OF THE CORONER

There are few sources from which we can understand how the coroner came to be. The coroner can be traced back to the September 1194 Articles of Eyre (Article 20) which states that, “in every county shall be chosen three knights and a clerk as custodians of the pleas of the Crown”.^{87, p. 254*} It has been suggested that the office existed before this time[†] and that the Articles of Eyre were simply, “a declaratory act referring to an office which was already in existence”^{88, p. 660}; however, the Articles of Eyre is the first official surviving document which outlines, albeit broadly, the responsibility of the coroner.^{88, 89} Though this legislation defines the duty the coroner is meant to perform (*i.e.* to keep the pleas of the Crown) there is no mention of the medieval coroner’s purpose. In order to understand precisely why the office was created we need to put the coroner into an historical context. Though the coroner has been described as a ‘uniquely English institution’, the office is a feature of Norman Britain and is perhaps better understood as a ‘uniquely Norman institution’, one which happened to originate in the English region of the Norman territories.⁹⁰ The *raison d’être* of the 12th century coroner was to act as a means to protect the financial interests of the Crown in England and later, following the Edwardian Conquest of 1282, Wales. In this chapter I describe the advent of the coroner system in England and Wales and, in so doing, illustrate *why* the system was established and *to what end*.

This review includes: literature addressing the history of the coroner in England and Wales, the legislation and legislative instruments which govern coroners, legal cases/rulings (accessed through Lexis Library and Westlaw UK), non-statutory policy documents, the various reviews and inquiries which address coroners, the discourse surrounding critical events in the history of coroners (generally in the form of Hansard transcripts, media reports, and formal statements issued by various organisations), and the academic literature.

The academic literature was identified using the principles of a rigorous systematic review as outlined in the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) guidelines.⁹¹ Seven databases (Academic Search Complete, EMBASE, Global Health, MEDLINE, PsychINFO, Social Policy & Practice, and Web of Science) were searched using various search strategies intended to maximise the identification of relevant literature. The initial search was carried out on September 2010 and was updated using the

* *Praeterea in quolibet comitatu eligantur tres milites et unus clericus custodies placitorum coronae.*

† A thirteenth or fourteenth century source indicates that the citizens of Norwich claimed that coroners had been appointed there since the reign of Stephen (the grandson of William the Conqueror) who was regent from 1135 until death in 1141. A similar claim is mentioned in the civic records of Norwich.⁸⁸

auto-alert features offered by Google Alerts, BMJ Topic Alerts, the National Center for Biotechnology Information (NCBI), SciVerse ScienceDirect, and SciVerse SCOPUS - the search terms used for the auto-alerts were broad and included either the terms: ‘coroner’, ‘coroner + public health’, ‘chief coroner + England’, and ‘Coroners and Justice Bill/Coroners and Justice Act’. In addition, United Kingdom Parliament offers e-mail notifications as Bills pass through Parliament - this feature was used to keep abreast of the progress of: the Coroners and Justice Bill, the Public Bodies Bill, and the Health and Social Care Bill. All relevant debates in the House of Commons and House of Lords were accessed through BBC Democracy Live or Hansard.

The articles ranged in topic from general consideration of the purpose of death investigations to specific public health initiatives and addressed systems in various countries and jurisdictions - though the majority of sources retained for the purpose of this review are necessarily concerned with the operation of the coroner system in England and Wales.

Norman Britain

In 1066, following the defeat of Harold II of England near Hastings, William the Conqueror was crowned William I of England (on 25 December 1066) and became the first of the Norman rulers of England. The Norman Conquest resulted in the displacement of the existing Anglo-Saxon aristocracy and marked the beginning of a lengthy period of foreign, French-speaking rule in England (from 1066), Ireland (from 1169), and Wales (from 1282). William parcelled out vast tracts of land to his followers and, in doing so, removed the native land-owners. This policy of land confiscation and reassignment was unpopular with the English and several revolts followed, often making life precarious for the newly placed Norman landowners. However; William was able to contain objections to his rule and, beginning in 1072, opted to rule England (by writ) from his native France. Many of his successors were also absentee rulers including Richard I (William’s great, great-grandson) who would later come to be known as Richard the Lionheart.

Regardless of his iconic status Richard was arguably one of the worst kings in English history. Though he was born in Oxford (in 1157) Richard spent nearly all of his time in France at his home in Aquitaine. He openly disliked his English territory and, during his 10-year reign, spent only 6 months in England, preferring instead to use his kingdom as a

source of revenue to support his many military campaigns. He has been described as, "...a bad king [who would] fight for anything whatever, but he would sell everything that was worth fighting for".^{92, p. 551}

The Third Crusade

Upon becoming king, Richard immediately set about raising money for a third crusade to the Holy Land. To do this Richard began selling land, sheriffdoms, and castles whilst simultaneously draining money from the English treasury. Richard, according to Bingham, "...used England as a bank on which to draw and overdraw in order to finance his ambitious exploits abroad".^{93, p. 99} In July 1190 Richard, Philip II of France and Frederick I of the Holy Roman Empire[‡] set out on the Third Crusade (1189-1192) with a sizeable army drawn from their respective kingdoms. Though the Crusade would result in Richard's capture of Acre and Jaffa he was not able to take Jerusalem which remained under Saladin's control. Richard signed a truce with Saladin in September 1192 and then, worried that his brother Prince John was scheming for his kingdom, he opted to depart for France.

Richard goes to jail

In 1192, having left the Holy Land, Richard was shipwrecked on the Italian coast. With no option to continue his journey by sea, he and his party elected to return home to France on foot. In late 1192 Richard opted to stop, incognito, at a pub near Vienna. He was easily recognised, however, and was soon apprehended owing to his sundry political offences. Richard was jailed in Austria (by Duke Leopold V) and subsequently turned over to Henry VI (of the Holy Roman Empire).

Richard's on-going continental wars had already put a tremendous strain on England's treasury; thus, when the extortionate ransom demand of 150,000 marks was levied, England was hard pressed to raise such an enormous sum. Regardless, Hubert Walter (Richard's Justiciar) emptied the royal coffers and Richard was released in February of 1194. He returned to England only briefly before leaving, permanently, for France. Before leaving, however, Richard appointed Walter to reign in his place over a country experiencing serious fiscal problems owing, in large part, to the cost of Richard's ransom. In addition, the corruption of the county sheriffs had, by the late 12th century, become widespread and was seriously compromising the amount of revenue remitted to the Crown.⁹⁴

[‡] Frederick drowned en route to the Holy Land and his army dispersed near Antioch in Turkey.

Itinerant judges and the coroner

One of the first of Walter's many reforms was intended to address the country's economic problems. In 1194 he formalised the office of the coroner (in the Articles of Eyre), describing the coroner as *custos placitorum coronas* or the 'keeper of the pleas of the crown'. This made official the coroner's responsibility for investigating and documenting various incidents from which the Crown might reasonably levy fines or seize property.^{88, 89, 94, 95} Thus, the purpose of the coroner at the time of the creation of the office was to facilitate the collection of fines on behalf of the Crown and, in so doing, the coroner would assume some of the duties of the larcenous sheriffs.^{94, 95} The coroner was tasked with serving the General Eyre[§] - an itinerant judge who travelled from county to county to hear pleas brought before the Crown. As the eyre might spend years travelling his circuit, he would often find himself holding court in each county only once every seven or so years. Holding court over incidents which had occurred years previously would represent a substantial loss of Crown revenue as many of the cases would have been forgotten, forgiven, or the parties involved may have moved on or simply died. The coroner was therefore responsible for documenting all pleas such that the details could be presented to the eyre upon his arrival in the county. The eyre would then levy large fines (called amercements) upon both individuals and the community as a whole for any breach of justice occurring in the time since the eyre's last visit.

The early coroners were appointed, elected^{**} or inherited their positions. Coroners of the King's Bench were appointed, as was the king's butler who acted as the *ex officio* coroner for the city of London.⁹⁵ Many coroners were 'elected' by lords who effectively appointed them to their position without the formality of an election. Henry III also appointed county coroners, though they were generally elected to their positions by the knights and freeholders in the shire. Borough coroners were elected in a similar fashion to the county coroners. In the later Middle Ages, as towns were granted more autonomy, coroners who had previously been elected officials were appointed by bailiffs who were themselves elected.⁹⁵ As was required by the Articles of Eyr, coroners were required to be knights - though by the end of the 13th century this practice had diminished considerably such that it

§ "The term 'general eyre' is modern; they were known to contemporaries as eyres 'for common pleas' or 'for all pleas'. The counties were grouped into circuits, each of which was ridden by a small group of justices in eyre. Eyre justices had, among other things, to hear all the crown pleas (criminal offences or those against the king's proprietary rights) in a county which had arisen since the last eyre in it, reported by panels of jurors in answer to questions brought by the justices, and called the 'articles of the eyre'".⁹⁶

** Most county coroners were elected by all knights and freeholders of the shire.⁹⁵

was the “...exception rather than the rule for coroners to be knights”.^{95, p. 173} Though the Articles of Eyre explicitly stipulated the qualifications of coroners, the duty of the coroner to act as ‘keeper of the pleas of the crown’ was perhaps deliberately vague.

Investigation of deaths

Holding an investigation in relation to a dead body was one of the primary responsibilities of the coroner and provided the opportunity for the Crown to collect considerable sums of money and property. A dead body was a likely object through which the eyre could levy a myriad of fines; this often resulted in bodies, upon discovery, being relocated to a neighbouring village or county.⁹⁰

There was a rigid procedure enforced at every unexpected death, any deviation from the rules being heavily fined. The rules were so complex that probably most cases showed some slip-up, with consequent financial penalty to someone. It was common practice either to ignore a dead body or even to hide it clandestinely. Some people would even drag a corpse by night to another village or hundred, so that they would not be burdened with the problem. Even where no guilt lay, to be involved in a death, even a sudden natural one, caused endless trouble and usually financial loss.⁹⁰

Lex murdrorum

All deaths within the coroner’s jurisdiction were investigated for the purpose of determining the identity of the deceased such that his or her ancestry could be established. If the community could not prove that the body was that of a Saxon (and not a Norman) then a substantial fine (called the *lex murdrorum* or *murdrum*) was imposed on the community. Not only did this fine provide the invading Normans with some protection against falling victim to resentful Saxons, it also provided the Crown with substantial revenue as all dead bodies were presumed to be Norman until proven otherwise. The standard of proof was notoriously exacting and, in many cases, it was simply impossible to prove ‘Englishry’.

The deodand

Any object which was involved in a death (called a *deodand*) was declared forfeit to the Crown. Occasionally the object (which historically has included all manner of objects from knives to steamships) was offered back to the owner (or the owner’s next-of-kin) at a substantially inflated price. All funds collected from *deodands* were remitted to the Crown.

Trials by fire and water, approaching the bier, outlawries and abjurations

The medieval coroner had many other duties which he was expected to carry out in his jurisdiction; for example, he was responsible for attending trials by fire/water (an ancient, and barbaric, means of determining guilt) at which he was required to document the outcome, "...again with an eye on the forfeiture of the felon's goods".⁹⁰ The coroner was also required to be present to witness accused murderers as they 'approached the bier' as it was believed that the wounds of murder victims would bleed in the presence of the perpetrator. Thus, those accused of murder were required to approach the body in the presence of the coroner who would document the ordeal. He also formally declared 'outlaw' an accused who did not present themselves for trial - a declaration which would allow anyone who came across the outlaw to cut off his/her head. Coroners also documented confessions and arranged 'abjurations of the realm' for criminals who had claimed the right of sanctuary. Arranging abjurations of the realm involved arranging a port of departure for the criminal and setting a date by which s/he had to depart: coroners would occasionally make it nearly impossible to abjure the realm by the 'deadline' (quite literally so) by requiring them to walk unfeasibly long distances - many Yorkshire Coroners required that felons walk to the port at Dover.⁹⁰

Ultimately, however, the coroner's primary mandate, in the early years of his office, was to facilitate the collection of money and property on behalf of the Crown which, owing primarily to Richard's various military exploits (and finding himself the subject of a hefty ransom), was in rather desperate need of revenue. Though the purpose of the *murdrum* became obsolete once the Normans had 'settled in' (and once they started to intermarry with the resident population) the levying of this fine developed into a major source of revenue even after the original purpose had disappeared.⁹⁴ Over time the fines resulting from the discovery of dead bodies were abolished (the *murdrum* fine was abolished in 1340 and the *deodand*, as per the Deodands Act⁹⁷, in 1846). Similarly the fines for corrupting the judicial process became of less and less relative importance to the royal purse.

**Chapter III: THE DECLINE OF
THE IMPORTANCE OF THE
CORONER**

In this section I describe the decreasing importance of the coroner in England and Wales, who had, by the end of the 18th century, been relieved of many of his duties - with the exception of investigating deaths and treasure trove.

A particularly inclement winter in 1257-8, followed by a severe famine, had left the whole of England “beyond measure disturbed”.⁹⁸ It is thought that between 15, 000 and 20, 000 people died in London alone as people left their villages for the larger cities looking for food, “...and there, upon the famine waxing still greater, many thousand persons perished”.⁹⁸ Many did not make it to the cities, dying instead at the side of roads, resulting in thousands of *murdrum* fines for unclaimed bodies. A writ sent to the sheriffs of the counties of eastern England (Norfolk, Suffolk, Cambridgeshire, Bedfordshire, Hertfordshire and Essex) read, “...many poor men die of hunger in the fields, and for a long time their bodies remain unburied: and no one dares to bury them before the coroners have viewed them, nor can the coroners cope with the cases and view them all”.⁹⁴ In response to a drastic increase in *murdrum* fines resulting from the famine, the barons (who were responsible for paying such fines) complained and, in 1259, the Provisions of Westminster⁹⁹ decreed that *murdrum* would only be applied to cases of felonious killing as:

No judgment of murder shall henceforth be rendered before the justices in a case that is adjudged merely one of accident; but [a judgment of] murder shall be proper in the case of a man feloniously slain, and not otherwise.¹⁰⁰

The abolition of the *murdrum* in all cases except those resulting from homicide drastically reduced the importance of the coroner’s inquest.⁹⁴ With the abolition of the *murdrum* the importance of the inquest, and by extension the coroner, declined considerably. In 1257 Henry III, in response to the famine of 1257-58, had ordered that, “...each person found dead, unless he be feloniously killed, might be buried without a view by the coroner”.^{94, p. 28} Edward I further decreed that during times of famine or plague this stipulation that the coroner need not view the body - which had previously only applied to the 1257-8 famine - could be observed and that the body could be disposed of without the coroner’s involvement.⁹⁴ The *murdrum* (along with the presentment of Englishry) was abolished in its entirety in 1340 - though it continued to be imposed in Suffolk until 1362. The abolition of the *murdrum* fine drastically reduced the amount of revenue that could be exacted from the investigation of deaths - a fact which contributed to an immediate devaluation of the coroner’s role.⁹⁵

The 14th century would see a further decline in the importance of the coroner as the practice of having justices of eyre operate as itinerants was discontinued. As a result there was no longer an incentive for coroners to collect the information previously required by the eyres (*e.g.* the details of the person who discovered the body or the names of the deceased's neighbours). Additionally, without regular visitation and oversight of coroners by the eyres, coroners became autonomously powerful local figures and increasingly inclined to take bribes and regularly engaged in extortion.⁹⁵ Coroners would frequently ask for a bribe in exchange for holding an inquest on a body which, under the law, had to take place before the body could be buried - a Sussex coroner is known to have waited nine weeks for his bribe to be paid before he would hold inquest on the body of a drowning victim.⁹⁵ Thus, “[i]t therefore reflects no credit upon the coroners that they continued to hold inquests after regular supervision had ceased”.^{95, p. 121} In the latter half of the thirteenth century there are, “...copious references to the activities of coroners in relation to concealment of felonies, collusion, monetary considerations demanded before agreeing to hold inquests, and other similar matters”.^{94, p. 29} Havard (1960) has noted that: “[t]hroughout the thirteenth century there is increasing evidence that the coroners had contracted from the sheriffs the disease which it had been intended they should cure - corruption”.^{94, p. 29} And, according to Hunnisett, “[t]hose were exceptional who did not use their chances of extortion”, the causes of which were, “... that the office was unpaid, punishments were not severe enough, and especially during the fourteenth and fifteenth centuries, supervision was completely inadequate”.^{95, p. 125}

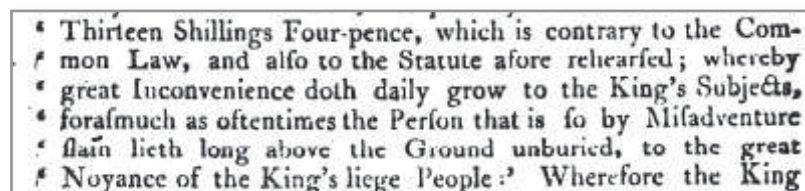
The justices of the peace and the escheator

In 1361 the Justices of the Peace Act was instituted requiring that, “in every County of England shall be assigned for the keeping of the Peace, one Lord, and with him three or four of the most worthy in the County”.¹⁰¹ These justices appropriated some of the coroners' remaining powers including the investigation of homicide. In 1380 justices of the peace were explicitly empowered to hear the indictments of extortionate coroners and to levy punishments for such misdeeds - in practice, however, they had been responsible for investigating such cases since 1361.^{94, 95} The rise in the importance of the office of the escheator also contributed to the decline of the coroner as the escheator was responsible for involving himself in death investigations for the purpose of establishing whether a deceased person's land holdings could be reverted to the Crown. These investigations were later extended *ex officio* to include: the appraisal and seizing of *deodands*, the seizing of the

property and possessions of outlaws, abjurations of the realm, the investigation of suicides, homicides, treasure trove and wrecks of the sea.⁹⁵ The fact that the escheator was required to be a landowner of considerable status - and as he was directly accountable to the Exchequer - elevated his position and authority throughout his jurisdiction.⁹⁵ By the end of the fifteenth century, "...the process of deterioration in the coroner's jurisdiction and in the importance of the investigation of sudden death was almost complete".^{94, p. 32} Much of the law dictating the responsibilities of coroners had been abolished or re-drafted to transfer coronial responsibilities to other authorities including the justices of the peace who offered, "...less protracted and cheaper procedures".^{94, p. 32}

The Coroners Act 1509

The Coroners Act 1509¹⁰² was enacted in the first year of Henry VIII's reign and was the first to impose fines on coroners for not fulfilling their duties. The fine of 40 shillings was to be levied on any coroner who did not view the body of someone, "slain, drowned or otherwise dead by misadventure"^{103, p. 3}; however, it is implicit in the statute that the reason for providing such incentive to view the body was not to ensure that coroners properly investigated deaths in order to rule out homicide, rather, it was to avoid the inconvenience and disgust resulting from an unburied body, which could not lawfully be interred without having first been seen by the coroner (Figure 1).



Thirteen Shillings Four-pence, which is contrary to the Common Law, and also to the Statute afore rehearsed; whereby great Inconvenience doth daily grow to the King's Subjects, forasmuch as oftentimes the Person that is so by Misadventure slain lieth long above the Ground unburied, to the great Noyance of the King's liege People: Wherefore the King

Figure 1: Section from the Coroners Act 1509 describing the "inconvenience" and "great [an]noyance" caused by unburied bodies

Havard (1960) has noted that, "nowhere in the complicated medieval machinery for investigating sudden death is there a glimmer of a suggestion that the purpose was to exclude homicide".^{94, p. 26} Medical examinations of bodies was never carried out in the medieval period though, "...the prevailing state of medical knowledge in England would have rendered it of little assistance".^{94, p. 26} It would be another two and a half centuries before the investigation of unexplained deaths for the purpose of ruling out homicide would be realised.⁹⁴ In addition to dictating the imposition of fines on coroners for not viewing bodies, the Act of 1509 also codified the authority of the Justices of Assize (justices responsible for hearing criminal cases) and the Justices of the Peace to inquire

into, and make determinations as to, the “default of coroners”.^{103, p. 4} According to Havard (1960), “this confirmation of the administrative power of justices of the peace over coroners was to have the most disastrous consequences at a later date”.^{94, p. 36}

For three centuries following Henry VIII’s Coroners Act there were, “...no developments of any importance affecting the coroner or his investigation of sudden death”.^{94, p. 37} It was not until the late Georgian Period that coroners would again become the focus of reform.

The Coroners Act 1751

By the mid-eighteenth century it had become apparent that coroners were accepting bribes and were, in exchange, opting not to investigate many cases of homicide.¹⁰⁴ The fact that there was no statutory requirement that coroners be paid for the execution of their office was assumed to be the cause of this practice and was addressed in the 1747-9 *Bill for the Better Ordering of the Office of the Coroner*¹⁰⁴ which set out the conditions for the payment of coroners.

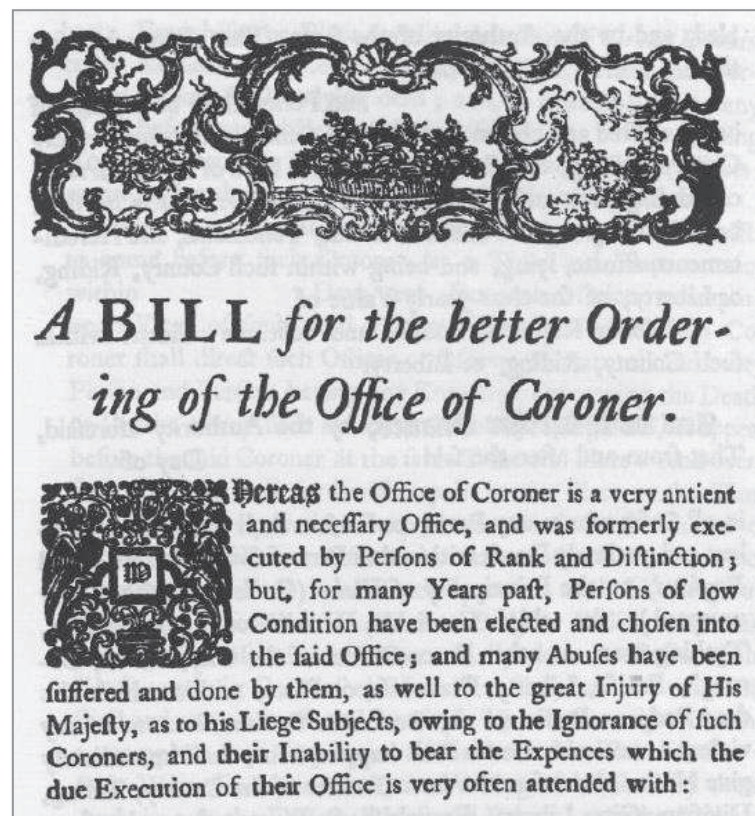


Figure 2: Preamble to *A Bill for the Better Ordering of the Office of the Coroner* 1747-1749 which describes the decline of the office and the problem of remuneration of fees for coroners.

In 1751 a new Coroners Act¹⁰⁵ was passed which allowed for the reimbursement of coroners for the cost of inquests (provided they were ‘duly held’) and for travel expenses. Prior to the 1751 Act coroners were only paid for inquests held on homicides. However, the new Act seems to have reflected a growing appreciation that homicides might not always be immediately apparent and that a more considered investigation for the purpose of exposing homicide was necessary. Payment to coroners was, however, dependent upon approval by judges in the Courts of Quarter Sessions who would not infrequently refuse reimbursement to coroners who had carried out inquests not ‘duly held’ (*i.e.* held in the absence of evidence of felonious violence). The judges also refused to increase coroners’ travel expenses in light of inflation such that by 1850 coroners were still being paid the rate of 9d/mile* as provided in the 1751 Act.

In 1761 Edward Umfreville - who would later go on to pen the vitriolic and ill-received *The Present State of Hudson’s Bay* lambasting the policies of the Hudson’s Bay Company in Upper Canada - described his efforts to collect information about the duties of coroners:

I also made application to some county coroners, but after all my endeavours, I could only discover, that the duty was not discharged with a becoming care and diligence; that the practice of the office was too frequently deputed, and the office itself in despise.^{1, p. iv}

He also discovered:

...a prevailing irregularity, and not only a general negligence and inuniform practice, but also the footsteps of a scheming *ipses* [sic] *fallendi*, and undue behaviour in the exercise of the office, to a degree even affecting the officer in a point of character.^{1, p. v}

It would not be until 1836 that two pivotal pieces of legislation would herald in a new age, one which saw England and Wales graduate to a medico-legal death investigation system, the likes of which had existed on the continent since the 16th century.^{106, 107}

* Nine pence (or 9d) was equal to about 4p in today’s money. Coroners were only reimbursed for travel one-way and the 9d was considerably less than the shilling/mile provided to Union local registrars.⁹⁴

**Chapter IV: THE ADVENT OF
MEDICO-LEGAL DEATH
INVESTIGATION**

In this chapter I will demonstrate that the advent of a medico-legal death investigation system in England was a consequence of an increased demand for accurate mortality data. The suggestion that medical causes of death were perhaps best discovered by someone with medical expertise was put forward by practitioners of public health as well as by some coroners (albeit medically trained coroners). This chapter documents the increasing advocacy, on behalf of the medical profession as well as by early agencies of public health, to re-orient the coroner system to render it better able to identify causes of death in order to reflect the aggregate health of the population.

In 1833 the Select Committee on Parish Registers¹⁰⁸ reported that insofar as death registration was concerned, “England was the most backward country in the civilised world”^{94, p. 45-46} and that the existent system was “in great measure totally useless”.^{94, p. 46} The evidence presented by the Committee showed that there were two main reasons for radically revamping the system of death registration. First, the current system was without means to legally prove that a person had actually died, and second “...the medical profession was agitating for more accurate information on mortality” as the existing system of burial registration did not provide information on cause of death and, “the old bills of mortality were hopelessly inaccurate”.^{94, p. 46} Deaths that were recorded were often documented in vague and medically meaningless ways, and included, for example, the following causes of death: ‘toes off’, ‘long sickness’ and ‘mother’.¹⁰⁹ One medical witness to the Committee pointed out that the resultant mortality statistics: “...gave such an excessive figure of deaths from epidemics of plague, cholera, etc., as to give rise to quite unnecessary panic amongst the population.”^{94, p. 46} The Committee examined death registration systems in various other countries and decided upon a new English system based on the Napoleonic system which existed in France at the time.¹⁰⁸

The Births and Deaths Registration Act of 1836¹¹⁰ was enacted in response to the Committee’s recommendations. It legislated for the creation of the General Register Office (GRO) and the appointment of a Registrar General as well as local registrars.¹¹¹ Amongst other provisions the Act required that bodies not be buried without a registrar’s certificate or a coroner’s order for burial; the fine for burying a body without the appropriate paperwork was up to £10.* Though the purpose of the Act was to formalise

* ...and every Person who shall bury or perform any Funeral or any religious Service for the Burial of any dead Body for which no Certificate shall have been duly made and delivered as aforesaid, either by the Registrar or Coroner, and who shall not within Seven Days give Notice thereof to the Registrar, shall forfeit and pay any Sum not exceeding Ten Pounds for every such Offence.¹¹⁰

the requirement of registering births and deaths in order to produce accurate statistical data, the unintentional effect was to make it far more difficult to conceal homicides.⁹⁴ It would be several years after the enactment of the legislation that Dr. William Farr, who was responsible for collecting medical statistics on behalf of the GRO, was able to establish a new system for routine recording of cause of death. The early years of the GRO were not without controversy, however, as Henry Rumsey (a spokesman for public health at the time), amongst others, demanded a complete reform of the registration system and advocated for the replacement of coroners with medical superintendents.¹¹² Dr. Farr would later propose not only that coroners be required to have training in both medical jurisprudence and toxicology, but that their investigations be made subject to oversight by a “superior medical officer”.^{113, p. xii}

The Coroners Act 1836¹¹⁴ was the first to allow for the remuneration of medical witnesses at inquests. However convincing was the emerging pressure from the medical profession to infuse medical expertise into the coroner system, the new Act maintained the *status quo* insofar as coroners’ qualifications were concerned. Coroners were still only required to be freeholders[†] and were not required to have any medical knowledge - yet it would henceforth be possible for the coroner to pay for medical expertise. This provision for the payment for medical testimony was becoming increasingly important owing to the rising popularity of poisoning^{94, 116, 117}, infanticide^{94, 116, 117} and ‘burial clubs’[‡] in England in the mid-19th century.^{94, 117, 119}

Despite various early-Victorian legislative measures intended to create a more modern and effective medico-legal death investigation system (including the Coroners' Inquests Expenses Act 1837¹²⁰ and the Evidence Act 1843¹²¹) and to address the problem of covert homicide (including the Friendly Societies Act 1850¹¹⁸ and the Sale of Arsenic Regulation Act 1851¹²²) the system was still the subject of a great deal of criticism. In a letter to the then Attorney-General, a Dr. Corrigan addressed the frequent and ongoing problems with the office of the coroner:

[†] Ownership of a grave plot was considered sufficient to be considered a freeholder.¹¹⁵

[‡] ‘Burial clubs’ (or ‘burial societies’) were insurance schemes whereby parents would pay a fee against the funeral expenses of their child. Given that children could be enrolled in several burial clubs the death of a child could result in a considerable pay-out, thus, it was believed by many (including Dr. Edwin Chadwick) that this provided parents with a strong incentive to commit infanticide.¹¹⁶ The Friendly Societies Act 1850¹¹⁸ was an attempt, though largely ineffectual, to curb this practice by forbidding children under 6 years of age to be enrolled in ‘burial clubs’.

I believe you are fully aware that coroners' inquests - so important a department of our jurisprudence - are an absolute disgrace to the administration of justice. In my own profession (which is the most capable of forming an opinion on the subject) the whole mode of conducting inquiries at *coroners' inquests*, whether in cases of poisoning, suspected murder, infanticide, suicide, &c., is regarded as nothing better than *a gross burlesque on jurisprudence*. On this the voice of the profession is unanimous; and still this important department of our laws remains in a state that should not be tolerated in any nation or community that deems human life worthy of protection.^{123, p. 934}

In an anonymous response to this letter which appeared in the second issue of *The Lancet*, and which may well have been penned by Dr. Thomas Wakley its editor-in-chief, the author makes a plea for reform stating, "...a calm, firm, and severe course of conduct is necessary [...] either to convert such culprits into honest [sic] servants of the Crown, or banish them from the seats of justice which they pollute".^{123, p. 934}

The Victorian coroner

The purpose of the coroner to facilitate the provision of money to the Crown had long passed and the coroner emerged into the Victorian era torn between two overlapping, but still reasonably distinct, purposes - those being to support the criminal justice system in the detection of covert homicide, and to produce accurate mortality statistics for the public health system which, though in its infancy, was becoming the primary means through which the state could control sanitation and disease. These increasing demands on the coroner only served to demonstrate the need for reform which occasionally came in the form of calls to radically increase the coroner's capacity to act in the interests of public health. In 1848 a report entitled *The Laws of England Relating to Public Health*¹²⁴, written by lawyer and political theorist J. Toulmin Smith, argued that it is a principle of the law of England, "to attempt, by means of legal sanction, to promote public health and to remove causes injurious to health".^{125, p. 122} It was Smith's belief that the distinction between 'natural' and 'unnatural' (*i.e.* violent or sudden) deaths should not determine whether or not the coroner assumes jurisdiction. Rather, those cases resulting from factors which, if known, would benefit the general good of the community should define the coroner's jurisdiction.¹²⁵

In his 1859 address to the Law Amendment Society Dempsey stated that:

I strongly maintain, my Lord, that the Coroner's Court should be intrusted [sic] with the sanatory [sic] welfare of the country; and that Coroners, in fact, should be regarded as chief officers of health. Powers should be given to hold investigations in all sanatory [sic] matters, and to issue orders for the abatement of dangerous nuisances. The health of the whole country is concerned, and what more impartial and observant officer could there be appointed for such purpose than the Coroner, who is constantly in the midst of disease, and by practical, if not professional experience, sees the real causes of a devastating epidemic, and, as far as human foresight goes, can direct the application of proper and effectual remedies. Thus, while external causes of disease might be prevented, the apothecary and chemist should be checked in the indiscriminate sale of poisons and the dispensing of impure drugs and compounds, and those who adulterate the common necessities of life could be dealt with in the same manner. These are all matters affecting the vital existence of the people, and who are better able to consider them than the people themselves through their own representative Court—the Coroner's?^{126, p. 7}

Coroner Wakley

Dr. Thomas Wakley (1795-1862) was elected coroner for the western district of the county of Middlesex in 1839, a roll he retained until his death in 1862. He was the first coroner to hold a medical qualification; a fact which clearly vexed the editor of the *Justice of the Peace* newspaper who wrote of Wakley's appointment: "[i]t is not either in one case out of twenty that any medical skill is required, the cause of death being of itself sufficiently obvious".^{94, p.}

⁵⁰ Wakley is now remembered less for his work as coroner and more for his founding of *The Lancet* (for which he acted as both editor and publisher from its creation in 1823), however, his reforms to the coroner system were considerable.¹²⁷⁻¹²⁹ Though many coroners may have contributed to reform at the time, Wakley has been the focus of much attention, owing perhaps to his association with *The Lancet* as well as having had the fortune of presiding over jurors Charles Dickens and the painter (and director of the National Portrait Gallery) George Scharf both of whom would immortalise Wakley in their writings. Scharf's sketch of one of Coroner Wakley's inquests involving the death of a 5-year old child from burns sustained whilst trying to light a fire is currently in the collection of the British Museum (*viz.* Figure 3) and depicts the spectacle that was the inquest in Victorian England.¹²⁸

The qualifications of coroners

Regardless of the likelihood of historical bias (Wakley was patently biased toward medical qualification for coroners), the reforms of Coroner Wakley are worthy of note. Dr. Wakley believed that the post of coroner should be democratically accountable and should be devoted to the cause of truth. Consequently he believed lawyers ill-suited to the task, and was strongly in favour of coroners being medically qualified. He saw the law governing coroners as easily mastered, while he believed medical knowledge to be all important in interpreting post-mortem findings.¹²⁷ Prior to being elected coroner in 1839 Wakley had been using *The Lancet* as a means of drawing attention to the need, as he perceived it, of requiring that coroners be medically-trained.¹²⁸ It has been suggested by Cawthorn (1986) that, far from re-orienting the system toward one reliant upon medical experts, Wakley's championing of the medical coroner, "...may have helped to solidify opposition to a strong inquest process on the part of lawyers, judges and magistrates, who saw themselves as involved in a struggle for local authority".^{128, p. 202}



Figure 3: An inquest into the death of a young girl chaired by Coroner Wakley on 26 February 1844 at University College Hospital, London.

Medical witnesses

In 1836, in large part owing to the efforts of Dr. Wakley, a new Coroners Act¹⁴⁴ had been passed, one which would empower the coroner to compel medical witnesses to attend inquests and to order such witnesses to conduct a post-mortem examination of the body in question. The Act was an attempt to provide a more accurate account of the cause of death and to increase the likelihood that homicide would be detected. The decision to call a medical witness was, ultimately, at the discretion of the coroner; however, not all coroners availed themselves of the provisions of the Act. In December 1841 Wakley launched a scathing attack in *The Lancet* on both the English Criminal Law Courts and on his fellow coroners for what he perceived to be, “irregular, injudicious, and improper conduct” for failing to call medical witnesses and to order post-mortem examinations and, in doing so, failing to properly apply the provisions of the Coroners Act.^{130, p. 410} This failure to apply the Act was noted by one Dr. McEgan in a letter to *The Lancet* dated 25 December 1841 in which he stated:

I fear, from personal experience, that very many of our country coroners are most willing at *all times* [emphasis his] to dispense with medical evidence, even if the case be shrouded in doubt, either from want of judgement (not being medical men) to discriminate what cases require such evidence, or to serve their personal convenience in some way.^{131, p. 438}

Occupational deaths, expert witnesses and compensation in the form of deodands

The early 19th century saw the advent of both rail travel and steam power and the massive industry that sprang up to create and operate these new technologies. Along with these new industries came new hazards; hazards not just for the employees but for travellers as well. Rail construction employed hundreds of thousands of workers who worked along vast lengths of rail lines and, “...presented such a striking example of employer callousness to employee welfare precisely because similar large-scale enterprises were relatively rare in the 1830s”^{128, p. 192}, while at the same time, “[t]he presence of steam power in some workplaces and on public transport had created enough hazards to make the duties of the coroners burgeon correspondingly”.^{128, p. 195} These new technologies also presented coroners with novel problems with regard to witnesses. Medical knowledge was no longer the only type of specialised knowledge to which the coroner needed to defer, as matters involving these new technologies required coroners to call inventors and engineers to explain to juries the nature and cause of faults to steam technology and rail systems. Wakley would come to use the long-since abandoned *deodand* fine to express his, and his

juries' view, that an employer had been negligent in cases of fatal accidents in the workplace. The mere threat of a large *deodand* would presumably have persuaded employers to provide financial assistance to the family of someone who had died in the workplace - needless to say this measure was not universally popular. The use of, "...such an arcane legal device as an instrument with which to effect punishment and compensation for occupational accidents was a development which infuriated lawyers and judges as well as employers".^{128, p. 201} This coercive practice on behalf of coroner's courts likely inspired the Deodands Act 1846⁹⁷ (which abolished the *deodand*) and the Fatal Accidents Act 1846¹³² (which allowed for wrongful death suits).

Coroner Lankester

In 1862 Coroner Wakley died and an election was called for the Central Middlesex coronership. Originally there were seven candidates for the position but five withdrew leaving one legal candidate, a Mr. Lewis (who publicly insisted that the coronership should not be held by a physician but by a "proper man"^{133, p. 226}), and one medical candidate, Dr. Lankester (a noted scientist and public health advocate). Mr. Lewis argued for his own election on the grounds that medical coroners held unnecessary inquests while Dr. Lankester argued that he wished to assume the position of coroner to promote sanitary measures and that the incumbent coroner should be medically trained, "...since a primary function of the inquest was to highlight issues of public health and disease".^{133, p. 226} With Dr. Farr's endorsement Dr. Lankester was elected coroner. Lankester would go on to become a Medical Officer of Health for London and would advocate that the clerical, legal and medical professions should receive tuition in public health.¹³⁴

In his lengthy response to the 1847 cholera epidemic, *The Laws of England Relating to Public Health*¹²⁴, J. Toulmin Smith stated that:

[t]he experience of all history teaches that, in the natural constitution of every nation originate, and to it belong, some certain and peculiar fundamental principles of law, It is only by working upon and carrying out those principles that any new legislative arrangements can be rendered effectual for any good end.^{124, p. 6}

Smith also noted that the, "...common law of England recognises it as good and wholesome, and for the welfare of the community, that [...] the fact of death, and the causes and circumstances of death should be inquired into...".^{124, p. 59} Smith would go on to advocate for the coroner to act as an "officer of health", and for the "obvious" importance

of employing coroners familiar with physiological and medical science, and a competent knowledge of medical jurisprudence.^{124, p. 61}

The Coroners Act 1887

In the last 200 years there have been six inquiries and reviews of the coroner service. Three of these resulted in reports that were produced by Parliamentary Select Committees in 1851¹³⁵, 1860¹³⁶ and 1878-1879¹³⁷; all of which together informed the Coroners Act 1887.¹³⁸ The Coroners Act 1887 was a consolidating act that brought together provisions from various acts including statutes dating from as far back as 1340¹³⁹ (the Engleschrie Act). The Act was notable in that it was the first to define the coroner's jurisdiction which was to include deaths for which, "there is a reasonable cause to suspect that such person had died either a violent or an unnatural death of which the cause is unknown".^{138, s.3(1)} The Act required the coroner to hold an inquest in all of the above cases representing a considerable departure from the long-standing practice of coroners forgoing inquests where possible in order to avoid having a judge decline remuneration when the death turned out to have not been the result of homicide.⁹⁴ The Act also compelled the coroner to call relevant witnesses to testify at inquests, and empowered the coroner to fine witnesses who did not provide evidence. The following year the Local Government Act 1888¹⁴⁰ was passed. This abolished the election of coroners and provided for their appointment by the newly constituted local authorities. The 1887 Act would be in place for nearly 40 years until 1926¹⁴¹ when the Coroners (Amendment) Act was passed bringing the coroner into the 20th century and codifying the coroner's uneasy relationship with both the medical profession and the modern welfare state.

The Coroners' Committee Report of 1910

Following the three reports produced by Parliamentary Select Committees, three far more extensive inquiries were held by Departmental Committees: in 1910 (submitted in four parts)¹⁴²⁻¹⁴⁵, 1935-36 (known as the Wright Report)², and 1971 (known as the Brodrick Report).³ The 1910 *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*¹⁴⁵ was headed by Lord Chalmers and was prefaced with the statement, "[t]he 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".^{145, p. 4} The Report describes the lack of professional qualification of coroners and the lack of

definition of the requirement that coroners only be deemed a ‘fit person’. Lord Chalmers suggested that coroners should hold a professional qualification as a barrister, solicitor or ‘medical man’ and that these criteria be made statutory. The Report also suggested that a coroner be permitted to dispense with an inquest following a post-mortem which rules out the possibility of death by unnatural or violent causes. Ultimately, however, the Report made three recommendations of paramount or ‘special’ importance namely: “the abolition of franchise coroners[§], the payment of all coroners by salary instead of fees, and the bestowal on a central authority of a power to make rules of practice and procedure”.^{145, p. 21}

In a 1913 editorial titled *The Futility of the Coroner’s Inquest* William Brend, a barrister and lecturer in forensic medicine, argues that the Departmental Committee Report “expresses chiefly the coroner’s point of view” and suggests that the Report, therefore, neglects to consider, “...the whole question of the functions of the coroner from the point of view of the community”.^{36, p. 1404} Brend stated that there is a “great diversity of principle” among coroners and that: some coroners believe their sole purpose is to ascertain whether a crime has been committed, others believe that they investigate deaths for scientific or statistical purposes, and others still investigate with the intention of settling compensation claims.^{36, p. 1404} Brend acknowledged that though the coroner was given a specific purpose for his inquiries, his duties had slowly disappeared and no new purpose had been substituted for the original and, as a consequence, “...each coroner has been a law unto himself, and the result is [a] remarkable divergence of principle”.^{36, p. 1404} He also considered whether the absence of a purpose for the inquest was commensurate with the suffering and the expense involved. He went on to consider why this divergence of principle was problematic:

Of course it will immediately be said that the object of the inquest is to find out the cause of death. But this question might be answered in a number of different ways, according to the fundamental purpose for which it is asked, any of which would be equally true and complete for that particular purpose. [...] Until the fundamental purpose of the inquiry is determined it is a waste of time to consider what alterations should be made in the coroners law; for it is clear that the qualifications in the coroner and the procedure adapted to one purpose are not those suited to another.^{36, p. 1404-1405}

[§] Franchise coroners are appointed officials. The City of London and the Temples (Inner Temple and Middle Temple) reserve the right to appoint franchise coroners. The Queen’s Attorney and Coroner as well as the soon to be abolished (under the Coroners and Justice Act 2009) Coroner to the Queen’s Household are also appointed franchise coroners. The appointment of franchise coroners falls outside of the remit of the local authorities which are responsible for the selecting the coroner for their region.

Brend proposed that the coroner's inquiry existed for either a legal or scientific purpose and concluded that it was the scientific purpose - with its concern for medical progress and the enacting of social legislation based on medical statistics - to be paramount.

The Coroners (Amendment) Act 1926

The Coroners (Amendment) Act 1926¹⁴¹ came into effect the same year as the Births and Deaths Registration Act 1926.¹⁴⁶ The Act codified many of the recommendations of Lord Chalmers' Departmental Committee Report including: the ability to waive inquest proceedings following the outcome of a post-mortem, the requirement that coroners hold a professional qualification as a barrister, solicitor or be a registered medical practitioner and the obligatory adjournment (until the conclusion of the criminal trial) of inquests in cases where someone is charged with homicide, manslaughter or infanticide. The Act would, with several exceptions, abolish the appointment of franchise coroners and would end the requirement that both the coroner and the jury view the body. Havard (1960) would later claim that:

Medieval institutions often reflect the prevailing need for something open and notorious, hence such formalities as livery of seisin and dower at the church door. The view of the body by the coroner's jury was probably the last example of this interesting feature of medieval life.^{94, p. 205}

The Wright Report

In 1936 the *Wright Report: Report of the Departmental Committee on Coroners*² was published. The Report presented the recommendations of the Departmental Committee on Coroners which was appointed by the Home Secretary, Sir John Gilmour, for the purpose of inquiring into, "...the law and practice relating to coroners, and to report what changes, if any, were desirable and practicable".^{2, p. 1} The first question the Committee considered was whether the office of the coroner should be retained. The Committee concluded that the abolition of the office was, "...neither practicable nor desirable"^{2, p. 10}; however, it did recommend that the coroner's jurisdiction be "limited to the investigation of the facts how, when and where the death occurred and this investigation of facts being clearly distinguished from any trial of liability, whether civil or criminal".^{2, p. 65} The remaining recommendations included in the report were few but all required substantial changes to the practice of coroners at the time. Broadly, the recommendations were: to abolish the power of the coroner to commit anyone for trial on the charge of murder, manslaughter or

infanticide; to prohibit the coroner's inquiry from deeming anyone guilty of such crimes; and to forbid the inquiry from addressing questions of liability. In addition, it was suggested that coroners should be obliged to adjourn inquests at the direction of the police for the purpose of allowing the police to investigate and, if necessary, proceed to an indictment. In addressing the matter of riders, the Committee recommended that: "verdicts, or riders to verdicts, of censure or exoneration should be prohibited, but this prohibition should not extend to recommendations of a general character designed to prevent further fatalities".^{2.p.65} Contrary to the provisions of the Coroners (Amendment) Act 1926 the Committee suggested that the legislation be changed such that coroners would have to be legally qualified with the added provision that "...they should have a knowledge of forensic medicine".^{2.p.67} The Committee also suggested the establishment of a Rules Committee which would convene for the purpose of making rules to govern coroners and inquests. It was envisaged that the members of the Committee would include representatives of the Lord Chancellor, the Home Secretary, the Coroners Society, the General Council of the Bar, the Law Society, the British Medical Association (BMA), and the general public. A Disciplinary Committee, made up of the same constituents as the Rules Committee, was also proposed as a means of dealing with complaints about the conduct of coroners with the specific mandate to control "the tendency of coroners to animadvert upon the conduct of persons" and to deal with the problems posed when a coroner's comments are defamatory of someone in their absence - in a court of record - leaving the individual(s) with no possibility of appeal or redress.

The Wright Report was not altogether well received. A correspondence^{**} sent to the British Medical Journal in 1936 addressed the Committee's recommendation that coroners should be either barristers or solicitors (and should no longer be qualified for the position by virtue of a medical qualification) stating that, "...the exclusion of doctors who are not also lawyers from these positions is unreasonable, and will be conducive to verdicts often discordant with sense".^{147, p. 389} In a scathing attack on the coronial system in general, and the tendency of coroners to "animadvert" in particular, Lord Morris announced in the House of Lords on 15 April 1937 that he did not believe that the Wright Report would, "rank amongst the classics of its kind" and asked government if they would consider, contrary to the recommendation of the Committee, the abolition of the "ancient office of the coroner".¹⁴⁸ The Wright Report did not recommend changes to the law in order to end the practice of so called animadversions, rather, it was hoped that the Report's

^{**} The article was written by a Mr. John Shiel who was himself a Barrister-at-Law.

denunciation of such practice would result in its discontinuation. Lord Morris noted that, “that pious hope unfortunately has never been fulfilled” and that, on the contrary, “coroners have paid no attention whatever to those recommendations but are getting worse and worse”.¹⁴⁸ He went on to describe several instances of “intolerable impertinence” on behalf of coroners and would appeal to Government to vet coroners’ behaviour stating that:

I suggest to your Lordships that it is time that a stop was put to this kind of thing and that steps were taken, if necessary by legislation, to check this frightful desire on the part of coroners to apportion moral responsibility, and act which has nothing whatever to do with their proper function...¹⁴⁸

Lord Morris went on to question the merit of coroner’s court stating that, “...there is nobody in the world so ill-fitted to inquire into these highly technical matters - as they often are - as a coroner’s jury instructed by such a person as the average coroner”.¹⁴⁸

With regard to the question of whether the office of the coroner should be abolished, Lord Morris offered this:

The coroner’s court is admittedly very old in origin; it goes back, I believe, to the thirteenth century; but that seems to me hardly a reason why it should survive to-day. I suppose it originated in the days when a man was found dead in a ditch and it was necessary to find out how he got there. To-day we have an efficient police force and the coroner serves no useful purpose whatsoever. He is merely a nuisance and an expense [...] the whole thing is extremely un-English [...] and I am convinced that there is a growing and considerable volume of opinion in this country which favours the complete abolition of the coroner and his inquest.¹⁴⁸

In response Lord Snell objected to the abolition of the office stating that, “...I should hesitate to apply my revolutionary zeal to an ancient institution with the spirit that [Lord Morris] has displayed”.¹⁴⁸ However, Lord Snell was of similar view that:

The worst moralist in the world is the amateur moralist, who knows practically nothing about it, and I think the noble Lord has made the point that coroners should stick to the job for which they are appointed, and leave these matters to the discretion of people whose knowledge upon them is superior to their own [...] we expect public officials in this country to do their duty according to their obligations to the State”.¹⁴⁸

The final word in the Lords that day was that of The Marquess of Dufferin and Ava who stated that, "...the suggestions of the Committee will probably be the subject of future legislation" and he concurred with the Wright Committee stating that Government "...cannot possibly contemplate [the] abolition of this ancient office".¹⁴⁸ Though the Marquess had offered assurance that the Committee's recommendations would be put into legislative form no action would be taken with regard to the recommendations until 1953.

The Coroners Rules 1953 and the Coroners Act 1954

The Coroners Rules 1953¹⁴⁹ implemented several of the Wright Committee's recommendations namely: that post-mortems should, where practicable, be carried out by qualified persons; that coroners be required to adjourn an inquest at the direction of the police; that coroners be prohibited from expressing an opinion on any matters other than those it is the duty of the coroner to determine; and that records of inquests (including copies of dispositions, notes of evidence and post-mortem reports) should be kept and made available to any 'properly interested' person. The Rules do not provide a definition of 'properly interested' thus it left the determination as to what constituted 'properly interested' to each coroner, a fact which would be challenged by the BMJ.^{150, 151}

Following two deaths in the early 1970's resulting from the medical use of methohexitone the BMJ began to consider the safety of its use as an anaesthetic. When a third death occurred following administration of the drug the BMJ approached the then Westminster coroner to ask for information regarding the circumstances of the death. The coroner refused to disclose information to the BMJ without providing a reason, however, the BMJ speculated that his refusal was owing to the fact that he, "took a very restricted view of the words 'properly interested' and was prepared to supply copies only to persons who could anticipate being parties to litigation".¹⁵⁰ A letter was subsequently published in the BMJ in which the authors suggested that a fourth death following the use of methohexitone may have been prevented had the BMJ been able to publicise the circumstances of the third.¹⁵¹ They went on to question the coroner's application of the Rules stating that:

Surely coroners' inquests have a value in preventing a repetition of the circumstances producing the death in the case before them. It must, therefore, be questioned whether the coroner concerned can feel that this function of that inquest was fulfilled.^{151, p. 103}

The following year government enacted the Coroners Act 1954¹⁵² which dealt specifically with medical witnesses and payment for post-mortem services and did little by way of

modernising the system. Despite the shortcomings of the 1954 Act the legislation governing coroners would not be reconsidered for another 25 years.

**Chapter V: THE CHANGING
UTILITY OF CAUSE OF DEATH**

The lack of significant change to modernise the coroner system led to the establishment of yet another substantial review of the system, this time under the tutelage of Norman Brodrick. This chapter will review the product of that review, the Brodrick Report, as well as Brodrick's suggestions as to the purpose of the coroner, and the subsequent legislation in the form of the Coroners Act 1988 - the legislation under which the system currently operates pending the implementation of the Coroners and Justice Act 2009.

The creation of the coroner in 1194 was an attempt by Hubert Walter, Richard I's Justiciar, to mitigate the embezzlement of funds by the increasingly untrustworthy and unruly sheriffs, and to secure a source of revenue to help offset the deficit caused by Richard's warmongering and the outrageous ransom demanded for his release from prison. The coroner's purpose at the time of his inception was, thus, strictly fiscal. In the mid-14th century abolition of the itinerant eyres, and subsequent creation of the justices of the peace and the escheator, resulted in appropriation of many of the coroner's revenue-producing duties by these new officials. In the absence of regular oversight by the eyres many coroners, like the sheriffs before them, became corrupt, resulting in early 16th century legislation granting justices the authority and the means to punish them.

The rather unfortunate popularity of poisoning as a means of covert homicide, coupled during the Victorian Period with the grisly fashion for murdering children for money, led to legislation aimed at curbing infanticide and calling for the creation of the General Register Office (GRO). The coroner's new two-fold purpose to detect secret homicide (a purpose championed by the legal profession) and to produce accurate mortality statistics (a purpose championed by the medical profession) placed the coroner at the intersection of two fundamentally distinct discourses; one concerned with criminal justice, the other with public health. Critics of the office would claim that the coroner was ill-equipped and ultimately unsuited to achieve either purpose effectively; however, several coroners argued for continuation of the office - though they would necessarily advocate substantial reform as, by the mid-20th century, the system still retained its vestigial form.

It would not be until the latter part of the 20th century that this frustration of purpose, this awkward relationship with the demands of the modern world, would become evident in very public and often deleterious ways.

THE MODERN EVOLUTION OF THE CORONER

The modern system in the UK and the British Isles

The office of the coroner was instituted in the early 12th century. The system was imposed on Ireland as well since it had previously come under Norman control in 1171 and would be extended to Wales following the Edwardian Conquest of 1282. Scotland did not come under English rule until 1707, but would be allowed to retain its legal system according to the provisions of the 1707 Treaty of Union. Thus, Scotland has never had coroners and has, for several hundred years, operated under a system of procurators fiscal. In 1846 the Coroners (Ireland) Act¹⁵³ was passed which rendered the Irish system distinct from that of England and Wales. In 1936 the Home Office published *The Wright Report: Report of the Departmental Committee on Coroners*² which proposed, amongst other things, the restructuring of coronial jurisdictions and the requirement that all coroners be legally qualified. Few of the recommendations in the Wright Report were enacted in England and Wales⁵; however, the report would provide the impetus for change in Northern Ireland (having become a distinct division of the United Kingdom in 1921) which would incorporate several of its recommendations in the Coroners (Northern Ireland) Act 1959.^{4,154} Passage of the Coroners (Northern Ireland) Act 1959 distinguished the system in Northern Ireland from that of England and Wales. Thus, today in the United Kingdom there are three separate death investigation systems, those of: Northern Ireland (as per the Coroners Act 1959), Scotland (as per the Fatal Accidents and Sudden Deaths Inquiry Act 1976), and England and Wales (as per the Coroners Act 1988 and the newly enacted Coroners and Justice Act 2009). The Republic of Ireland now operates under the Coroners Act 1962.⁵³

The antiquity of the coronial service was acknowledged in three successive reviews of the system, as was the resultant need for substantial reform.³⁻⁵ The modern reform process is generally thought to have begun with the 1971 Brodrick Report and, as the new Coroners and Justice Act 2009 is still undergoing amendments largely as a consequence of the Public Bodies Bill 2010 as is the secondary legislation (*i.e.* the Coroners Rules), the process is largely ongoing and will continue following the completion of this thesis. As such, every attempt has been made to ensure that this background is not only extensive but current.

The Brodrick Report

There have been three substantial reviews of the coroner system since the enactment of the Coroners Act 1954. The first of these reviews was the 1971 *Report of the Committee on Death*

*Certification and Coroners*³ (a.k.a. The Brodrick Report) which was Chaired by Norman Brodrick a criminal court judge who is described in a 1992 obituary as being, “full of common sense”.¹⁵⁵ The review was commissioned largely in response to a damning report by the Private Practice Committee of the British Medical Association titled *Deaths in the Community* which, “...had as its theme the argument that the existing law failed to ensure that causes of death were established with sufficient accuracy and hinted that, in consequence of the deficiencies in the existing law, homicides might go undetected”.^{3, p. ix} Brodrick’s review was carried out between 1967 and 1971 with the terms of reference covering extensive consideration of the then current system of medical certification, the disposal of dead bodies, and the law and practice of coroners and coroner’s courts. The Committee was tasked with recommending “desirable” changes to the system.³ The report began by considering what coroner’s law should seek to achieve stating that:

The many different objectives served by the present law (*e.g.* the recording of causes of death for statistical or research purposes, the investigation of an unusual or accidental death, the identification of new hazards to life, or the provision of a safeguard against secret homicide) are all more likely to be achieved within a framework of law and administration which is designed with this purpose in view.^{3, p. xii}

The report indicated that, “...not many coroners appear to have a clear idea of their role in contemporary society”.^{3, p. 130} The committee deemed that there were “certain principles of public interest which coroners should bear in mind when they consider the form of investigation which they propose to undertake”.^{3, p. 160}

- (i) to determine the medical cause of death;
- (ii) to allay rumours or suspicion
- (iii) to draw attention to the existence of circumstances which, if un-remedied, might lead to further deaths;
- (iv) to advance medical knowledge; and
- (v) to preserve the legal interests of the deceased person’s family, heirs or other interested parties.^{3, p. 160}

In considering point (iii) the committee recommended that it is in the public interest for coroners to hold inquest on any death which might give warning to the public so that precautions might be taken, by individuals or a responsible authority, against any new fatality. With reference to point (iv) the committee concludes that:

...we do not discount the possibility that a number of deaths could occur, either within a particular district or nationally which, although they could be certified by doctors...[,] might appear to indicate the presence of some hitherto unsuspected hazard, and justify research in the interests of public health generally. We believe that if such research were promoted and the systematic co-operation of coroners were deemed essential, individual coroners would be justified in ordering post-mortem examinations, and, if necessary, in proceeding to inquests, in order to determine the relative significance of factors leading to those deaths and in order to enable possible methods of prophylaxis to be studied.^{3, p. 161-162}

The committee acknowledged that many individuals believed that there was “not much wrong” with the system as it existed at the time, however, it was the opinion of the committee that the system was in need of change, albeit “evolutionary”, and not “revolutionary”, change.^{3, p. 233}

Regardless of its self-described evolutionary approach the committee put forth a substantial number of changes addressing the following:

The Coroner’s Present and Future Responsibilities

The committee suggested that reporting of certain types of deaths (*i.e.* deaths in prisons, police custody, and psychiatric institutions) to the coroner be made compulsory under the law with pecuniary penalties for non-compliance. The committee also outlined the jurisdiction, duties and the powers of investigation of the coroner in addition to the procedure for dealing with: inquests in the absence of a body, deaths outside of England and Wales, exhumations, and treasure trove. It called for the repeal of the City of London Fire Inquests Act of 1888 (which required that the coroner investigate all instances of serious fire). A proposed procedure for dealing with deaths reported to the coroner was outlined including the arrangements to be made for the holding of inquests and the procedure for dealing with certain types of deaths, namely those resulting from pneumoconiosis (an occupational lung disease). The committee also recommended that the compulsory requirement that the coroner view each body prior to inquest be abolished suggesting that viewing the body has been, “...rendered obsolete by the autopsy”.^{3, p. 166}

Perhaps most notable, is the suggestion that coroners not be permitted to attach a rider (*i.e.* a statement made by a jury in addition to its verdict) to the findings of a coroner’s court. The committee concludes that, “...the coroner should confine his inquiry to ascertaining and recording the facts both medical and circumstantial which caused or led up to a

death...”.^{3, p. 193} The committee recommends that, should the coroner feel that a death may have resulted from a departure from “proper standards which, if uncorrected, might result in further danger”, then he/she should report “in neutral terms” to an appropriate expert body or public authority.^{3, p. 193} It was suggested to the committee that to do otherwise would be irresponsible given that coroners should not comment on, “issues which have only been superficially considered in the evidence”.^{3, p. 192} Ultimately, the committee believed that, in the event that the coroner sees fit to inform an appropriate expert body or public authority of the cause and circumstances of a death, “[t]he decision whether any further action is required may depend on many factors of which the coroner will know nothing and we think that these matters would best be left to the expert authorities concerned”.^{3, p. 193} The committee also considers the practice of coroners making comments or recommendations during inquest proceedings, “[c]omments on the morals, ethics or professional standards of those who have no opportunity to answer back made by someone who speaks from a position of privilege are reprehensible and we should like to see them discontinued”.^{3, p. 193}

Additionally, the Committee came to the conclusion that, “the duty of a coroner’s jury to name the person responsible for causing a death and the coroner’s obligation to commit a named person for trial should be abolished” - this would be one of the few recommendations in the report which would be implemented.

Development of the Coroners’ Service

The committee made sundry recommendations as to the definition of coroners’ areas, the appointment of coroners, the qualifications of coroners (*i.e.* that they be barristers or solicitors of at least 5 years’ standing), and various other provisions defining remuneration, retirement, and the qualifications of coroners’ officers (*i.e.* it is suggested that police officers no longer be allowed to act as coroner’s officer).

Responses to Brodrick

Like the Wright Report before it, the Brodrick Report was not unanimously approved. John Havard, the author of *The Detection of Secret Homicide*⁹⁴, one of the publications thought to have inspired the review¹⁵⁶, deemed the report, “...full of tendentious reasoning and sadly lacking in scientific evidence for the more sweeping of its recommendations”.^{157, p. 117} Dr. David Kerr, himself a member of the Committee and Member of Parliament for Wandsworth Central, would later write:

The irony of the Brodrick Committee's report (and those of us who served on the committee recognised this) is that nearly all its recommendations were little more than a list of current practices, progress already achieved, or changes made inevitable by the demands of technical developments. Why this all needed 'further study' by the Home Office I shall never understand. Its magnificent staff of civil servants advised us constantly, guided us incessantly, and finished our work by writing the report for us.^{158, p. 117}

It is perhaps worth noting that it was the opinion of the Committee that, "...our general conclusions are the risk of secret homicide occurring and remaining undiscovered as a direct consequence of the state of the current law on the certification of death has been much exaggerated".^{3, p. 30} It is ironic, perhaps, that during the course of Brodrick's inquiry Graham Young (a.k.a. The Teacup Poisoner) was arrested for poisoning his colleagues with thallium*, and Harold Shipman graduated from medical school and was soon to begin what would be a 20+ year career murdering his patients while, "...remaining undiscovered as a direct consequence of the state of the current law on the certification of death".^{3, p. 30}

Ultimately, however, regardless of the wisdom of many of the Committee's recommendations very few were implemented either as part of the Coroners Rules 1984 or the Coroners Act 1988 - though the Committee's suggestions that the practice of having coroners hold inquests on fires (as per the City of London Fire Inquest Act 1888) be ceased, as well as the recommendation that the coroner's power to commit people to trial be abolished, were both realised in the form of section 56 of the Criminal Law Act 1977.¹⁵⁹

Brodrick's Coronial Purpose and Preventable Deaths

In an article published in the *Lancet* in 1994 Cordner and Loff noted that the coroner's original purpose (to secure money for remit to the Crown) had been assumed by the justices of the peace and had been replaced by the purpose to deter and detect homicide, a purpose which was itself assumed by municipal police and the supporting justice system.¹⁶⁰ The Coroners (Amendment) Act 1926¹⁴¹ put an end to coroners holding inquests for the purpose of determining culpability, a fact that was reiterated in the Criminal Law Act 1977.¹⁵⁹ Cordner and Loff question what the current purpose of the coroner is and begin by considering the five purposes of the coroner's inquest as suggested by Brodrick (*viz.* above). Brodrick's first purpose, "to determine the medical cause of death"³ is not,

* Young had poisoned his step mother a decade earlier, a fact which could not be forensically confirmed as she had been cremated by the time Young had decided to confess.

according to Cordner and Loff, specific to the coroner's inquest and is generally determined prior to the coroner's inquest. Another purpose of the inquest put forward by Brodrick was to advance medical knowledge³ though Cordner and Loff believe this may "be regarded with circumspection [...] as it is unlikely that medical knowledge is much advanced [through the inquest]".^{160, p. 799} The purpose to "preserve the legal interests of the deceased person's family..." has since been challenged by Lord Justice Dillon's ruling in *R v Poplar Coroner ex p Thomas* (*viz.* p. 63) when he stated that: "it is not the function of a coroner's inquest to provide a forum for attempts to gather evidence for pending or future criminal proceedings".¹⁶¹ This, according to Cordner and Loff, leaves only two of Brodrick's purposes: to allay rumours or suspicion, and "to draw attention to the existence of circumstances which, if unremedied, might lead to further deaths".^{3, p. 160} Though the authors acknowledge that the inquest is helpful in assuaging public anxiety it is the latter purpose - and a clear public health mandate - which they believe the coroner's inquest best suited to pursue. Citing the recent formalisation of the public health mandate in coronial systems in Canada, Australia and the United States, the authors suggest that the coroner system in England and Wales would benefit from rejuvenation. They conclude that the coroner system in England and Wales has as its fundamental weakness the "absence of a clear purpose".¹⁶⁰ The Australian system, having been recently reoriented to identify threats to public health and safety (the system has specifically identified and mitigated deaths owing to: reversing heavy vehicles, falls through fibreglass roofing, road fatalities on bridges, forklift-related deaths, cooling fan fires, and methadone deaths) which, according to Cordner and Loff, "...shows what can be achieved when the coroner concentrates on identifying and investigating potentially preventable deaths".^{160, p. 800}

The Coroners Rules 1984

The Coroners Rules 1984¹⁸ (*viz.* **Appendix A**) is the primary statutory instrument governing coroners. The Coroners Rules 1984 represented a sweeping consolidation of many earlier statutory instruments governing coroners including the Coroners Rules 1953¹⁴⁹ and 1956¹⁶² and the Coroners (Amendment) Rules 1974¹⁶³, 1977¹⁶⁴, 1980¹⁶⁵ and 1983¹⁶⁶. The Rules outline the conduct of inquests and the logistics of post-mortems though they (along with the Coroners Act 1988) have been criticised as not being "particularly helpful in giving guidance to either pathologists or coroners".^{167, p. 117} In the Third Report of the Shipman Inquiry Dame Janet Smith suggests that, "[the Rules] have not changed with changing times [and] there is no committee charged with regular review of the Rules".^{5, p. 158} Perhaps

most notable, in terms of defining the coroners' purpose, are rule 36 (which defines the 'matters to be ascertained at inquest') and Rule 43 (which defines how the coroner may attempt to ensure the 'prevention of similar fatalities').

Rule 36

Rule 36 (1) of the Coroners Rules 1984 establishes the 'matters to be ascertained at inquest' including: who the deceased was; how, when and where the deceased came by his death; and the particulars for the time being required by the registration acts^{42, 48} to be registered concerning the death. Rule 36 (2) states that, "neither the coroner nor the jury shall express any opinion on any other matters".¹⁸ Dame Janet Smith noted in the Shipman Inquiry that Section 8 of the Coroners Act (which defines the jurisdiction of the coroner) and Rule 36 of the Coroners Rules offer little in the way of establishing the purpose of the inquest:

It is possible to infer from section 8 and from rule 36 that the function of an inquest is to discover, in the case of a violent or unnatural death, a sudden death of which the cause is unknown or a death in prison, who the deceased was and how, when and where s/he came by his/her death. The inquest will also seek to establish the particulars required for the registration of the death. However, these provisions throw little light on why it is thought desirable to discover these facts in the deaths caught by section 8.^{5, p. 213}

Rule 43

Rule 43 of the Coroners Rules 1984 is concerned with the 'prevention of similar fatalities'. It is the only Rule which alludes to a coronial purpose with the possible exception of Rule 17 which states that all inquests must be held in public which may be seen as facilitating Brodrick's suggestion that one of the coroners' roles in contemporary society is to, "allay rumours or suspicion".^{3, p. 160} Rule 43 reads:

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.¹⁸

Thomas *et al* has addressed some of the shortcomings of Rule 43 stating that, "[t]here has been particular concern at the ineffectiveness of the current coronial system in satisfying what many see as its primary purpose: to learn lessons to prevent deaths in the future".^{50, p.}

⁵⁰⁰ A selection of Rule 43 reports and responses are included as **Appendix B**. Thomas *et al* point out that Rule 43 does not compel coroners to report the circumstances of preventable deaths. A commissioned report on the use of Rule 43 by coroners was summarised in the Luce Review.⁴ The report indicated that Rule 43 reports were made following less than 1 inquest in 50, that there was no difference in reporting between full and part-time coroners, and that 1/3 of coroners made no recommendations during the previous year.⁴ The agencies to which Rule 43 reports were addressed were “...local road and health bodies”.^{4, p. 93} The recommendations of the Luce Review specific to Rule 43 are included as **Appendix C**. The Luce Review suggested that 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”^{4, p. 96} and that, in many 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”.^{4, p. 96}

Amendments to the Coroners Rules

The Coroners Rules 1984 have undergone three statutory amendments in 2004¹⁶⁸, 2005¹⁶⁹, 2008¹⁷⁰ and 2010¹⁷¹. The Coroners (Amendment) Rules 2004 relate primarily to excusal from jury service. The 2005 Amendment was largely a response to the Human Tissue Act 2004¹⁷² and defines the terms by which ‘material’ may be retained following a post-mortem. The Coroners (Amendment) Rules 2008 are concerned with changes to Rule 43; in particular they place a statutory duty on organisations who receive Rule 43 reports to respond to the coroner within 56 days. This Amendment also requires that reports and responses, “...be centrally collated for the first time so that lessons learned can be disseminated widely where appropriate and there is national oversight more generally”.¹⁷³ In 2009 the Ministry of Justice published a guidance document for coroners addressing changes to Rule 43 and stating that, “Rule 43 has been amended to give greater prominence and importance to coroner reports to improve public health and safety”.^{174, p. 4} In addition, the guidance document indicated that the Ministry of Justice “intends to produce a regular bulletin on coroner reports and responses”.^{174, p. 18} Summaries of Rule 43 reports and responses were published in July 2009¹⁷⁵, March 2010¹⁷⁶, September 2010¹⁷⁷, March 2011¹⁷⁸, September 2011¹⁷⁹, and May 2012¹⁸⁰. Currently there is no known literature assessing the impact of Rule 43 reports on either overall, or cause-specific, mortality. Concern over the lack of effective evaluation of coroners’ recommendations has been raised by Bugeja and Ranson 2003¹⁸¹ and 2005¹⁸², and Brodie *et al* 2010.¹⁸³ On 1 April 2010 the Coroners

(Amendment) Rules 2010 came into force to rectify a defect in the Coroners (Amendment) Rules 2008 relating to Rule 57A which addresses the supply of information on child deaths to Local Safeguarding Children Boards.

On 11 March 2010 the Ministry of Justice launched a consultation on the secondary legislation (*i.e.* the Coroners Rules) and invited contributions on a range of issues from the conduct of inquests to the training of coroners and staff. The response to consultation was published on 14 October 2010¹⁸⁴ and, though there were no questions in the consultation document relating to the purpose of the coroner (nor any questions specifically about public health and safety), the question of the purpose of the post-mortem was fielded. The Royal College of Pathologists, for example, suggested that:

...whether a post-mortem examination is carried out for the coroner or not, one of the benefits of holding one is that it provides information for the benefit of the living. Aside from identifying inherited diseases, they could also help to inform future public health policy, as well providing information that supports clinical audit and review.^{184, p. 17}

The review and update of the Coroners Rules is on-going. The Parliamentary Under-Secretary of State stated before Parliament on 13 March 2010 that a further consultation would be held upon completion of draft Coroners Rules - the consultation was expected in 2011¹⁸⁵; however, it is now likely to take place in late 2012.¹⁸⁶

The Coroners Act 1988

As the new Coroners and Justice Act 2009 is not slated for implementation until 2012 the current legislation governing coroners is the Coroners Act 1988 (*viz.* **Appendix D**)[†]

Though the Act introduced some important improvements to the system it is largely a consolidation act of Coroners Acts 1887 to 1980 and, “...certain related enactments, with amendments to give effect to recommendations of the Law Commission”.^{34, p. 1} Many sections reproduce legislation verbatim from earlier acts, for example, Section 30 (the section defining the coroners jurisdiction over treasure) of the Coroners Act 1988 is taken

[†] Coroners are also governed by the Treasure Act 2006, however, the coroner’s jurisdiction over treasure is beyond the scope of this thesis and will, thus, not be covered.

(in translation) directly from the 1276 Act[‡] (*De Officio Coronatoris*)¹⁸⁹ which was written in the reign of Edward I.³

The Coroners Act 1988 legislates: the appointment of coroners (coroners are to be appointed by the local council), the qualifications for appointment of coroners (one is required to be a barrister, solicitor or qualified medical practitioner), the terms on which coroners hold office (which includes the provision that coroners may be removed from office at the discretion of the Lord Chancellor), the definition of coroners' districts, and the appointment and functions of deputy coroners. The Act also details the coroner's duty to hold inquests when there is reasonable cause to suspect that the deceased; "has died a violent or unnatural death", "has died a sudden death of which the cause is unknown", or "has died in prison or in such a place or in such circumstances as to require an inquest under any other Act"^{34, s. 8(1)§} The Act also outlines the conditions under which the coroner is obligated to summon a jury (*e.g.* deaths in custody or deaths which occurred, "in circumstances the continuance or possible recurrence of which is prejudicial to the health or safety of the public or any section of the public"^{34, s. 8(3)(d)}), the requisite qualifications of jurors, the sanctions for absent jurors/witnesses, and the matters to be ascertained at inquest which are set out as follows:

11. (5) An inquisition -

(b) shall set out, so far as such particulars have been proved -

(i) who the deceased was; and

(ii) how, when and where the deceased came by his death³⁴

The general conduct of inquests and the requirement that coroners adjourn inquests in cases involving: murder, manslaughter and infanticide; any offence involving reckless driving; or any offence under the Suicide Act 1961 (including aiding, abetting, counselling or procuring a suicide). The Act also states that a coroner may require that a post-mortem examination be carried-out and, in the event that the results of the post-mortem absolve the coroner from the duty to hold an inquest, the coroner may forgo an inquest and may

[‡] It has been suggested that the 1276 Act (*De Officio Coronatoris*) is apocryphal⁹⁴, and that the content of the apocryphal Act is simply that of Bracton's *De legibus et consuetudinibus Angliae*¹⁸⁷ (On the laws and customs of England) 1235.¹⁸⁸ Regardless, the wording is the same and Bracton is considered a sufficiently authoritative source from which to invest in the coroner with the power to hold *ex officio* inquests into treasure trove.⁹⁴

[§] There is no definition in the statute or in the relevant statutory instrument (*i.e.* The Coroners Rules 1984) of precisely what constitutes an 'unnatural' or 'sudden' death.

instead send a certificate of cause of death to the registrar. On 1 February of each year each coroner is subject to the statutory requirement to remit to the Secretary of State, “in such form and containing such particulars as the Secretary of State may direct”^{34, s. 28(1)}, record of all cases in which an inquest has been held during the previous calendar year. In addition, the Act details the appointment of the coroner of the Queen’s household (s/he is appointed by the Lord Steward) and stipulates that:

29. (2) The coroner of the Queen’s household shall have exclusive jurisdiction in respect to inquests into the deaths of persons whose bodies are lying -

- (a) within the limits of any of the Queen’s palaces; or
- (b) within the limits of any other house where Her Majesty is then residing³⁴

As was suggested in the Brodrick Review, the Act stipulates that the coroner need not view the body of the deceased and that, “the validity of [an] inquest shall not be questioned in any court on the ground that the coroner did not view the body”^{34, s. 11(1)}.

The Coroners Rules 1984 and the Coroners Act 1988 are respectively the statutory instrument and statute governing coroners at present. Though the Coroners and Justice Act is set to be implemented in 2012, and an update to the Coroners Rules is now in the consultation phase, the legislation under which coroners were operating at the time of the completion of this thesis are the above Rules 1984 and the Act 1988.

Chapter VI: CASE LAW

It is a feature of common law that judges can create law on a case by case basis which cannot be found in legislation. Case law is also an important means through which to address vague or inconsistent legislation; though addressing such problems in this manner “tend[s] to be incremental rather than dramatic”.^{190, p. 136} Much of the ambiguity in the Coroners Act 1988 has been clarified by the courts and, as a consequence, there is a considerable body of case law relating to coroners in England and Wales. What follows is a précis of some of the relevant case law: it is not a comprehensive summary, but a selection of cases that have become fundamental in defining (or in some cases redefining) coronial law. In particular, cases which address the purpose of the coroner in the context of: the coroner’s jurisdiction, notions of the public good, the matters to be ascertained at inquest, and the European Convention on Human rights.

The coroner’s jurisdiction

Section 8(1) of the Coroners Act 1988 defines the coroner’s jurisdiction and, by extension, the section requires the coroner to conduct a preliminary investigation (under Section 19 of the Act) of a death for the purpose of establishing jurisdiction. The question of jurisdiction has not been straightforward however, owing in large part to the provision that the coroner hold an inquest if there is reasonable cause to suspect that the deceased has died an ‘unnatural’ death. The problematic lack of a standard definition of ‘unnatural’ is the focus of much of the case law relating to coronial jurisdiction. Regardless of the attempts to clarify the construct of the natural/unnatural death there is still a significant lack of agreement among coroners as to how they decide whether a death is natural or unnatural.^{5, 29, 191} Illustrative of the types of issue that arise when the legislation is imprecise is the matter of deaths due to HIV-related illness. In a 2008 study by Roberts *et al* coroners were provided with 16 short clinical scenarios and asked to decide, based solely upon the information given, whether they would deem the death to have been the result of natural causes or unnatural causes (and in so doing assuming jurisdiction to hold an inquest).¹⁹¹ There was a “considerable variation” in coroners’ decisions.^{191, p. 367} Interestingly several coroners believed that death owing to HIV contracted through homosexual sex would be considered unnatural owing to the assumption that “homosexual activities are not natural”.^{191, p. 371} It is implicit, however, that contracting HIV through heterosexual sex would be deemed natural by these coroners and that they would be thus inclined to not assume jurisdiction in such cases. Though the case law regarding the question of how unnatural is to be defined has been addressed by the following cases, the fact that a recent

study has confirmed that an adequate definition of an unnatural death is lacking, or that the existing definition under case law is inconsistently applied, speaks to the complexity of the issue.¹⁹¹

R v Poplar Coroner ex p Thomas (1993)

The deceased in this case was Mavis Thomas a 17-year old severe asthmatic who had experienced an asthma attack on 9 April 1989 that was of sufficient severity that the decision was made *en route* to hospital to stop and call an ambulance.¹⁶¹ Twenty minutes elapsed between the initial call for an ambulance (at which time Thomas was alive but in considerable distress) and its arrival at the scene (by which time Thomas had stopped breathing). Efforts to revive her at the hospital were not successful. Upon being notified of the death the Poplar coroner ordered a post-mortem to be carried out in order to establish if the case could be deemed 'unnatural', thus, confirming his jurisdiction and requiring the conduct of an inquest. The pathologist determined that the death was the consequence of the asthma attack and, therefore, not unnatural. The coroner agreed, dispensing with the need for an inquest. The family sought to review the decision on the grounds that had the ambulance attended Thomas sooner she would not have died, the circumstances of the death being thus unnatural. The application for review was also based on the claim that a public inquest would be an appropriate means to investigate the circumstances of the death. Though the Administrative Court acknowledged that natural deaths can be brought about 'unnaturally' (*i.e.* as a consequence of human fault) the court did not believe this to be the case in Thomas' death owing to the fact that Thomas was not actually in the care of the ambulance when she died. However, Simon Brown L. J. did offer the following:

Although "unnatural" is an ordinary word of the English language, that is not to say that whether or not a particular death is properly to be regarded as unnatural is a pure question of fact. Cases may well arise in which human fault can and properly should be found to turn what would otherwise be a natural death into an unnatural one, and one into which therefore an inquest should be held.¹⁶¹

R v Inner North London Coroner ex p. Touche (2001)

Upon admission to a private hospital in London, Mrs. Touche gave birth to twins via caesarean section. Following the procedure Mrs. Touche was in good health; however, several hours later her blood pressure had doubled resulting in a cerebral haemorrhage and, subsequently, her death. The coroner declined to conduct an inquest on the grounds that

the death was the result of natural causes and that he could not, therefore, claim jurisdiction. Mr. Touche, having come across several expert opinions suggesting that his wife would not have died had her blood pressure been monitored, challenged the coroner's decision on the basis that the hospital had failed in its duty of care to Mrs. Touche. The hospital staff should have been monitoring her blood pressure post-operatively and, had this been done, it was reasonable to assume she might not have died. The coroner refused to change his decision not to hold an inquest; Mr. Touche sought to review the coroner's decision and the court ordered the coroner to hold an inquest. In his subsequent appeal against the decision to order an inquest, the coroner stated his view: "I asked myself whether this was a case in which the defects and human fault complained of lifted the case out of the category of natural and into a category of unnatural death and, applying my common sense as a coroner, I concluded that it did not".¹⁹² Simon Brown L.J. concluded the case, and in doing so refused the coroner's appeal, by stating:

[U]ndoubtedly there will be cases which fall outside the category of "neglect" and yet appear to call for an inquest on the basis already indicated, namely cases involving a wholly unexpected death from natural causes which would not have occurred but for some culpable human failure... It is the combination of their unexpectedness and the culpable human failing that allowed them to happen which to my mind makes such deaths unnatural. Deaths by natural causes though undoubtedly they are, they should plainly never have happened and in that sense are unnatural.¹⁹²

Though other cases have addressed the issue of the unnatural death *R v Poplar Coroner ex p Thomas*¹⁶¹ and *R v Inner North London Coroner ex p Touche*¹⁹² have done much to redefine the unnatural death and, in so doing, have redefined coronial jurisdiction. Regardless of these developments, however, the question of coronial jurisdiction remains a challenge with which coroners are daily confronted.

The public good

R v South London Coroner, ex parte Thompson (1982)

On 18 January 1981 a fire broke out at a home in South London resulting in the death of 13 youths of Afro-Caribbean descent who had been attending a birthday party at the residence. The incident, which came to be known as the New Cross Fire, resulted in an escalation of the existing racial tension in the community following the investigation and conclusion, on behalf of the police, that the fire was accidental. It was suggested by the

families of the deceased that the coroner had led the jury to come to the conclusion that the fire had been accidental, though it returned an open verdict. The family of one of the deceased (Mr. Owen Thompson) requested a judicial review of the coroner's actions claiming that the inquest was inadequate to meet the needs of the case.¹⁹³

In considering the scope of the inquest Lord Lane stated that:

Once again it should not be forgotten that an inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends, the judge holding the balance or the reins whichever metaphor one chooses to use. [T]he function of an inquest is to seek out and record as many of the facts concerning the death *as [the] public interest requires* [emphasis added].¹⁹⁴

Interestingly, this ruling (in addition to that of *R v HM Coroner for North Humberside & Scunthorpe ex parte Jamieson*¹⁹⁵) clearly refutes the last of Brodrick's five stated purposes of the inquest (*viz.* p. 51) - that being to "preserve the legal interests of the deceased person's family, heirs or other interested parties".^{3, p. 160}

R on the application of Takoushis v HM Coroner for Inner North London (2006)

The deceased in this case had a lengthy history of schizophrenia and had been found, subsequent to his most recent admission to a psychiatric hospital, attempting to jump into the Thames.¹⁹⁶ The Metropolitan Police detained him and escorted him to Guy's and St Thomas' Hospital where he was assessed by a triage nurse. The deceased, prior to being seen by the doctor, left the hospital and was later found dead, having drowned himself. The family of the deceased suspected that the death might have resulted, albeit indirectly, from a systemic lack of care on behalf of the Accident and Emergency Department at the hospital. The family requested that the coroner's inquest consider the NHS policy for dealing with patients who on admission had been identified as being at risk of suicide. The coroner declined as he had, prior to the inquest, in the absence of a jury, and based on limited evidence, come to the conclusion that there had been no systemic neglect and that holding an inquest with a jury was unnecessary owing to the fact that the policy of the

hospital in dealing with those at risk of self-harm had since been amended. The wife of the deceased applied for a judicial review of the coroner's decision, was refused, and appealed. Her appeal was allowed.

The Court of Appeal held that where a death occurs as the result of possible medical negligence in a state-operated facility (*i.e.* the NHS) the state has a positive obligation to have a system in place for the investigation of the death, and a mechanism for the determination of civil liability (though this is not the remit of a coroner's) as per Article 2 of the European Convention on Human Rights.¹⁹⁶ In addition, the Court of Appeal noted that all inquests should investigate the possibility of systemic problems which may have led to the death and consider how the risk of injury and death in similar circumstances might be averted in the future. Though the Court of Appeal accepted that deaths occurring under the care of a state medical facility differ from those deaths that occur while in state custody, there still exists an obligation on the part of the state to investigate, in large part, for the benefit of the health and safety of its citizens.

Matters to be ascertained

R v HM Coroner for North Humberside & Scunthorpe ex parte Jamieson (1995)

The Jamieson case has been pivotal in defining the scope and limitations of the coronial inquest and further defines the extent of the inquest as established in *R v South London Coroner ex p. Thompson (1982)*.¹⁹⁵ The case involved the suicide of a prisoner who was at known risk of self-harm but who, it was posited, would not have died had he been properly monitored. The coroner was required to hold an inquest with a jury under Section 8(3)(a) of the Coroners Act 1988 in order to answer the questions set out in Section 11(5)(b), namely, who the deceased was; and how, when and where the deceased came by his death. The coroner instructed the jury that 'lack of care' could not constitute any part of the verdict. The jury found the deceased to have died of suicide by hanging. The deceased's brother subsequently applied for judicial review on the grounds that had the deceased been appropriately monitored he would likely not have died, thus, the coroner should not have disallowed a verdict of 'lack of care'. In the ruling Sir Thomas Bingham M.R. stated that:

It is not the function of a coroner or his jury to determine or appear to determine, any question of criminal or civil liability, to apportion guilt or attribute blame [...] the prohibition on returning a verdict so as to appear to determine any question of civil liability is unqualified, applying whether anyone is named or not.¹⁹⁵

He went on to describe the matters to be ascertained at inquest:

Both in section 11(5)(b)(ii) of the Act of 1988 and in rule 36(1)(b) of the Rules of 1984, ‘how’ is to be understood as meaning ‘by what means’. It is noteworthy that the task is not to ascertain how the deceased died, which might reach general and far-reaching issues, but ‘how the deceased came by his death’, a more limited question directed to the means by which the deceased came by his death.¹⁹⁵

Further, the Court of Appeal held that, in answering the question of ‘by what means’ it would be acceptable to incorporate into the verdict a brief, neutral and factual statement.*

Dame Janet Smith acknowledged that the narrow scope of the inquest, as defined in *R v South London Coroner, ex parte Thompson*¹⁹⁴, and later in *R v HM Coroner for North Humberside & Scunthorpe ex parte Jamieson*¹⁹⁵, presented coroners with, “...a difficult task with uncertain parameters”^{5, p. 214}

The European Convention on Human Rights

In 1950, in response to the atrocities of World War II and the post-war spread of communism throughout Eastern Europe, the Council of Europe drafted the *Convention for the Protection of Human Rights and Fundamental Freedoms*¹⁹⁷, now known as the European Convention on Human Rights (ECHR). The United Kingdom became a signatory on 4 November 1950 and the Convention came into force on 3 September 1953. Article 2 of the ECHR has had a significant impact on inquest law in the UK and its application is of particular concern to coroners in England and Wales.

Article 2 of the ECHR

Article 2 of the ECHR codifies the right to life and reads as follows:

Right to life

1. Everyone’s right to 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 this penalty is provided by law.

* The following are examples of these types of statements taken from inquest data collected for this research: “[the deceased] inserted a knife into his jugular vein which caused the injuries which resulted in his death”; “[the deceased] died as a result of choking on a large piece of sandwich that had been given to him” and “the deceased died from injuries sustained when she was struck by a delivery lorry outside her home”.

2. 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 defence of any person from unlawful violence;
- (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;
- (c) in action lawfully taken for the purpose of quelling a riot or insurrection.¹⁹⁷

In cases where there is cause to suspect that an individual's right to life has been violated by the state the European Court of Human Rights has ruled that there exists a procedural duty on the part of the state to carry out an effective and public investigation of the circumstances. The following case law has been used to establish this procedural duty:

McCann v UK (1996)

On 6 March 1988, Special Air Service (SAS) agents shot and killed three known members of the Irish republican Army (IRA) in Gibraltar. It was later confirmed that Danny McCann, Sean Savage and Mairead Farrell had conspired to disrupt a military parade by detonating a car bomb. They were all killed prior to the detonation of the bomb by SAS agents leaving the European Court of Human Rights to consider whether the killings were "reasonably justified".¹⁹⁸ The Court ruled that the actions of the SAS agents responsible for shooting the three IRA members did not constitute a breach of Article 2 as the use of force was deemed necessary given the circumstances. However, the fact that intelligence agents did not consider alternative means to prevent the bombing - including apprehending the IRA members at the border or considering potentially non-lethal responses to alternative possibilities with regard to the detonation of the explosives - constituted a procedural failing at the operational level and, consequently, a breach of Article 2. Ultimately, the case raised the issue of system deficiency (as distinct from personal liability) and as something to be subject to legal scrutiny and that there exists under Article 2 of the ECHR the: "...obligation to protect the right to life [...] and requires by implication that there should be some sort of official investigation when individuals have been killed as a result of the use of force...".¹⁹⁸

Osman v United Kingdom (1998)

Mr. Ali Osman was fatally shot on 7 March 1988 by Paul Paget-Lewis, a teacher who had developed a "reprehensibly suspect" friendship with Ahmet Osman (the victim's son and one of Mr. Paget-Lewis' students).¹⁹⁹ For nearly a year Mr. Paget-Lewis' erratic behaviour

had been repeatedly reported to the police who, at no time, undertook to apprehend or interview him, search his home, or charge him with an offence until his arrest on suspicion of murder on 8 March 1988. The applicants, Mrs. Osman (the widow of Mr. Ali Osman) and Ahmet Osman, contested that the authorities failed to appreciate and act on a series of warning signs which suggested that Mr. Paghet-Lewis represented a threat to the safety of Ahmet Osman and his family. Though the Court would ultimately establish that the action (or inaction) of the police did not constitute a violation of Article 2, it was the ruling of the court that:

In the opinion of the Court where there is an allegation that the authorities have violated their positive obligation to protect the right to life in the context of their above-mentioned duty to prevent and suppress offences against the person, it must be established to its satisfaction that the authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual or individuals from the criminal acts of a third party and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk.¹⁹⁹

The case thus established that the state is obligated “to take reasonable steps to avoid a risk to life of which they knew or ought to have known”.⁵⁰ By extension, there must be an effective investigation by the state in cases where a death has resulted from the failure of the state to act to avoid the risk of death (the risk to which they ought to reasonably have known) in order to meet the positive obligation under Article 2.

Jordan v UK (2001)

On 25 November 1992 Pearse Jordan, an IRA volunteer, was shot three times by officers of the Royal Ulster Constabulary (RUC).²⁰⁰ Though statements from witnesses differed from those provided by the RUC, certain facts were not in dispute. It had been established that Jordan was not armed at the time of the shooting and was shot in the back after leaving his vehicle. However, the Director of Public Prosecutions did not believe there was sufficient evidence to warrant the prosecution of any of the officers responsible for Jordan’s death.

In Northern Ireland the only matters to be ascertained during a coroner’s inquest - as per section 31(1) of the Coroners(Northern Ireland) Act 1959¹⁵⁴ - are who the deceased person was and how, when and where the deceased died. The father of the deceased argued that the original inquest, in strictly adhering to the statute, was insufficient to meet the positive

obligations under Article 2 of the ECHR to conduct an effective official investigation following a lethal use of force on behalf of an agent of the state, as it did not permit the inquest to address questions of responsibility for his son's death.²⁰⁰ Moreover, as the death clearly engaged Article 2 of the ECHR; however it had not been subject to a sufficiently effective investigation into the circumstances of the death for the court to conclude that the positive obligation under Article 2 had been met as certain minimal requirements had to be present to satisfy the state's procedural duty under the ECHR. These requirements are:

- the investigation must be independent;
- the investigation must be effective;
- the investigation must be reasonably prompt;
- there must be a sufficient element of public scrutiny;
- the next of kin must be involved to an appropriate extent; and
- the state must act of its own motion^{50, p. 361}

Ultimately, the Court ruled that it was not for the European Court of Human Rights to specify precisely which body should be responsible for carrying out the positive obligation under Article 2; however, it has since been ruled that the coroner's inquest is, in fact, sufficient to meet the obligation provided it is allowed to deliver findings relating to the responsibility for a death (*viz. Middleton* and *Amin* below) - this is generally done via a narrative verdict. Though an effective investigation was not completed owing to the limited statutory scope of the original inquest, a second inquest into Jordan's death has yet to be held. However, on 24 February 2011 a new inquest was announced and was provisionally set to take place on 3 October 2011, nearly 20 years after Jordan's death.²⁰¹ In September 2011 the coroner opted to delay the inquest until Spring 2012 owing to the disclosure of new evidence by the RUC.²⁰²

R (on the application of Middleton) v West Somerset Coroner (2004)

In *McCann v UK* it was established that compliance with Article 2 of the ECHR required a procedure to investigate deaths resulting from the use of force on behalf of the state.¹⁹⁸ In *Jordan v UK* the appellant questioned, amongst other things, whether the coronial inquest into the death of Pearce Jordan had been sufficient, in terms of scope and degree of scrutiny, to meet the obligation to carry out an effective official investigation into his death.²⁰⁰

As in the cases of *Jamieson and Sacker* (*viz.* p. 73), *R (on the application of Middleton) v West Somerset Coroner*²⁰³ involved a suicide in prison and questioned the state's duty of care in custodial institutions. On 14 January 1999 Colin Middleton, who had been incarcerated since the age of 14 for the murder of his 18 month-old niece, hanged himself in his cell at HMP Bristol. Only a few months prior Middleton had caused himself serious harm resulting in staff opening a F2052SH (at risk of self-harm) form which was closed several days later by two officers with no prior knowledge of Middleton's state of mind. Middleton had been receiving medication for depression, had spoken to other prisoners of suicide and had written to prison staff expressing his unhappiness. Despite his depressive state, his suicidal ideation and his recent attempt to self-harm Middleton was not put on suicide watch and, as a consequence, was left unsupervised allowing him to hang himself. The initial coroner's inquest was quashed "for want of sufficient enquiry" requiring a new inquest which was held in 2000 during which the coroner directed the jury not to consider a verdict of 'neglect'.²⁰³ The jury returned a verdict stating that the cause of death was hanging and that the, "deceased had taken his own life when the balance of his mind was disturbed".²⁰³ The coroner indicated to the jury that, should it so wish, it could submit a note to him with its verdict as well as any other matters that the coroner might reasonably include in a Rule 43 letter which he had planned to send to the Chief Inspector of Prisons. Though the jury did pass a note to the coroner expressing its opinion that the prison staff, in not putting the deceased on a seemingly warranted suicide watch, failed in their duty of care for the deceased, the coroner refused to allow the note to be made public. Lord Bingham, in considering the case addressed three questions:

- What, if anything does the Convention require (by way of verdict, judgement, findings or recommendations) of a properly conducted official investigation into a death involving, or possibly involving, a violation of Article 2?
- Does the regime for holding inquests established by the Coroners Act 1988 and the Coroners Rules 1984 [...] meet those requirements of the Convention?
- If not, can the current regime governing the conduct of inquests in England and Wales be revised so as to do so, and if so how?²⁰³

Lord Bingham concluded that where the inquest is the means through which the procedural obligation under Article 2 is addressed an explicit statement of the jury's

findings is required. With respect to the second question Lord Bingham deemed that in some cases the then current practice of issuing short form verdicts would allow the jury to address matters required under Article 2 and therefore in some cases the system was “quite satisfactory”.²⁰⁴ However, in other more complicated cases involving a number of factors (systemic and otherwise) a short form verdict would not suffice. Responding to the third question Lord Bingham concluded that the coronial inquest system could be adapted to meet the positive obligation under Article 2 provided the statutory requirement to determine ‘how’ the deceased died be interpreted (contrary to the ruling in *R v HM Coroner for North Humberside & Scunthorpe ex parte Jamieson*¹⁹⁵) to mean, “by what means and in what circumstances”.²⁰⁴

R v Secretary of State for the Home Department ex parte Amin (2003)

The above questions were similarly raised in the case of *R v Secretary of State for the Home Department ex parte Amin*²⁰⁵ which considered the murder of Zahid Mubarek, a prisoner in the Feltham Young Offender Institution, by his cellmate. On 8 February 2000, Robert Stewart, a known racist and violent offender who had a history of violent attacks on fellow prisoners and who had been described by one of the registered mental health nurses at the prison as having, “a long-standing, deep seated personality disorder [and] a glaring lack of remorse, feeling, insight, foresight or any other emotion”^{206, p. 629}, was placed into the 19 year-old Mubarek’s cell. On 21 March 2000 (the day of Mubarek’s release), Stewart beat him into a coma with a wooden table leg. Mubarek would die the following week as a consequence of the injuries sustained in the beating and again questions would be raised as to the nature and extent of the Article 2 procedural obligation to conduct an investigation which meets the requirements as defined in *Jordan v UK*.^{200, 205}

The purpose of the procedural obligation under Article 2 was defined in *Jordan v UK* as, “secur[ing] the effective implementation of the domestic laws which protect the right to life and, in those cases involving State agents or bodies, to ensure their accountability for deaths occurring under their responsibility”.²⁰⁰ Additional purposes for an investigation into an Article 2 case were described in *Amin* and are as follows:

The purposes of such an investigation are clear: to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of

knowing that lessons learned from his death may save the lives of others.²⁰⁵

However, it was also implied that the coroner's inquest is not the sole option for meeting the Article 2 obligation as, "the European Court has not prescribed a single model of investigation to be applied in all cases [and] there must be a measure of flexibility in selecting the means of conducting the investigation".²⁰⁵ In addition, the case addressed the question of to whom the procedural duty is owed and suggested that the duty is to both the family and others in similar circumstances to that of the deceased.²⁰⁵

R v HM Coroner for the County of West Yorkshire ex parte Sacker (2004)

Section 11(5) of the Coroners Act 1988 and Rule 36(1) of the Coroners Rules 1984 identify the matters to be ascertained following an inquest. This section requires that "so far as particulars have been proved" the inquest determine who the deceased was; and how, when and where the deceased came by his death.³⁴ It has been argued that if the state is to execute its procedural obligation under Article 2 of the ECHR the scope of the inquiry must necessarily be widened.

On 29 July 2000 Sheena Creamer was remanded into custody for an alleged crime of dishonesty. During her second court appearance she was tearful and expressed a veiled intention to self-harm stating that "...she had nothing left and her life was a mess".²⁰⁷ Creamer was later assessed by a locum medical officer who did not believe her to be suicidal and deemed her *compos mentis*. She was returned to her cell where she was found hanged approximately 12 hours later. The prison officer who discovered Creamer hanged was not in possession of keys to her cell and, as a result, had to call for assistance - a fact which slowed the response to the incident. In addition, the fact that Creamer was a known intravenous drug user who had, since the time of her remand, been experiencing heroin and alcohol withdrawal was not communicated to the proper prison authorities. As per sections 8(1)(c) and 8(3)(a) of the Coroners Act 1988 the coroner was required to conduct an inquest, with a jury, on the death of Creamer. The coroner limited the scope of the inquiry to establishing 'how' the deceased came to her death, thus limiting the information that could come of it and, as a consequence, the degree to which the inquest considered those matters addressed in Article 2 of the ECHR and the procedural duty established in *Jordan v UK (2001)*. In order to achieve the goals of the procedural duty under Article 2 the question of 'how' needed to be understood as "by what means and in what circumstances".²⁰⁷ The coroner's actions in limiting the jury to determining 'how' the

deceased came to be dead, though consistent with the statutory requirement under the Act, deprived the inquest of the ability to, “...to address the positive obligation that article 2 of the Convention places on the State to take effective operational measures to safeguard life”.²⁰⁷

Chapter VII: THE MODERN IDENTITY CRISIS

Through a system of reviews, select committees, statutes, statutory instruments and case law the coronial system has, however inadequately, become defined under the law. However, the system does not operate in a vacuum and has been criticised publicly as a consequence of inquiries into various systemic failures culminating in the egregious system failures that allowed Harold Shipman to kill at least 215 of his patients. Much of the impetus for the current change has been the result of Harold Shipman's crimes, however, over the last 20 years coroners in England and Wales have been implicated in several public inquiries involving serial killers, mass disasters, and tissue retention. These public scandals have at different times, and to varying degrees, resulted in calls for change, thus, it would be wrong to suggest that the law is exclusive in its ability to define the functioning of the modern coroner, as much of the current legislation has been implemented in reaction to what are often exceptional events which have highlighted the modern coroner's awkward existence. In this chapter I shall review some of the more recent scandals to befall the coroner system including the Shipman Inquiry and the responses to the recommendations contained therein.

The Allitt Inquiry

Between 21 February and 22 April 1991 four children died after being admitted to the children's ward at Grantham and Kesteven Hospital, Lincolnshire. Nine other children were injured as the result, it would later be found, of deliberate injections of insulin and potassium chloride. In November of that year registered nurse Beverly Allitt was charged with the four murders as well as nine counts of attempted murder and nine counts of causing grievous bodily harm with intent. Subsequent to Allitt's conviction on all 22 counts the Secretary of State for Health announced that an inquiry would be conducted into the events at Grantham and Kesteven Hospital and would additionally consider, "...such other matters [...] as the public interest may require".^{208, p. 7} With respect to the murder of the first child the inquiry levied some harsh criticism on the coroner's actions following the post-mortem:

There were circumstances relating to the death of one child that do call for serious adverse comment. It is of particular significance that this was the first child in the series of victims. We had evidence that the Consultant in charge of the case made a determined effort to have a post-mortem carried out by a paediatric pathologist. He was thwarted by the combined efforts of the locum general pathologist and the Coroner's Officer in

circumstances that are not entirely clear, since their evidence was conflicting. The post-mortem findings were in fact inexplicable. Their mysterious nature was conveyed to the Coroner but he accepted death as being due to natural causes. There is a distinct possibility that had the Consultant Paediatrician been listened to, the whole train of events might have been brought to a halt as the result of the first incident.^{208, p. 126}

The Bristol Royal Infirmary Inquiry and the Royal Liverpool Children's Inquiry

In response to concerns about a series of deaths of children following cardiac surgery at Bristol Royal Infirmary (BRI) an inquiry was carried out to consider events at the BRI between 1984 and 1995.⁵² In the course of the inquiry evidence was given regarding the removal and retention of tissue following post-mortem examinations of children who had died at the BRI. Following lengthy consideration of the broad implications of the events at the BRI the committee panel began the preparation of an interim report addressing the matter of tissue retention. During the course of the investigation evidence was given which suggested that routinely, and in the absence of consent, tissue was being retained at the Royal Liverpool Children's Hospital (a.k.a. Alder Hey Children's Hospital). This revelation provided the impetus for The Royal Liverpool Children's Inquiry which was announced in December 1999 and was tasked with investigating the "...removal, retention and disposal of human organs following post-mortem examination at Alder Hey."^{209, p. 5} It was discovered that: tissue was taken following both coroner's post-mortems and hospital post-mortems, tissue was taken in violation of the Human Tissue Act 1961^{210†}, the pathologist responsible for retaining the tissue in question (Professor van Velzen) acted unethically and illegally, and that hospital management behaved in an evasive and paternalistic manner towards the bereaved.[‡]

In the course of considering the professional practice surrounding the retention of the tissue the coroner's conduct, as well as the general shortcomings of the coroner system (including the conduct of the coroner's officer), were addressed. A witness giving evidence

† Which has since been superseded by the Human Tissue Act 2004.¹⁷²

‡ Coroner ordered post-mortems are carried out at the request of the coroner in order to determine cause of death in cases which are the remit of the coroner to investigate under the Coroners Act 1988 - consent is not required. Hospital autopsies are always carried out with the consent of the next of kin and are not limited to establishing the cause of death. The hospital autopsy may establish the extent and efficacy medical interventions, any pathologies which may/may not be related to the patient's death, the accuracy of the diagnosis and, ultimately, a cause of death.

to the Inquiry commented on the competence of the coroner's officer -whose job was to decide whether a post-mortem would be necessary or not:

The communication [between the physician and the Coroner's Office] has been with an Officer who, from my point of view, had very little understanding of what the problem was and who seemed to have difficulty spelling the name of the pathologist. We could tell these people just about what we wanted and we could decide almost whether or not we wanted a Coroner's post mortem report by putting the emphasis on the severity of the disease and their happiness to produce a cause of death.^{209, p. 332}

The Inquiry was equally critical of the competence of the coroner, particularly with regard to cases of Sudden Infant Death Syndrome (SIDS):

On several occasions SIDS was accepted by the Coroner as a proper cause of death despite the lack of histology. It exemplifies the Coroner's lack of medical knowledge in a relatively routine matter. In failing to insist on histology Mr Barter must have recorded an inaccurate cause in a number of cases.^{209, p. 349}

The Inquiry concluded its investigation with a comprehensive summary and a series of recommendations, of which seven related to the coroner whose "slackness", the Inquiry concluded, had "...undoubtedly contributed to the delay in identifying Professor van Velzen's abuse of post mortem procedures".^{211, p. 4} The Inquiry's recommendations for the coroner system included: medical education for coroners, direction for coroners in the "proper exercise of their judicial discretion", proper training for coroners' staff, thorough communication with the bereaved as to the coroner's function and procedure, and the establishment of an efficient system for securing post mortem reports.^{211, p. 19}

On 30 January 2001, the day *The Royal Liverpool Children's Inquiry* was published (and exactly one year after Harold Shipman's conviction), Alan Milburn the then Secretary of State for Health announced in the House of Commons that the Home Secretary had "set in train a review of the coroner system".²¹² During the same debate Mr. Ivan Lewis, the MP for Bury South, commented that one of his constituents (Mrs. Elaine Isaacs) had discovered that, following her husband's suicide, his brain had been retained during the post-mortem without her knowledge or consent. Mr. Lewis requested that Mr. Milburn request a thorough investigation of the Isaacs' case. The Secretary agreed and in 2003 *The Isaacs Report*²¹³ was published, as was the Department of Health's response to the Report.²¹⁴ The Report and the response largely reiterated the findings of the Royal Liverpool Children's

Inquiry stating that coroners are confused by their own rules and that: the Coroners Rules “refer only obliquely to tissue retention”^{213, p. 373}; coroners have no authority to retain tissue for research as this is not the purpose of a coroner-ordered post-mortem; and tissue from post-mortems could be used for the ‘public good’ but that the consent for research on post-mortem tissue requires the consent of the next-of-kin.²¹³

Ministers in the House of Commons, in responding to the publication of the Royal Liverpool Children’s Inquiry, unanimously condemned the practice of tissue being retained without consent and agreed that reform was needed of the then 40 year-old Human Tissue Act.²¹⁰ Ministers also welcomed a thorough review of the coroners system, “especially after the Shipman case”.²¹² However, they were quick to express the views of their constituents that, “...had they been asked properly, they would have been only too willing to allow their child’s death to help another child live” and that “had they been given the opportunity, they would of course gladly have donated their child’s organs to help another child”.²¹² Mr. Wilshire, the MP for Spelthorne, spoke with respect to the death of his own daughter stating, “[i]n the anguish of the moment, I forgot to ask whether any parts of my daughter could be used to help others. I can only say that I wish that someone had asked me”.²¹²

The Clarke Inquiry

On 20 August 1989 the passenger boat *Marchioness* collided with the 2,000 tonne dredger *Bowbelle* on the Thames near Southwark Bridge killing 51 of the 131 of the people onboard. The recovery effort resulted in the retrieval of all 51 bodies, 27 of which were found in the Thames while the remaining 24 were extracted from the wreckage. The bodies were recovered over a course of two days; 26 of the bodies had decomposed sufficiently by the time of retrieval to render them “not suitable” for visual identification.³⁹ For the purpose of facilitating the identification of the deceased (for which identification via fingerprint analysis was thought necessary) the coroner for Inner West London authorised the removal of the hands of the deceased persons - this occurred prior to the retrieval of any bodies deemed not suitable for visual identification. Both hands were, thus, removed from 25 of the deceased - in 21 cases the hands were removed from bodies which were identified using other means. The families of the deceased whose hands had been removed were not informed that this had been done, nor were the hands reunited with the bodies prior to being released to funeral homes. The hands remained in a refrigerator in Westminster mortuary until August 1993 when the coroner authorised their destruction.

Relatives of those whose hands were removed discovered what had occurred and pressed for a public inquiry. The *Public Inquiry into the Identification of Victims Following Major Transport Accidents*^{39, 215} (a.k.a. *The Clarke Report*) was published in 2001 and was critical of the coroner's decision to authorise the removal of the hands of deceased persons who could reasonably be identified using other non-mutilating means; as well as the coroner's practice, at the time of the disaster, of not informing families that the deceased would be undergoing a post-mortem examination, or any other procedure which would involve invasive means. The coroner had, between the time of the disaster and the commencement of the inquiry, opted to change his approach to communicating with families, to one that was "open and honest" and which the Lord Justice lauded as being "recognised as right in principle"^{39, p. 45}. The Inquiry was critical of the lack of training of coroners, as well as the fact that coroners' attendance at training sessions held by the Home Office was entirely voluntary.

Lord Justice Clarke concluded that the law relating to coroners is "arcane"^{39, p. 119}:

...my experience in this inquiry and my reading of the Bristol and Alder Hey reports have persuaded me that it is time for a detailed review of the role of the coroner [...] in order to consider in what form the office should continue and to propose a statutory scheme which would codify the powers, duties and responsibilities of the coroner so that they can be found in one place and be readily comprehensible to all.^{39, p. 60}

The Luce Review and the Shipman Inquiry

Background to the Luce Review

On 30 January 2001 the Secretary of State, Alan Milburn, announced that the Home Secretary had begun the process of reviewing the coroner system "...so that we can learn the lessons of what went wrong at Alder Hey and elsewhere".²¹² In July 2001 Mr. Tom Luce was selected to chair a review and report on the death certification and coroner services in England, Wales and Northern Ireland. The *Fundamental Review of Death Certification and the Coroner Services in England, Wales and Northern Ireland* (a.k.a. The Luce Review) was published in its entirety in April 2003.⁴

The need for change

It was the opinion of the Review Committee that the death certification and coronial systems were not "fit for purpose in modern society".^{4, p. 16} The "critical weaknesses" of the systems are extensive and relate, amongst other things, to the fact that they are

“internally fragmented”^{4, p. 16} as well as the fact that “although both deal with individual deaths they are not concerned with patterns or trends”^{4, p. 17} In addition:

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 coroners service is not identifying some suicides, drug related deaths and deaths to which adverse reactions to prescribed drugs may have contributed.^{4, p. 17}

The Committee was also critical of the lack of medical skills within the system, the absence of a “clear modern legal base for the conduct of most death investigations”, no mechanisms to encourage either system to adapt to emerging needs and, perhaps most notably, “there are no agreed objectives or priorities”^{4, p. 18} Though the Review defines, at considerable length, the problems with the coroner system and its inability to effectively support public health and safety it does accept that there is “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”^{4, p. 172}

A lengthy report submitted to the Review on behalf of the London School of Hygiene & Tropical Medicine - entitled *Improving the health of the living? An investigation into death certification and coronial services and some suggestions for change*²¹⁶ - included a list of the overall functions of the coronial system. The functions were:

- To provide information for the relatives of the deceased
- To rule out criminal activity, accidents, neglect, and unnatural causes
- For collation of statistics which inform public health, policy and research at local, regional, national and international levels
- To feedback findings to referring doctors to allow for investigation and audit in individual cases in order to improve subsequent practice^{216, p. 6}

The LSHTM report indicates that “these functions are not being fulfilled”^{216, p. 6}, there are “major problems”^{216, p. 9} with the coronial system and that it “needs urgent reform and revisions”^{216, p. 7}

The “functional objectives” and “service values” of the coroners service

The review outlined proposed “functional objectives” of the coroner service. They include the following objectives:

- 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;
- 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;
- to contribute along with other public services and agencies to the avoidance of preventable deaths.^{4, p. 24}

The list of service values is extensive but begins with the need to have a service which meets, “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” and which ensures that “information on preventable deaths is made fully available and has proper influence”.^{4, p. 25}

The recommendations of the Luce Review

The Luce Review outlined six areas of “major change” which inform the specific recommendations put forth in the review. These major changes involve establishing: a “consistent professional service based on full-time leadership”^{4, p. 21}; a consistent service for families; a new death certification and cremation process; a system which emphasises “informative and accessible outcomes to coroners’ investigations”^{4, p. 23}, a system for recognising the work of coroners’ officers; and 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”.^{4, p. 22} Included in the Review’s 123 recommendations was the suggestion that a new position of Statutory Medical Assessor be created in each coronial area. The Statutory Medical Assessor would be a physician and would: provide support for other physicians in the process of death certification, audit death certification procedures, review all post-mortem reports, and liaise with public health agencies with respect to the findings. In addition, the Review strongly recommended the creation of the office of the Chief Coroner to oversee a proposed “unified national coroner jurisdiction”.^{4, p. 192}

Harold Shipman

On the evening of 7 September 1998 Harold Shipman surrendered himself to the Greater Manchester Police having been charged with murder, forgery and attempted deception.²¹⁷ Over the following months the extent of Shipman's crimes would become apparent resulting, ultimately, in his October 1999 trial, at which the police presented evidence implicating him in the serial murder of 15 of his patients. As early as 1985 Shipman began targeting elderly patients, usually women, to whom he would administer with a lethal dose of diamorphine. He would generally 'discover' the body himself and would complete a death certificate listing a cause of death that was consistent with the patient's medical history, or not entirely unexpected given the patient's age. In January 2000 Shipman was convicted of the murder of 15 elderly women between 1995 and 1998. He would eventually be found, posthumously[§], to have been responsible for an additional 200 murders.⁵ As the extent of Shipman's actions was discovered, the inevitable questions began: how could he have eluded detection for so long while operating entirely within the rules and regulations of the death investigation, certification and registration systems which were themselves intended to prevent such crimes?

Background to the Shipman Inquiry

On 1 February 2000 Alan Milburn, the Secretary of State for Health, announced that an independent inquiry would be established with the following terms of reference: "to consider the extent of Harold Shipman's unlawful activities", "to enquire into the actions of the statutory bodies, authorities, other organisations and responsible individuals concerned...", to enquire into those organisations responsible for monitoring primary care provision and the use of controlled drugs, and "...to recommend what steps, if any, should be taken to protect patients in the future".²¹⁸

The review was initially to be held in private, however, following a successful judicial review, the Health Secretary announced that the inquiry would be held in public in accordance with the Tribunals of Inquiry Act 1921.²¹⁹ In February 2001 Dame Janet Smith DBE was appointed Chairperson of the inquiry, aptly named The Shipman Inquiry. On 26 February 2003, prior to the publication of the Third Report, Caroline Swift, counsel to the Shipman Inquiry, was invited to speak at the British Academy of Forensic Science annual meeting. In her speech, *The Shipman Inquiry: A progress report*²²⁰, Swift would hint at the findings of the Third Report by acknowledging that simply reforming the system for the

[§] Shipman committed suicide while in Wakefield Prison in 2004.

purpose of preventing another physician from killing his patients would not suffice - the changes would need to be far more extensive and would require consideration of “wider issues of public interest”.^{220, p. 192} She would go on to state that an effective death investigation and certification system is critical to public health, as mortality data is foundational in terms of the development of public health policy. She would also acknowledge the potential contribution of a reformed system to protecting public safety by identifying preventable deaths and offering guidance on how to prevent their reoccurrence.²²¹

The Inquiry’s findings and responses were published as six reports between July 2002 and January 2005. On 14 July 2003 the Second²²¹ and Third Reports⁵ of the Shipman Inquiry were published. The Second Report considered in detail the 1998 police investigation into the concerns of Dr. Linda Reynolds - a physician at the clinic opposite that of Shipman’s surgery - regarding the number of Shipman’s patients who had died. The investigation was concluded after only three weeks on the basis that Dr. Reynolds’ concerns were deemed to be unfounded. Following the conclusion of that investigation Shipman murdered three more of his patients before being arrested. It was the opinion of Dame Janet Smith that, “...if the police and the Coroner had moved with reasonable expedition, the lives of Shipman’s last three victims would probably have been saved”.^{221, p. 10 & 137}

Despite any personal culpability on the part of the coroner, it had become apparent that it was in fact the entire death certification system, as well as the coronial service as a whole which had failed, in part, to deter and/or detect Shipman’s crimes. Dame Janet began the Third Report of the Shipman Inquiry, *Death Certification and the Investigation of Deaths by Coroners*⁵, by stating that:

[t]he evidence received by the Inquiry suggests that there is much dissatisfaction with the present arrangements. It is said that the existing system is fragmented, is not sufficiently professional, is applied to very variable standards in different parts of the country and does not meet the needs of the public, especially the bereaved. It is said that it does not satisfy the public interest in the discovery of the true causes of death in the population. It does not contribute, to the extent that it should, to the improvement of public health and safety. If these complaints are well founded, as I have found they are, then there are good reasons for radical change, quite apart from the need to ensure that, so far as possible, homicide does not go undetected.^{5, p. v} [...] It is my hope that some good may now come from those tragic events and that in the

future we will have, in this country, systems of death investigation and certification that will bring real benefits in the fields of public health and safety and will meet the needs and expectations of private individuals, especially the bereaved.^{5, p. vi}

The Need for a Reorientation of Purpose

Following a lengthy and far-reaching investigation the Inquiry concluded that the death certification and coronial systems required radical change, that what was required was a, "...complete break with the past, as to organisation, philosophy, sense of purpose and mode of operation".^{5, p. 25} The Inquiry recommended that:

The aim of the new Coroner Service should be to provide an independent, cohesive system of death investigation and certification, readily accessible to and understood by the public. It should seek to establish the cause of every death and to record the formal details accurately, for the purposes of registration and the collection of mortality statistics. It should seek to meet the needs and expectations of the bereaved. Its procedures should be designed to detect cases of homicide, medical error and neglect. It should provide a thorough and open investigation of all deaths giving rise to public concern. It should ensure that the knowledge gained from death investigation is applied for the prevention of avoidable death and injury in the future.^{5, p. 25}

The Purpose of the Coroner's Inquest

The inquest process was not considered at great length by the Inquiry (none of the deaths caused by Shipman had been subject to an inquest, in effect rendering this aspect of the coronial system beyond the remit of the Inquiry), however, it did consider the purpose of the inquest as well as the findings of the Luce Review which addressed the inquest purpose and procedure in considerable detail.

In considering the purpose of the coroner's inquest the Inquiry noted that though the relevant legislation (Section 8 of the Coroners Act 1988, and Rule 36 of the Coroners Rules 1984) identifies the facts to be ascertained at the inquest it, "...throws little light on *why* it is thought desirable to discover these facts".^{5, p. 213} Rule 36 of the Coroners Rules 1984 reads as follows:

- (1) The proceedings and evidence at an inquest shall be directed solely to ascertaining the following matters, namely -
 - (a) who the deceased was;
 - (b) how, when and where the deceased came by his death;

- (c) the particulars for the time being required by the Registration Acts to be registered concerning the death.
- (2) Neither the coroner nor the jury shall express any opinion on any other matters.¹⁸

The Inquiry noted that the purpose of public investigations as defined by Section 8 is unclear, however, it was the opinion of the Inquiry (in agreement with Lord Lane in *R v South London Coroner, ex parte Thompson*¹⁹⁴) that the purpose of the inquest is to grant public inquiry in cases where there is a public interest generally and, in particular, the purposes of the public inquest should be:

- to conduct a public investigation into deaths which have or might have resulted from an unlawful act or unlawful acts
- to inform interested bodies and the public at large about deaths which give rise to issues relating to public safety, public health and the prevention of avoidable death and injury
- to provide public scrutiny of those deaths that occur in circumstances in which there exists the possibility of an abuse of power^{5, p. 215}

Recommendations of the Third Report of the Shipman Inquiry

The Inquiry concluded that the coroner system should be retained owing the fact that, "...the tradition of the coroner's inquest is so well rooted in this country that most members of the public would regret its loss"^{5, p. 489} However, its recommendations were so extensive that it was suggested that the proposed coronial system would, "...be barely recognisable as the offspring of its parent"^{5, p. 489} Though the recommendations of the Inquiry were extensive its conclusions, in a general sense, were that the system was in need of leadership, training and expertise.

Leadership, it was suggested, should aim to achieve a much called for consistency of practice and a high quality of service. This leadership should take the form of a centrally-governed national service operated through regional and district offices. The proposed leadership would take the form of a Chief Judicial Coroner, a Chief Medical Coroner and a Chief Coroner's Investigator who together would form the executive core of the new service. This governing board would be assisted by a formal Advisory Council made up of, for example, members of the Department of Health (and the Welsh Department of

Health), the Department for Constitutional Affairs**, the Home Office, the General Register Office, and the Office for National Statistics.

The Inquiry concluded that all coroners (as well as coroners' investigators) should be provided with initial training as well as on-going professional development as well as being trained specifically to deal with the bereaved and should be educated in the needs of minority groups when it comes to death and the disposal of remains.

Coroners should, in the opinion of the Inquiry, only carry out those functions for which they are professionally qualified rather than executing many of their functions with little or no training in the requisite field. The Inquiry also concluded that, "...the job of coroner requires medical knowledge far more often than legal knowledge and entails a medical judgement far more often than a legal one"^{5, p. 490} The Inquiry concluded that far too many inquests are held and that the service as a whole, as well as the public, would benefit from a reduction in the number of inquests. Increasing the medical expertise available in the system would, it was suggested, help to achieve this aim.

In addition, a clinical epidemiologist spoke to the inquiry with regard to the certification of deaths following femoral fracture citing cases in which coroners "wished" doctors to avoid mentioning femoral fractures on medical certificates of cause of death (MCCDs) since, were this included on the medical certificate, the coroner would be obligated to become involved owing to the possibility that the death had been the result of a fall.^{††} This practice, "quite apart from any other consideration [...] has the effect, as the epidemiologist pointed out, of rendering completely unreliable statistics for excess mortality following a fractured femur"^{5, p. 167}

Responses to the Luce Review and the Third Report of the Shipman Inquiry

The Coroners' Society of England and Wales (CSEW) was quick to respond to both the Luce Review and the Third Report of the Shipman Inquiry. With respect to the Luce Review the CSEW addressed several of the specific recommendations in the review stating that though it was pleased to see many of its own recommendations appear in the Review, the CSEW had "reservations about the workability of some of the other proposals and

** The Department for Constitutional Affairs (DCA) was created in mid-2003 to replace the Lord Chancellor's Department. By mid-2007 the decision had been taken to merge the DCA with several departments of the Home Office (primarily those departments in charge of prisons) into the newly created Ministry of Justice which is now responsible, amongst other things, for the administration of the coroner service.

†† The coroner would have to assume jurisdiction in such a case as a fall is generally considered an 'unnatural' cause of death.

generally about whether adequate resources will be allocated for their implementation”.²²² Though the Review includes numerous recommendations to address the shortcomings of the Service in terms of supporting public health and safety, there is no mention of these in the CSEW’s response.

In response to the Third Report of the Shipman Inquiry the CSEW stated that the, “[c]oroners’ main aim is to provide certainty to grieving families as quickly and efficiently as is possible” and that, “the Society has grave concerns as to whether the proposed re-organisation of the coronial service as suggested will deliver all the benefits hoped for by Dame Janet”.²²³

In an article subsequently published in the BMJ both the recommendations of the Luce Review and the Shipman Inquiry were considered by two forensic pathology professors who concluded that, “of the two proposals, it seems to us that Dame Janet Smith’s provides the most comprehensive system” one which would, “provide for greater integration of the services required in death investigation, with medical issues left to those with appropriate medical training...”.^{224, p. 176} The authors concurred with Dame Janet Smith that, “proper death investigation protects the public” and conclude that, “[the system] cannot be neglected any longer”.^{224, p. 176} The NGO INQUEST^{##}, in its Annual Report for 2003²²⁵, accepted that there were many positive proposals in both the Shipman Inquiry and the Luce Review. However, the directors of INQUEST expressed concern at the proposed reduction in jury inquests and abolition of the verdict of ‘unlawful killing’.

Dr. James Young, the former Chief Coroner for Ontario, Canada responded to the Third Report of the Shipman Inquiry in his 2004 editorial *Speaking for the Dead to Protect the Living*²²⁶ stating that:

The primary focus of the British coroner’s system is to investigate cases with the goal of answering who, how, when, where and by what means someone died. Inquests are frequent and cursory, and their main purpose is not preventative. It is my impression that the public is relatively unaware of the role of the coroner and would view it as primarily administrative. This system does not actively promote the coroner as an independent investigator of potential healthcare issues. Families did not approach coroners with concerns about Dr Shipman and I believe it would be beneficial to promote such dialogue in future.^{226, p. 162}

^{##} INQUEST is a charitable organisation in the UK which provides people with advice on the coronial inquest process and a free casework service.

Young also believed that in order to be viable the coroner system would need to be, “...independent, well managed, with central policy making and direction” and that it would require “adequate financing and on-going training”.^{226, p. 163} He also believed that the coroner’s office should “provide public education”.²²⁶ Dr. Young concluded that:

If the proposed model to modernise the coroner’s system is adopted, the Inquiry will achieve the greater role of improving public safety through recommendations, improving the quality and confidence in the medical system by acting as a watchdog and providing valuable information to families. In my view the Inquiry has *got it right*.²²⁶

In a 2008 article published in the *British Journal of General Practice* Baker acknowledges the sluggish response by some organisations to the recommendations of the Shipman Inquiry stating that, “...the route by which evidence is translated into policy can be tortuous”.^{227, p. 307} In 2009 in an article published in the BMJ titled *What are coroners and pathologists for?*²²⁸, retired consultant physician Colin Reisner recalls the events surrounding the death of his mother. He describes her death from dementia and the subsequent involvement of the coroner and a pathologist who “ended up causing unnecessary anguish to someone very close to the deceased, wasted public money [...] and then ultimately failed to identify the correct cause of death”.^{228, p. 835} The author concludes that:

It would probably have helped if successive governments had taken more action on the reports they have received over many years showing that the coroners’ system is no longer fit for purpose. In my mother’s case, had there been a medical coroner to support the legal coroner [this was one of Dame Janet’s suggestions - *viz.* pp. 85-86], he might well have been satisfied, having spoken with my mother’s GP, her carer, and myself, to have a certificate issued without a post-mortem examination.^{228, p. 835}

Chapter VIII: THE CORONER TODAY

Regardless of the unanimous call for a drastic reform of the coroner system, and the recognition that a modern system would have to undergo a significant redefinition of purpose in order to respond to the wider public interest in public health and safety, little has been done to accomplish this and the system remains ill-suited to effectively support public health and safety. A review of the post-Shipman reform process (in the form of the oft-contested Coroners and Justice Act) follows. The controversial decision of the Coroners Society of England and Wales to not participate in a national vCJD survey is presented to illustrate that, despite Dame Janet Smith and Tom Luce's explicit acknowledgement that the coroners have a responsibility to public health, the CSEW continued to operate in a manner which undermined this responsibility.

THE SUB-CLINICAL VCJD SURVEY AND THE IMPLICATIONS OF CORONIAL AUTONOMY

[*viz.* **Publication One:** reprinted from McGowan CR, Viens AM. *Coroners and the Obligation to Protect Public Health: The case of the failed UK vCJD study*. Public Health. 2010; 125(4): pp. 234-7].¹²

In light of new evidence that vCJD has the potential to emerge as a second wave infection resulting from human-to-human transmission, the Health Protection Agency (HPA) proposed the creation of a post-mortem tissue archive to determine the prevalence of abnormal prion protein (a marker for vCJD infection) in the UK.²²⁹ This study required tissue from a large number of autopsies, necessitating the participation of coroners in England and Wales. Following a protracted correspondence (available at: www.coronersociety.org.uk) with the Chief Medical Officer (CMO) - and despite efforts by the HPA to accommodate coroners' concerns - the Coroners' Society of England and Wales (CSEW) declined to participate in the study, citing various issues including its legality, cost and feasibility of the proposed methodology. The CSEW concluded that to participate in this public health measure on the basis proposed would, "...adversely affect the independence of the coronial service and would further erode public confidence...".

Background

By the time bovine spongiform encephalopathy (BSE) was identified in 1986, it was thought that up to 50,000 cattle had been infected with the disease.²³⁰ Owing to suspicions that ingestion of meat from BSE-infected cattle might result in prion infection in humans, the Specified Bovine Offals Ban was imposed in November 1989. However, by this time, a significant proportion of the human population was believed to have been exposed to BSE.²³¹ Back calculations have estimated the number of infected cattle that entered the

human food chain may be as high as two to three million.²³² In March 1996, the government stated that a number of recent CJD cases in young people had likely been the result of exposure to BSE.

Until 2003, dietary exposure to BSE was the cause of all cases of vCJD in humans. However, four infections are thought to have resulted from blood transfusions from asymptomatic donors infected with vCJD.^{233,234} It is also believed that iatrogenic transmission may occur as a result of contaminated plasma products, surgical instruments, dental procedures, and transplanted tissue. All of these scenarios suggest the possibility of a second wave of vCJD infections resulting from human-to-human transmission.

As of June 2010, 172 cases of vCJD have been identified in the UK.²³⁵ A lengthy pre-clinical period is typical of vCJD infection suggesting there may be many potential carriers in the population, and these people may not exhibit signs of infection. Tests on animal models suggest infection by a sub-clinical carrier may result in clinical disease.²³⁶ It has been suggested that the number of clinical cases represent only a small number of the total number of vCJD infections.²³⁷ The Spongiform Encephalopathy Advisory Committee (SEAC) - which is responsible for advising the Department of Health (DH) on matters pertaining to vCJD - has concluded that it is “very important” to establish the prevalence of subclinical vCJD infection in order to: assess the risk of transmission, to determine the efficacy of current precautionary measures, and to determine if further measures are necessary to reduce the risk of human-to-human transmission.^{238, p. 2}

In November 2006, SEAC suggested that tissue collected at autopsy would provide valuable, complimentary data to that of the National Anonymous Tonsil Archive and that these two tissue archives could together constitute, “the best route to estimating the prevalence of subclinical vCJD”.^{238, p. 5} The HPA, at the request of the DH, subsequently convened a Working Group, the recommendations of which were presented to the CMO (Sir Liam Donaldson) in May 2007.²²⁹ The Group concluded that since the study required tissue from a large number of autopsies it would be necessary to secure the participation of both coroners (in England and Wales) and procurators fiscal (in Scotland) - there were no plans, at the time, to extend the study to Northern Ireland. It was suggested that the study be implemented initially in England and Wales as further arrangements were deemed necessary before Scotland could be included. The Group proposed that coroner’s officers obtain - on behalf of the coroner - consent for the retention of tissue from the spleen and, if possible, the brain following autopsy. The low prevalence of sub-clinical vCJD in the

population led the Group to propose a sample size of approximately 100,000 people, which would be obtained over a three-year period.

The Coroners' Society's Position

In July of 2007, the CMO wrote to the Honorary Secretary of the CSEW, Mr. André Rebello, to communicate the recommendations of the Group and to endorse their implementation. The CMO acknowledged the pressures under which coroners operate, but noted that it was important to secure the participation of a large number of coroners.

The Secretary replied to the CMO and, after acknowledging the importance of the study, raised two issues with coroner's officers obtaining consent for tissue retention. First, he stated that it was beyond the coroner's jurisdiction to have their officers ask families to consent to tissue removal that does not directly bear upon the determination of cause of death, or the identification of the deceased. Second, the Secretary stated that there was no spare capacity to facilitate the recommendation that coroners' staff obtain consent for tissue retention. He further indicated that, "it was spelled out before the [HPA] report was written that it would be unfair if unrealistic expectations are raised by the report's recommendations, resulting in criticism for the [c]oroner's system if this study cannot be delivered." In a subsequent letter addressed to the Infectious Disease and Policy Branch of the DH, the Secretary confirmed that it would not be against the law for coroners or their officers to take part in the study, however, in his view (on behalf of the CSEW) to do so would be "inappropriate". He raised the additional concern that it was not the role of coroners or their officers to seek consent for any purpose other than the coroner's statutory duty and that, "coroners, and those who work with coroners, are not trained to obtain consent". The fact that some coroners and their officers have recently participated in research studies for which coroners officers were, in fact, obtaining consent from next-of-kin^{239, 240} was not referred to by the Secretary.

The DH subsequently wrote to the CSEW Advisory Group in September 2008, including a copy of a revised methodology, addressing the Secretary's earlier concerns that it was beyond the coroner's remit to participate, that coroner's officers were not trained to obtain consent and that there was no additional funding to execute the study. The letter confirmed the DH was prepared to pay for any, "administrative costs needed to undertake the survey", and reiterated that it was "extremely important for protecting public health", and was key to "reducing large uncertainties around current risk assessments". The revisions were intended to minimise interference with the coroner's activities and proposed

that coroner's officers, upon being informed of a death, contact the NHS Blood and Transplant's tissue service (NHSBT) to pass on contact details of the next-of-kin. The NHSBT would then contact the next-of-kin to discuss tissue retention and to obtain formal consent. The DH stated that it had taken legal advice which indicated that the proposed methodology, and requisite data transfer from the coroner's officer to the NHSBT, did not constitute a violation of the terms of either the Data Protection Act or the Coroners Act.

The DH's letter was considered at the Ministry of Justice Coroners Advisory Group meeting in October 2008. The Secretary of the CSEW replied to the CMO on behalf of the Group indicating that the, "main concern is that the methodology would require the coroner to disclose contact details which are only held as a result of the coronial investigation". In the Secretary's view, this disclosure would be, "bound to raise questions for the public as to the independence of the coroner and the real reason for the autopsy" which he believed would, "adversely affect the independence of the coronial service" and would likely, "bring the office of the coroner into disrepute and adversely affect the coronial statutory function". In addition, the Secretary recorded his "grave doubts" as to the lawfulness of the Secretary of State's powers under section 28(2) of the Coroners Act to request the information required by the study from the coroner. The Secretary closed by noting that, of the 118 coroners, deputy coroners and assistant deputy coroners in attendance at the 2008 Annual General Meeting of the CSEW, all voted unanimously that to follow the HPA methodology, "would be to adversely affect the independence of the coronial service and would further erode public confidence in the service". Despite the reservations expressed in October 2008, subsequent studies involving coroners have used precisely the method proposed in the revised study.²⁴¹

On 14 July 2011, at the first meeting of the Advisory Committee on Dangerous Pathogens Transmissible Spongiform Encephalopathies (ACDP TSE) Risk Assessment Subgroup, a Department of Health representative reiterated that there was "no likelihood of Coroners' participation" in the vCJD study and suggested that, "the post mortem study pilot should close, and any remaining funding reallocated to other prevalence studies".^{242, p. 12} The ACDP TSE was in agreement that the study should close but not before "noting its frustration that the necessary cooperation had not been forthcoming".^{242, p. 13}

THE CORONER AND JUSTICE ACT 2009

In March 2004 the Home Office published a position paper addressing the recommendations put forth in the Luce Review and the Shipman Inquiry.²⁴³ The position paper acknowledged the “irrefutable case for reform”^{243, p. 1} and proposed a reformed service which would, amongst other things, have “direct links to public health” and “regional oversight of death trends through Regional Directors of Public Health”.^{243, p. 10} The paper questioned whether the Home Office was the most appropriate “parent Government Department” for the coroner service which, it proposed, should become a national service, divided for the purpose of effective administration and staffed by full-time coroners.²⁴³ The position paper proposed the creation of the position of Medical Examiner* a response, in part, to Luce’s ‘Statutory Medical Assessor’ and Dame Janet Smith’s ‘Medical Coroner’. The Medical Examiner would be a qualified physician employed by the coroner service and would screen all cases and would assist in death certification by physicians in cases where the death would not automatically require investigation by the coroner. It was proposed that Regional Directors of Public Health “play a role” in the appointment of Medical Examiners and that the new coroners service would have “systematic links with public health intelligence arrangements”.^{243, p. 14} The Medical Examiner would provide supplementary advice on medical matters “making all coroners’ decisions much more medically sound”.²⁴³ Medical examiners would also be responsible for keeping a database of deaths, “to help support public health initiatives as part of the need to strengthen our understanding of the pattern of deaths that occur”.^{243, p. 14} In turn, it was envisaged that the Regional Directors of Public Health would be responsible for identifying mortality trends, monitoring the effectiveness of and informing future public health initiatives. The position paper also calls for the creation of the positions of Chief Coroner and Medical Advisor to the Chief Coroner. Consistent with the proposals put forth by both the Luce Review and the Shipman Inquiry, training would be mandatory for coroners and their staff. Finally, the paper concludes that, “[i]t is vital for better use to be made of the lessons that can emerge from a coroner’s investigation”.^{243, p. 22}

The coroner reform draft Bill

On 6 February 2006 Harriet Harman, then Minister of State for Constitutional Affairs, announced that work had begun on reforming the coroner system and that her proposals

*The proposed position of Medical Examiner bears no resemblance to the position as it is understood in North American medical examiner systems of death investigation.

for reform built on the work of both the Luce Review and the Shipman Inquiry.²⁴⁴ The coroner service reform draft Bill would not be published until June 2006.²⁴⁵ The Regulatory Impact Assessment which was published concurrently addressed the recommendations put forth in the Luce Review, the Shipman Inquiry, and the response to these contained in the Home Office position paper.²⁴⁶ The option to totally reform the coroners system and implement all of the changes suggested in the position paper was considered and rejected, “...on the basis of the risks of high cost[†] and excessive bureaucracy with unproven benefits”^{246, p. 16}

The foreword to the draft Bill stated that the coroner’s task is to “give certainty and reassurance to bereaved people” and to “meet the public interest” in deaths that are reported to them.^{245, p. 3} The Bill explicitly concurred with the findings of the Luce Review and the Shipman Inquiry that the system is “fragmented, non-accountable, variable in its processes and its quality, ineffective in part and archaic in its statutory basis”.^{245, p. 4} The draft Bill suggested “five key reforms”[‡] which include: improvements to the coroners’ service to the bereaved; the introduction of national leadership through the Chief Coroner (who would be accountable to Parliament), Deputy Chief Coroners, and an advisory Coronial Council; the reduction of the number of coroner regions and an increase in the number of full-time coroners; increasing the power of coroners to obtain evidence; and allowing coroners to limit the reporting of information in cases where no public interest would be served. Despite similar recommendation by both the Luce Review (recommendation #94) and the Shipman Inquiry (section 19.15) the Bill did not include provision for a national service. Coroners would continue to be appointed and funded by local councils as the option to create a unified national service was deemed “unaffordable”[§] and Government was not convinced that the system would necessarily benefit from a national service.^{246, p. 26}

The Bill also proposed that coroners be required to hold a legal qualification and that the office of the Coroner for the Queen’s Household be abolished. The Bill defined the purpose of the coroner’s investigation as: to establish who the deceased was and when, where and the means by which they died and, 2) to establish the details needed to register

[†] It was believed that just implementing a system of independent checks on all deaths (one of the many of the recommendations contained in the position paper) would cost £40 - £50 million/year plus £30 million start-up costs.²⁴⁶

[‡] The Draft Coroners Bill: Regulatory Impact Assessment²⁴⁶ was published on 12 June 2006, the same day as that of the Draft Bill; there were six ‘key reforms’ in the Impact Assessment, the sixth being the provision to allow coroners access to better medical advice. This had been mentioned in the Bill as not requiring statutory provision.

[§] The costs for this model were valued at £17 million/year plus £31 million at start-up.²⁴⁶

the death. In addition the Bill required that the investigation by a coroner include an investigation of the circumstances of a death in situations where the death must be investigated to comply with Article 2 of the ECHR (in which case the purpose to determine ‘by what means’ the death occurred should be read as ‘in what circumstances’). The Bill contained no mention of the Medical Examiner as proposed in the Home Office position paper, though, in the Regulatory Impact Assessment of the draft Bill the Government states that the level of scrutiny which would have been offered by the Medical Examiner posed a risk of over-regulation and was too costly.^{**246}

In introducing the draft Bill the Secretary of State for Constitutional Affairs and the Lord Chancellor and the Minister of State Department for Constitutional affairs stated that they would “welcome the scrutiny” that the Bill would be subject to as a result of the forthcoming consultation.^{245, p. 4}

Welcoming the scrutiny...

The response to the draft Bill was swift and reflected a considerable disappointment on the part of a range of interested parties. In an article published in the *British Medical Journal* Baker and Cordner lament the Bill’s lack of consideration for the recommendations of the Luce Review, the Shipman Inquiry, and the Home Office’s position paper.²⁴⁸ In particular, the authors express concern with the draft Bill’s stated aim to “identify lessons for preventing future deaths”^{245, p. 3}:

[I]n the main text of the draft bill the aim of investigations and inquests is stated simply as to find ‘who the deceased was, and when, where and by what means he came by his death’ [...] the absence in the draft bill of any more explicit aim to prevent death or injury, arguably the major policy basis for a modern coroner’s system, is a lost opportunity for public health.^{248, p. 108}

On 1 August 2006 the House of Commons Constitutional Affairs Committee published their response to the draft Bill stating that, “[w]e believe that this draft Bill falls well short of what is required to reform the system”.^{249, p. 3} The Committee lambasted the Government for its late submission of the Bill preventing proper execution of the pre-legislative process, a failure the Committee deemed “wholly unsatisfactory”.²⁴⁹

** The Department of Health (DH) was appointed the lead agency for handling changes to the death certification system. The DH called for the creation of medical examiners who would be attached to the clinical governance teams of PCTs and would, thus, not meet the requirement of an independent scrutiny of all deaths by an independent Medical Examiner situated within the coroner system. The DH began consultation on the death certification system in July 2007.²⁴⁷

The first witness to give evidence to the Committee was Mr. Michael Burgess, the coroner for Surrey and for the Queen's Household. When asked to explain the function of the coroner he responded:

Before one even looks at [matters of resourcing] it is necessary to understand what the coroner's function is and currently in statute that is not clear. All we have got is that we are to hold inquests and those inquests are expected to find certain things as proved or not as the case may be.^{51, evidence p. 1}

In his formal written submission to the Committee Mr. Burgess^{††} reiterated this lack of stated purpose stating that, “[o]ur current legal duties can be stated as a matter of law but doing so does not clearly indicate what purposes society intends the coroner service should serve and in what priority”.^{51, evidence p. 68} Similarly, the written submission of the Victorian Institute of Forensic Medicine (Australia) included the following:

Perhaps the most striking feature of many of the modern institutions of Coroner is the lack of a clearly defined purpose for the jurisdiction. The role of the ancient Coroner clearly had a fiscal purpose as well as a quasi-political function to represent the King. With the loss of these functions and in the absence of a statutory purpose the Coroner's role became relegated to a largely administrative and procedural overseer.^{51, evidence p. 123}

Evidence was also presented to the Committee from the State Coroner of Victoria and the Deputy Director of the Victorian Institute of Forensic Medicine in Australia.⁵¹ Together they recommended that “there should be a legal model of death investigation which integrates public health and safety”.^{249, p. 59} They suggested that:

Perhaps the key to understanding a society's death investigation process lies in the identification of the underlying purpose of obtaining knowledge about deaths. It could be said that a society is interested in investigating deaths because it needs to know who is alive for the purpose of administration, and how they can best be kept alive in order to ensure the survival and continued prosperity of the community. In this regard the community can be considered to be a single organism, needing both an awareness of self and an ability to protect itself from harm.

^{††} The submission was made in agreement with Mr V F Round, HM Coroner for Worcester and the then Honorary Secretary of the Coroners' Society of England and Wales.

Knowledge about the reasons for a death and how it could have been prevented has the potential to contribute to the common weal. It enables the community to grow and develop in an environment that minimises risk to individuals and groups. The coroner as an independent judicial investigator, if sufficiently resourced, can operate free from commercial, corporate, administrative and political pressures to the benefit of the whole community. As was stated in the introduction:

A coronial system that goes beyond blame and has, as its *raison d'être*, the role of contributing to death and injury prevention activity in the local or general community allows Coronial resources to be expended in an efficient and highly productive manner that maximises the benefits it provides to public health and community safety.^{51, evidence p. 143-144}

The Committee concluded that the recommendation for a national service should be observed, that the Home Office proposal to introduce a system of Medical Examiners be instated and that, “Government should take a bolder approach to reform the coronial system, embodying in legislation an enhanced role in relation to public health and safety”^{249, p. 60}

The British Medical Association also issued a response to the draft Bill with a lengthy list of grievances prefaced with the declaration that it, “would not be able to endorse a partly reformed, under-funded system that was not fit for purpose”.²⁵⁰ Both the Coroners’ Society of England and Wales (CSEW) and the Coroner’s Officers Association (COA) responded to the Bill with the CSEW stating that, “[t]he proposals in the draft Bill will not work”²⁵¹ and the COA claiming to be “dismayed”.²⁵² The CSEW acknowledged in their response that, “[t]here should be an enhanced role for coroners in the promotion of public health and safety”²⁵¹ INQUEST also published a response stating that, “there are serious omissions in the draft Bill”.²⁵³ The National Council for Civil Liberties (a.k.a. LIBERTY) expressed its concern with the Bill claiming that, “many of the intrinsic problems of the existing coroners system have not been addressed”.²⁵⁴ An editorial in *The Lancet* claimed that, “[p]erhaps the biggest omission is the Government’s failure to spell out what the coroners’ system is for”^{255, p. 1468}

The Government published a response to the Constitutional Affairs Select Committee’s Report in November of 2006.²⁵⁶ The response concluded that:

While respecting the strength of the Committee's reservations, and the thoroughness of its inquiries, we have concluded that our approach is most likely to achieve the aims we set out when we published the draft Bill.^{256, p. 4}

The Government responded to the Committee's recommendation that, "Government should take a bolder approach to reform the coronial system, embodying in legislation an enhanced role in relation to public health and safety"^{249, p. 60} stating simply, "[t]he Government rejects this recommendation".^{256, p. 13} Two surveys were commissioned by the Department for Constitutional Affairs to form part of the consultation: *Users' experience of the coroners' courts* (Ipsos MORI) and *Analysis and Scrutiny by Bereaved People's Panel*²⁵⁷ (Opinion Leader Research). This latter report elicited feedback from the Panel addressing the purpose of the coroners' service which, it was suggested, "...had a broader responsibility than solely ascertaining reasons for individual deaths [...] preventing the next death should be the key aim of the inquest"^{257, p. 19}.

The Government subsequently published the very brief *Response to Consultation* in February 2007 in which it responded to some of the main issues from the total of 150 responses to the consultation paper.²⁵⁸ In the consultation response Government reiterated that it would not legislate to create a national coroner service and would instead leave the funding and appointment arrangements for coroners with local authorities. The Government acknowledged that the responses to the consultation "have been mixed" and that "many called for a return to the proposals set out in the Shipman Inquiry Report and the Home Office Position Paper of 2004".^{258, p. 7} By May of 2007 the Department for Constitutional Affairs had become part of the newly created Ministry of Justice (MoJ) which would take over responsibility for coroners' reform. On 27 March the MoJ published the changes made in response to consultation which outlined several changes which would appear in the revised Bill - though all changes relate to very specific aspects of the Bill, including an amendment to clause 12 of the draft Bill ('action to prevent other deaths') which would be revised in order to compel organisations to respond to coroners Rule 43 letters (*viz.* pp. 56-58).²⁵⁹

The Coroners and Justice Act

The Queen's Speech of 3 December 2008 announced the creation of the Coroners and Justice Bill which would include not only the proposed revised legislation to reform the coroner system, but would also include proposals to reform the justice service.²⁶⁰ The

Coroners and Justice Bill contained nine parts (only the first of which addressed coroners), and was introduced on 14 January 2009.²⁶¹ On 23 January the House of Commons issued its report relating to the Bill in which it stated that, “localised provision with national guidelines remains the Government’s approach to the coroners service”.^{262, p. 5}

The Commons report was critical of the plan to have Medical Examiners^{##} employed by the NHS, as was proposed in the Bill, rather it suggested that Medical Examiners be employed by the MoJ. However, the Bill in its revised form (as brought from the Commons on 26 March 2009), contains no amendment in this regard.²⁶³ The Bill remained primarily unchanged upon passing through the House of Lords and received royal assent on 12 November 2009 (Part 1 of the Coroners and Justice Act is included as **Appendix E**). Few of the recommendations of the Luce Review and the Shipman Inquiry were realised in the Coroners and Justice Act with the most obvious exception being the introduction of the office of the Chief Coroner. Dame Janet Smith would describe the Coroners and Justice Act as, “good in parts and not so good in other parts”.^{264, p. b660}

On 11 March 2010 the Ministry of Justice published a consultation paper to inform the drafting of the secondary legislation.²⁶⁵ The topics selected for comment included: the types of deaths to be reported to coroners; the logistics of transferring of cases from one coroner to another; post-mortem examinations; search, entry and seizure; disclosure of documents; the conduct of inquests; appeals and complaints; training; and short death certificates. The consultation response was published on 14 October 2010 - the same day that the coalition government announced its intention to draft a Public Bodies Bill which would outline plans to abolish 192 public bodies (*viz.* pp. 101-103), including the position of Chief Coroner. The response to the question of the purpose of the coroner-commissioned post-mortem examination indicated that the majority of respondents felt that the purpose of the post-mortem was to establish the cause of death, “...and whilst other findings may be desirable and helpful, they were not part of the coroners’ remit”.^{184, p. 1655} The CSEW suggested that the purpose of the autopsy was, “to establish the absence of violence and unnatural causes and [...] to assist the coroner in establishing the underlying

^{##} As defined in the Bill (chapter 2, section 18) medical examiners would be appointed by Primary Care Trusts (England) and Local Health Boards (Wales). Sub-section 18 (5) provided for their independence stating that, “[n]othing in this section, or in regulations under this section, gives a Primary Care Trust or a Local Health Board any role in relation to the way in which medical examiners exercise their professional judgment as medical practitioners”.²⁶¹

⁵⁵ A 2006 study titled *The Coroner’s Autopsy: Do we deserve better?*, published by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD), suggested that there was confusion over the purpose of the coroner’s autopsy. One of the principal recommendations included in the report was that, “Government should consider and agree the fundamental purposes of the coronial autopsy”.^{266, p. 120}

cause of death”.^{184, p. 16} The remaining three published responses were from the British Paediatric Pathology Association, the Royal College of Pathologists, and Cardiac Risk in the Young all of whom felt that the purpose of the autopsy should be oriented toward prevention (*i.e.* by providing the means to establish the likelihood of similar deaths in the family, for the general benefit of the living, for informing future public health policy and for the ultimate purpose of producing mortality statistics).¹⁸⁴ A further consultation on the rules and regulations which will underpin the Coroners and Justice Act 2009 is expected to be held in late 2012.¹⁸⁶

‘BONFIRE OF THE QUANGOS’

On 14 October 2010 the newly formed coalition government announced that 192 public bodies^{***} (including the Health Protection Agency) would be abolished in an attempt to cut costs and improve accountability.²⁶⁷ This measure would come to be referred to in the popular media as the “bonfire of the quangos” referring to its sudden and drastic cull of so many public bodies.²⁶⁸ The position of Chief Coroner was to be abolished as part of this initiative.²⁶⁹ In an e-mail sent out by the Ministry of Justice on 16 October 2010 Dr. Elizabeth Gibby (the Deputy Director responsible for Coroners, Burials and Legal Services Regulation and Redress) stated that the Minister (Kenneth Clarke QC MP) was keen to see reform and improvement of the coronial system; however, owing to the current financial situation, the reforms would have to be implemented without the national leadership framework (including a new system of appeals) which was to be headed by a Chief Coroner (and which would have included a Medical Advisor to support the Chief Coroner).²⁷⁰

The Coroners’ Society of England and Wales was quick to respond to this announcement through their secretary, Mr. André Rebello, who wrote on the Society’s website:

The Society understands the reasoning behind this difficult decision given the financial situation the Government faces. [...] The Minister agreed with me that reform of the coronial system is only in part about implementing the Coroners and Justice Act in full and that it is far more about changing attitudes, standardising practices and partnership working.²⁷¹

Following the announcement that Government intended to abandon plans to institute statutory changes to the coronial system INQUEST’s co-director, Deborah Coles, issued a press release expressing her lament that bereaved people are, “...forced to grapple with an

^{***} Often termed ‘quangos’: quasi-autonomous non-governmental organisations.

archaic, unaccountable system which is in urgent need of fundamental reform’’²⁷², and denouncing Government’s decision to abolish the position of Chief Coroner:

The government’s rationale for abolishing this post on grounds of accountability and cost are not justified. The model agreed by Parliament in the Coroners and Justice Act 2009 is rendered completely hollow without the driving force and national leadership of a Chief Coroner.²⁷²

She went on to say:

[t]he inquest is vital to the public interest and democratic accountability. It is usually the only public forum in which contentious deaths such as accidents, deaths at work, deaths in custody or deaths of military personnel are subjected to public scrutiny. However the coronial service is often unable to fulfil its vital preventative role in relation to public health and safety and safeguarding lives in the future. This is a false economy if there ever was one.²⁷²

On 29 October 2010 the Public Bodies Bill was presented to parliament with the express provision that the yet to be filled positions of Chief Coroner, Deputy Chief Coroners, Medical Advisors to the Chief Coroner and Deputy Medical Advisers to the Chief Coroner be abolished.⁴⁵ In response Tom Luce, in an article published in *Medicine, Science and the Law*, described government’s decision to forgo modernising the coroner service as “deplorable” claiming that outstanding matters not addressed in the Coroners and Justice Act (including the independence of medical examiners, the coroner’s jurisdiction, evidentiary standards, appeals against post-mortems, the scope of the inquest, lack of a working definition of Article 2, and the reduction in public inquests) as well as the government’s proposed abolishment of the Chief Coroner and the Chief Medical Officer failed to constitute a “properly effective response to the widespread complaints of inconsistency and unpredictability” that have plagued the coroner system.^{273, p. 177}

The House of Lords opted to omit the positions of Chief Coroner, Deputy Chief Coroners, Medical Advisors to the Chief Coroner and Deputy Medical Advisers to the Chief Coroner from the Bill on 13 December 2010. Lord Ramsbotham, speaking to peers with regard to the position of Chief Coroner, said that “...until, and unless, you have some named person with responsibility and accountability for making things happen, things don’t happen”.²⁷⁴ During the Bill’s second reading Baroness Finlay, a former president of the

Royal Society of Medicine, expressed her concern about the abolition of the Chief Coroner:

The Coroners and Justice Act was brought in because the coroners system was outmoded for the 21st century, yet the proposal to abandon the office of Chief Coroner has been subject to no consultation with stakeholders, no opportunity for parliamentary debate and no published evidence of cost analysis.²⁷⁵

The Baroness went on to claim that:

...justice is threatened when we abandon something that was long debated, particularly in this House, and was revised and improved and universally welcomed by those who have gone through the inquest process and by the professions involved, which wanted the coronial system modernised and made fit for purpose.²⁷⁵

Lord Taylor of Holbeach, speaking for the Government, responded to these concerns by stating that, “the Government remains committed to improving the colonial [sic] system”.²⁷⁶

THE GUIDE TO CORONERS AND INQUESTS

On 19 May 2011 the Ministry of Justice published a consultation paper on the newly proposed Draft Charter for the current Coroner Service, the intention of which was to help “create national standards that allow for the local management and delivery of the coroner service”.^{277, p. 3} The Charter consultation included suggestions as to changes to the Guide to Coroners and Inquests which was to be published with the Charter. In draft form, the Guide stated the following:

2.2 The purposes of the coroner service, when a death is reported to it, are:

- to establish whether a coroner’s investigation is required
- if so, to establish the identity of the person who has died, and how, when, and where the person died
- to assist in the prevention of future deaths
- to provide public reassurance.²⁷⁷

The consultation response was published on 15 December 2011.²⁷⁸ With respect to the list of proposed purposes, comments from both the Aneurin Bevan Community Health Council, and the Police federation of England and Wales reflected a concern that the

Charter does not make explicit that the purpose of a coroner's inquest is not to apportion blame and that the Charter should address the misunderstanding that, "...the coroner process is the first step in finding blame before a criminal investigation takes place".^{278, p. 12} In response Government committed to revise the Charter such that it would make clear that it is not the purpose of the inquest to apportion blame or address matters of liability. In addition, several responses to the Charter lamented the fact that the Charter is not statutory, or otherwise legally binding. Government responded that as the primary legislation and statutory instrument (*i.e.* the Coroners Act 1988 and the Coroners Rules 1984) do not provide for a statutory Charter, thus, the Charter would remain voluntary. The Guide to Coroners and Inquests and Charter for Coroner Services [*Canllaw ar gyfer Crwneriaid a Chwestau a Siarter ar gyfer Gwasanaethau Crwneriaid*] was published in its final form in March 2012.²⁷⁹

THE PUBLIC BODIES BILL 2010

In response to widespread criticism of the proposal to abolish the Chief Coroner Government amended the provisions for abolishing the position, instead moving the position of Chief Coroner into Schedule 5 (Power to Modify or Transfer Functions) of the Public Bodies Bill which would allow the transfer of some of the Chief Coroner's statutory powers to the Lord Chancellor and the Lord Chief Justice. It was also announced that it was the government's intention to create a Ministerial Board which would provide "oversight of the non-judicial aspects of the coroner system" and to "provide a direct line of accountability on these matters to Parliament".^{275, column 259}

On 25 October 2011 the House of Commons voted (235 to 287) against an amendment to the Public Bodies Bill which would have ensured that the office of the Chief Coroner would have been retained as was originally legislated in Section 35 of the Coroners and Justice Act 2009.²⁷⁵ The following month, on 22 November 2011, the government announced that it had decided to drop the Chief Coroner from the Public Bodies Bill as the Bill was facing a possible defeat over the issue.²⁸⁰ As of June 2012 the power of the Chief Coroner to hear appeals (as per section 40 of the Coroners and Justice Act) is still to be repealed under the Public Bodies Bill, however, the remaining functions of the Chief Coroner, Deputy Chief Coroners, Medical Advisers to the Chief Coroner, and Deputy Medical Advisers to the Chief Coroner are to be retained. Presumably this decision precludes plans to establish a Ministerial Board; however, the status of the Board remained unclear. On 22 May 2012 the Lord Chief Justice, following consultation with the Lord

Chancellor, announced the appointment of Judge Peter Thornton QC as the first Chief Coroner of England and Wales.²⁸¹ The announcement also indicated that Judge Thornton would take up the post of Chief Coroner in September 2012, and that plans for implementing the Chief Coroner's statutory powers and other reforms to the system as required by the Coroners and Justice Act would be brought into force in 2013.²⁸¹

**Chapter IX: AN EMPIRICAL
STUDY OF CORONERS TODAY**

This study arises directly from the preceding discussion and provides an empirically-based understanding of the purpose of the coroner in England and Wales. It aims to explore how different actors within the coronial system and the broader death investigation system define and justify the coronial purpose. Finally, using the preceding historical and legal survey together with the results of this empirical investigation, it aims to arrive at a coherent, modern, responsible, and appropriate definition of the purpose for the coroner in England and Wales.

The research objectives have been divided into four categories: contextual, diagnostic, evaluative, and strategic (after Ritchie and Spencer⁸⁵). Contextual objectives are meant to identify the form and nature of what exists; diagnostic objectives are those which examine the reasons for, or causes of, what exists; evaluative objectives appraise the effectiveness of what exists; and strategic objectives are those which identify new theories, policies, plans or actions.⁸⁵ The objectives of the present study are to understand and describe:

CONTEXTUAL

- What coroners believe their purpose to be

DIAGNOSTIC

- What factors underlie the coroners' understanding of their purpose

EVALUATIVE

- How coroners' beliefs about their purpose are manifest

STRATEGIC

- What is an appropriate purpose for the coroner
- How the system could overcome the problems identified in the study so far in order to better support this purpose

It is hoped that this research might ultimately inform policy, thus, an applied policy research methodology was deemed the most suitable choice to address these aims and objectives as applied policy research in general, and framework analysis in particular, are intended to, "...meet specific information needs and [have] the potential for actionable outcomes"^{85, p. 173}

STUDY DESIGN

This is a largely descriptive, empirical study based on qualitative data and which uses deductive reasoning to come to solution-oriented conclusions. Qualitative research can

offer policy makers, "...a theory of social action grounded on the experiences - the world view - of those likely to be affected by a policy decision or thought to be part of the problem".^{282, p. 19} The study is necessarily descriptive as this is the appropriate stage of evidence given the paucity of research on this subject. Since coroners in England and Wales are disparate, independent, and often geographically isolated, they do not frequently come into contact with other coroners. Decisions about the daily operation of the coroner are generally not made in collaboration, and coroners are often left to decide what they are to do and why. The Coroners Act 1988 and the Coroners Rules 1984 leave much discretion as to their interpretation and afford coroners a great deal of professional latitude in terms of policy and practice. As there is currently no formal leadership within the system^{†††}, no singular authority to approach to ask about the purpose of the coroner, it was necessary to approach the coroners themselves. The study relied on multiple means for obtaining data, not only to highlight possible sources of bias, but also to provide an appropriate degree of triangulation. As such, the study was based on four sources of data including: in-depth, semi-structured interviews with both coroners and professionals whose work requires that they have contact with coroners; observation of coroners in their conduct of inquests; inquest data (which was intended both to assess whether coroners would release the data and as a means to determine response rate and the reasons given for not providing the data as requested); and finally, extensive consideration of policy documents (including proposed legislation, acts of parliament, Hansard transcripts of parliamentary debates, statutory instruments, legal judgements, and public consultation documents).

The research aims and objectives necessitated an in-depth understanding of the coronial identity, one which was unlikely to be obtained using quantitative or structured survey data. Thus, the collection of qualitative interviews (supplemented by data recorded while observing inquests) was the most appropriate method for obtaining the required data. Much later in the data collection process it became apparent that certain assumptions (*i.e.* that coroners will not release information to researchers) could not be confirmed or refuted without attempting to obtain inquest data from coroners; therefore, a data request was sent to those coroners who did not agree to the original interview request. It was always my intention to produce research which might inform the policy process, therefore, an applied policy research approach was considered the most reasonable means through which to

††† One coroner balked at my referring to coroners as operating as part of a 'system' *per se* suggesting that the term implies a level of cohesion and organisation that did not, in fact, exist.

analyse and present the data. An applied research approach can be distinguished from ‘theoretical’ research by virtue of its requirements, “...to meet specific information needs and its potential for actionable outcomes”.^{85, p. 173}

Given the diversity of practice within the coronial system it was important to obtain as many research subjects as possible so as to understand fully the extent and nature of this diversity. Though all coroners have a deputy coroner (and often several assistant deputy coroners), these individuals were not included in the study population. As it is often the case that a coroner’s deputy is the senior coroner in another region (and would, therefore, have already received an interview invitation) and because assistant deputy chief coroners, owing to the fact that they generally deal with fewer cases and inquests, are unlikely to be in a position to direct how coronial work is carried out in their region - as this is generally the prerogative of the senior coroner.

A complete list of coroners and their office addresses was obtained from the Ministry of Justice. All coroners who appeared on the list received a letter informing them of the purpose of the study and requesting their participation in a face-to-face interview (*viz.* **Appendix F**). All interview requests were mailed along with an information sheet (*viz.* **Appendix G**) which stated the reason for the study, the proposed format for the interview, and offered explicit assurance that the interview would be entirely voluntary, private and confidential.

Since coroners operate in a capacity which necessarily involves other government departments and agencies, as well as academics and researchers. A selection of individuals from these organisations and professions was also interviewed in order to contextualise, supplement and provide a contrast to the data collected from coroners. This research is not a comparative study *per se*, as the outcome is not meant to explore the differences between the two groups, rather the research method is intended to include as many sources as possible to help determine the different understandings of the purpose of coroners in England and Wales. Coroners would, it was hoped, be in the best position to comment on their own purpose. However, the additional interviews with non-coroners were considered necessary to provide a normative alternative to the coroners’ own reports.

Respondents who were to provide this kind of context were purposively selected because of their position within the death investigation system, their experience working with coroners, or their role in the reform process. A list was made of people whose work likely

required that they engage with coroners; the list included members of: the London Metropolitan Police Homicide and Serious Crime Investigation Unit, the Department of Health, the Coroners and Burials Division of the Ministry of Justice, the Health Protection Agency, and the Office for National Statistics. Other individuals not employed by government were selected either because they had been part of the various reform initiatives, or because they had been referred by other interviewees. As such, several coroners' officers, physicians, academic researchers, one solicitor and one barrister (both are in private practice and engage with coroners regularly) were interviewed.

The strength of observational methods is that they, "...provide data on phenomena (such as behaviour), as well as on people's accounts of those phenomena".^{283, p. 131} Observation of coroners whilst they presided over inquests was intended to provide some context to coroners' self-described duties and to understand some of the pressures under which they operate in the execution of their duties. How coroners respond to these pressures and how effective these responses appear to be are both ideally understood through observation in addition to the accounts provided during the interview process. Observation of coroners was undertaken in coroner's court (*i.e.* during inquests and, in one case, in a pre-inquest briefing) and was primarily intended to help corroborate claims made by coroners during their interviews. In addition, as much of a coroner's work revolves around the inquest, it seemed prudent to gain some understanding of the process, the setting, and the outcomes of coronial inquests. In addition, questions considered during the observation of inquests included: How do coroners operate in an inquest setting? How are witnesses treated? How are the bereaved treated? How do witnesses and the bereaved react to the inquest setting and procedure? What does the purpose of the inquest appear to be? Is this process conducive to positive public health outcomes? Also, though many individuals who are not coroners were interviewed in order to understand how they themselves understand coroners' work, it was not deemed appropriate to request interviews from the bereaved. Observing coroners during inquests provided the opportunity to observe how they interact with the bereaved without subjecting them to research requests which might seem callous, or cause them distress. Though, arguably, there are well established methods for approaching and interviewing bereaved people these were deemed logistically impractical.

As much coronial policy is based on primary and secondary legislation, and as the legislation has been in a state of change and debate for the duration of the study, keeping abreast of the legislative processes as well as the statutory material was a crucial component

as the interpretation of the law, as was exploring the many opinions expressed during the lengthy pre-legislative consultation process, all of which speak to the understandings of the coroner's purpose.

Pilot

The initial list of topics to be covered during the interviews was pilot tested on a single senior coroner. This interview resulted in moderate changes in the topic list. My familiarity with death investigation systems outside of England and Wales had resulted in my erroneous assumption that coroners in England and Wales would have experience in certain aspects of death investigation which they are not actually required to have. For example, coroners in England and Wales are not required to attend scenes of death. In most coroner districts coroner's officers also do not attend scenes of death, instead, all information pertaining to the scene is provided to the coroner's officer, and subsequently to the coroner, by the police. Thus, coroners are not often in a position to comment on what occurs at scenes of death and it was assumed that any comment by them on this matter would be speculation and, therefore, of questionable value. As coroners are not required to attend scenes of death, and as the coroner is, in most cases, the principal death investigator, the fact that coroners can act in his/her capacity without ever having seen the object of his/her investigation was clearly a source of embarrassment for the pilot interviewee, thus, I decided not to raise this issue routinely though this fact was alluded to on occasion by the participants themselves.

As there were only 105 coroners in England and Wales at the time the data collection began and, as it was important that as many of them as possible would be included in the study, it was deemed best not to have more than one participant serve as a pilot. Follow-up questions pertaining to the pilot interview were directed to a coroner in Northern Ireland who, while clearly not operating as part of the system in England and Wales, was sufficiently familiar with the system to offer useful advice and comment.

STUDY AREA

As has previously been noted, in the United Kingdom today there are three separate death investigation systems, namely: Northern Ireland (as per the Coroners Act 1959), Scotland (as per the Fatal Accidents and Sudden Deaths Inquiry Act 1976) and England and Wales (as per the Coroners Act 1988, and the newly enacted Coroners and Justice Act 2009).

Owing to the fact that the coroners system in England and Wales is a distinct system which

has recently been scrutinised for its many shortcomings, including its lack of capacity and the will to support public health, the study area includes the entirety of England and Wales.

Selection of the Study Area

Defining the Study Area

There were, at the time this research was commenced in October 2009, 113 coroners' districts in England and Wales (Figure 1). As one coroner may preside over more than one jurisdiction, 105 senior coroners had jurisdiction over the 113 districts. Coronial jurisdictions do not correspond to administrative, Primary Care Trust (PCT), or police authority districts. Ultimately coroners' districts are determined by the Secretary of State (as per the Coroners Act 1988, section 4), though county council officials may appeal to the Secretary of State to redefine a coroner(s) district to their specifications.

There is a great deal of diversity among the population of England and Wales in terms of socio-economic status²⁸⁴ (which includes measures of income²⁸⁵, education²⁸⁶ and occupation^{284, 287}), population²⁸⁸, age-distribution²⁸⁹, unemployment²⁹⁰, health^{284, 289, 291-298}, violent crime²⁹⁹, and other lifestyle indicators³⁰⁰ all of which are causally related to mortality.^{301, 302} Ultimately, this results in varying case-loads among coroners in terms of the numbers investigated, differences in the types of deaths investigated, and the degree to which deaths need to be investigated (*e.g.* some types of deaths require an inquest, while others require an inquest with a jury).

Religion and Ethnicity

Religious and ethnic affiliations also vary throughout England and Wales. As many religions prescribe how bodies are to be handled, this may impose some expectations on the coroner. Though coroners have the authority, under the Coroners and Justice Act 2009 *inter alia* the Coroners Act 1988, to have bodies removed from their place of death and, should the coroner deem it necessary, subjected to post-mortem examination, many try to accommodate requests by next-of-kin regarding the post-mortem and the time taken to carry out an investigation. Insofar as possible given their jurisdiction and discretion, in cases where religious law or custom requires the body to be buried as soon after death as possible, coroners may feel obligated to expedite investigations and modify how he/she carries out his/her statutory duties. Coroners with jurisdiction over districts with large numbers of people who, owing to religious and/or ethnic considerations, have specific

requirements in relation to the treatment of the dead may be subject to increased pressure to limit post-mortem examinations, and to decrease the time taken to investigate deaths.⁵

Prisons and Hospitals

All prison deaths must be investigated by a coroner as per section 2(c) of the Coroners and Justice Act 2009, *inter alia* section 8(1)c of the Coroners Act 1988.^{34,43} For some coroners prison deaths require a disproportionate amount of their time and necessitate a large number of what are often lengthy and complex inquests. Her Majesty's Prison Service operates 8 high security prisons and 116 medium/low security prisons (including juvenile and youth offender facilities, women's prisons, prisons for foreign nationals, and an 'immigration removal centre'). The Prison Service also contracts 11 private prisons. Prisons are not evenly distributed around England and Wales and, as a result, the number of prisons varies by coroner's district.³⁰³

Military Deaths and Repatriated Bodies

The presence of airstrips (military or otherwise) in a coroner's jurisdiction may also affect a coroner's work, as it is generally the case that the coroner with jurisdiction over a body's 'point of entry' into England or Wales is responsible for the investigation of that death. As a result, coroners with jurisdiction over military bases into which bodies of deceased service personnel are flown (*e.g.* Dalton Barracks, formerly RAF Abingdon, in Oxfordshire) will conduct far more inquests on military deaths than do other coroners. Coroners with jurisdictions over major air travel destinations may also investigate non-military deaths owing to the repatriation of civilian bodies.

The fact that regions are so different in terms of the challenges they pose, and the means through which coroners address those challenges, was an important methodological consideration which ultimately required that all coroners be invited for an interview regardless of how remote their location. Therefore, each of the 98 senior coroners working in England and Wales was invited to participate in the study.

Interviews

All interviews were conducted in private. Interviews were semi-structured and lasted from 1 to 2.5 hours. A topic guide was used to structure the interview (*viz.* **Appendix H**). For the coroners, this included questions about what coroners do and what they believe is the purpose of their work. All coroners were asked basic demographic questions including how long they had been a coroner, how they were qualified to be a coroner (either legally

or medically), and how many cases/inquests they generally preside over in a year. The topic guide for non-coroners included questions such as: “how would you describe the coroner’s purpose”, “do you believe this to be an appropriate purpose for the coroner”, “what do you believe would be an appropriate purpose for the coroner”? Interviewees were also encouraged to discuss other matters which they deemed relevant. As the qualitative research process is meant to be iterative, the substance of the topic guide was refined throughout the data collection period. Whenever possible I made every effort to follow up on anecdotal evidence pertaining to coroners’ policy or practice during the interviews.

Coroner interviews

Coroners were normally interviewed in their offices; however, in four instances coroners from outside of London met me either at the LSHTM or somewhere else in London. In one instance the coroner preferred to meet midway between his district and London. One coroner accepted my invitation to interview but would not consent to be recorded - on this occasion I took notes only. Severe weather affecting northern England and Northwest Wales in December 2009 and February 2010 prevented face-to-face interviews in three instances; on all three occasions the interview was conducted by telephone; these calls were recorded and consent obtained verbally. There are few research studies exploring the benefits and drawbacks of different systems of interaction; however, Kazmer and Xie³⁰⁴ have cautioned that either participants’ or interviewer’s discomfort with different systems of interaction may be mistaken for discomfort with the interview topics. The authors concluded that when both participant and interviewer are comfortable communicating through a certain medium they are more likely to effectively exchange meaningful information. As coroners spend a considerable amount of time communicating via telephone for their work, it was assumed that telephone interviewing would be appropriate means of communicating in lieu of a face-to-face interview. There was no indication during the telephone interviews that communicating in this way was in any way uncomfortable for coroners. As with the face-to-face interviews, coroners interviewed by telephone were not provided with the topic guide in advance. One coroner was asked for a follow-up interview in order to clarify several points which had been raised during his initial interview, he consented and was interviewed a second time but was not recorded in this instance. None of the interview transcripts had to be amended owing to requests from coroners to retract interview material.

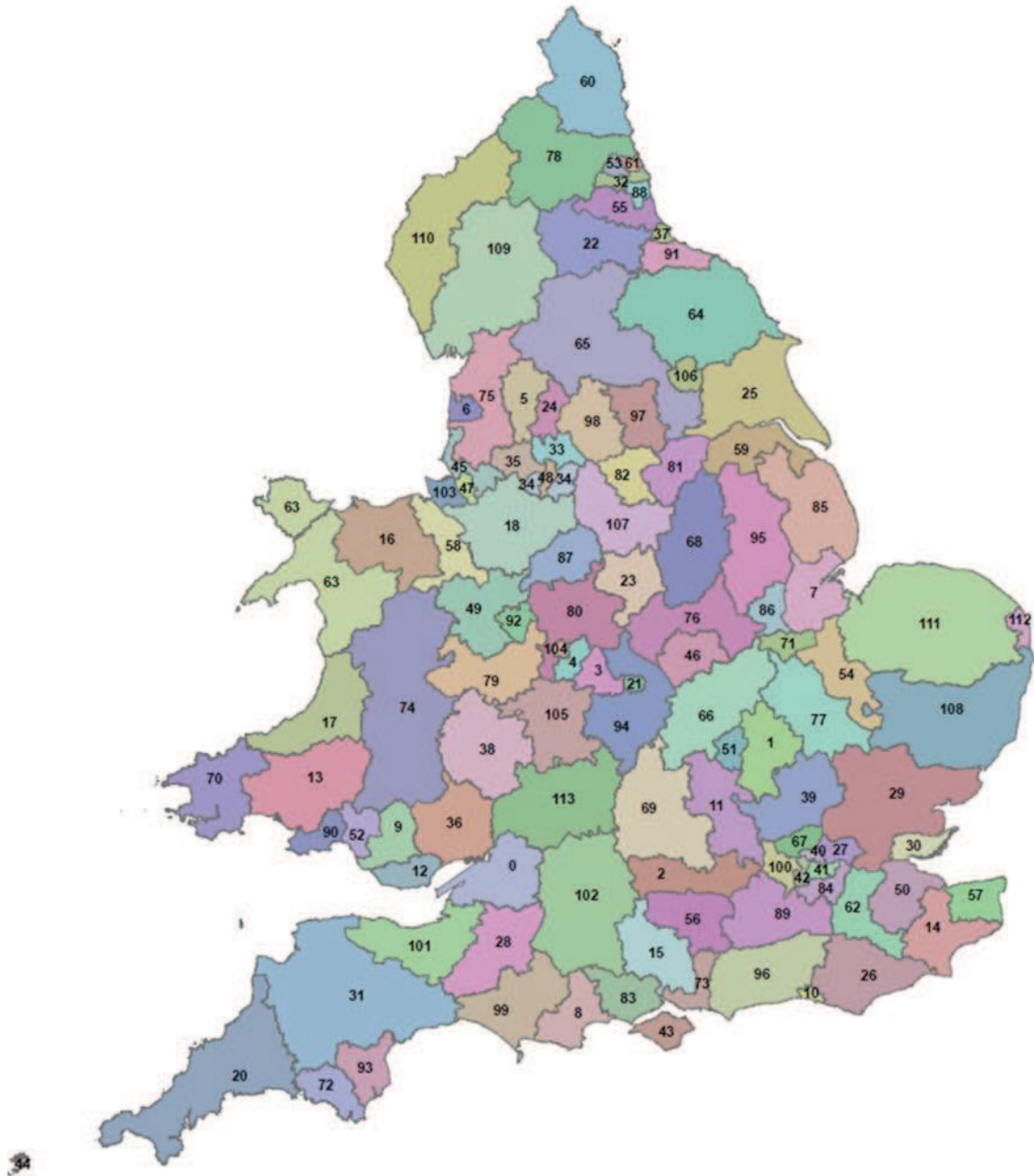


Figure 4: Coroner districts in England and Wales (2007). Reprinted from the Resilience Research Branch: London.

All coroners who were interviewed were asked to provide some routine data about their position including: their length of service as coroner^{##}, a recent estimate of the average number of cases referred to the coroner in a year, a similar estimate of the number of cases which go to inquest, the coroner's qualification, and the coroner's status (*i.e.* full/part-time). Additionally, the gender and of the coroner and the region in which the coroner's

^{##}This refers to their length of service as a coroner and does not include time served in the capacity of deputy coroner.

jurisdiction fell were documented. All numerical data were coded as intervals in order to protect the identity of the respondents.

Statistical Analysis

Though demographic data were collected during the course of each interview, testing for statistical significance of association in small sample sizes (*i.e.* using a Fisher's Exact Test) was not possible as coroners were not limited to two categorical responses. Data are presented as frequency tables (*viz.* pp. 131-132).^{§§§} The frequency tables do not suggest any association between the independent variables (gender, length of service, number of cases, number of inquests, qualification, region or status) and the outcome variable (purpose).

Non-coroner interviews

Individuals who were not acting in a capacity of coroner but who were expected to be able to comment with authority on coroners and their work were approached for interviews. Individuals who work with coroners or who are dependent on data produced by coroners were invited to provide context and to allow the data to be triangulated. Data saturation for non-coroners was not deemed necessary for this study as non-coroners were meant to provide accounts to compare and contrast with those of coroners, as well as to provide insight into the feasibility of some of the proposed recommendations outlined at the conclusion of this study. The sampling strategy for non-coroners was purposive.

Snowball sampling was employed to recruit 19 individuals representing: the Ministry of Justice, the Metropolitan Police Service, the Coroner's Officers Association, the Health Protection Agency, the Department of Health, private law firms, the Office for National Statistics, and the Home Office. In every case my research request was granted and interviews took place in the summer/autumn of 2009. Most respondents were interviewed in their place of work; however, I met one interviewee at his home, another at the LSHTM, and one at King's Cross station, all at the request of the participant. Of the 19 non-coroner interviews only nine were recorded. In the remaining 10 cases either the participant objected to being recorded or the circumstances of the interview were such that it did not seem appropriate to make a recording. In these situations copious notes were taken with the interviewee's verbal consent. On one occasion an individual would not

^{§§§} A comprehensive frequency table (including all variables including gender, number of cases, number of inquests, qualification, region, and status) is not included as it would be possible to identify research subjects were all of this data tabulated for each respondent.

consent to meet me alone and would only do so if he/she were accompanied by another employee. In this case the individuals were interviewed together.

For non-coroner interviews nearly all of the interview topics were the same as those raised with coroners and involved describing what they feel is the coroner's purpose, why they understand this to be the coroner's purpose, and how this functions in practice. Many of the individuals had been involved in the reform process and were invited to comment on the current and proposed reform initiatives. Some demographic information was also collected including the precise capacity in which they work, their length of experience and their occupational background. One interviewee was asked for a follow-up interview in order to clarify some of the points she had made in the initial interview. The interviewee consented and a second interview was held at the LSHTM. This interview was recorded and a second consent form signed.

Inquests

Approximately 50 inquests^{****} were attended between summer 2009 and summer 2010. Observing coroners while they conducted inquests was purposively carried out in several coroner districts including those in rural and urban areas. Coronial inquests are public, (as per the Coroners Rules 1984^{18, section 17}), and therefore my presence at inquests was not required to be sanctioned by the LSHTM ethics committee, nor was permission to attend required.^{†††} Inquest schedules are often set well in advance, thus, it was often possible to select for appropriate variability in the types of inquests by contacting the coroner's clerk or coroner's officer to request an inquest schedule. In some coroner jurisdictions the inquest schedule is available online. As coroners' staff will often ask that visitors confirm their attendance in advance coroners may have been made aware of my presence prior to the inquest. In two instances my presence at inquests was at the invitation of the coroner him/herself. Inquests were selected to include as many different types of fatal incidents as possible (*e.g.* suicides, accidental overdoses, alcohol poisonings, drownings, motor vehicle accidents). It is forbidden to make recordings of inquest proceedings so only field notes were taken.

**** All inquests attended were inquests on deaths (*i.e.* not treasure).

††† The Coroners and Justice Bill (2009), despite a great deal of Parliamentary objection, contains the provision in Schedule 1, Part 1, Section 3 (*Suspension pending inquiry under Inquiries Act 2005*) to terminate public inquests and replace them with what has been termed in the popular media as 'secret inquests' under the provisions of the Inquiries Act 2005. Regardless, nearly all inquests are, and can be expected to be, held in public.

Data request

A request for inquest data was sent out late in the data collection process to all coroners who did not agree to the initial interview request. The requested data included a list of all narrative verdicts and all open verdicts rendered over a six month period beginning 01 July 2009 and ending 31 December 2009. A sample of inquest rulings was intended primarily to test the hypothesis that coroners, and in particular coroners who did not consent to an interview, would not release research data owing to the fact that they did not appreciate their role in protecting public health. Previous interviews with coroners and non-coroners suggested that this might be the case and, as this suggestion was entirely speculative, it was deemed appropriate to test this assumption. The data request was also intended to yield information about how and why coroners might allude to public health failures, and/or make public health recommendations through narrative inquest verdicts. The letter requesting inquest data is included in **Appendix I**.

DATA ANALYSIS

Triangulation

Triangulation can be defined broadly as the, "...us[e] of different data sets, methods or approaches within a study [to] increase the validity of the findings, or our confidence in their credibility".^{305, p. 157} Triangulation does not imply that one assumes a positivist position with respect to reality, but that the use of several methods can bring the object of the research into sharper focus.²⁸³ The use of multiple methods has the effect, ultimately, of: either confirming or refuting each other (*e.g.* when interviews with coroners were compared to those of non-coroners). Additionally, the data request was intended to validate/invalidate the information provided by both coroners and non-coroners. Contrasting multiple methods also helped to identify biases and inconsistencies in the data.

Framework analysis

Framework analysis is a type of applied policy research developed in the UK by the National Centre for Social Research³⁰⁶ and can be distinguished from other forms of analysis in that it is entirely concerned with answering a specific research question in a manner which is explicitly intended to produce policy and practice-oriented conclusions. This seemed a particularly suitable approach given that the coronial policy reform process has been on-going for the duration of the research project and can be expected to continue

for some time once it is finished. Framework analysis prescribes a fairly well-defined methodology which includes the following steps⁸⁵:

Familiarisation

Familiarisation is defined by Ritchie and Spencer as essentially involving immersion in the data.⁸⁵ Following the completion of the data collection the interview transcripts, field notes, and the relevant documents were considered as a whole. Much time was spent in consideration of each source of data, the consistencies and inconsistencies among and between them, and the possible reasons for outlying or unexpected results.

Identifying a Thematic Framework

As I was the sole interviewer for this study I was familiar, during the process of collecting data, with some of the emerging themes. Once all of the data were reviewed themes were identified, as was a list of issues which I felt necessary to explore further. Nearly all of these issues related to aspects of law, most notably public law with which I had only passing familiarity and which, owing to the frequency with which it was referenced by participants, warranted further research. In creating a thematic framework great care was taken not to deviate from the original research question. Based on the research aims and objectives, and on a thorough consideration of the data, an index was created which delineated the major themes derived from the interviews, the notes taken during inquests, the policy documents, and the inquest data.

Indexing

The index was subsequently applied to the interview data using NVivo qualitative research software. All interviews, and much of the inquest data, were imported into NVivo in their entirety and were subsequently coded based upon the parameters set out in the index. Relevant information from the inquest notes was also entered into NVivo.

Charting

The data were then arranged into charts by themes in order to, “build up a picture of the data as a whole, by considering the range of attitudes and experience for each issue or theme”.^{85, p. 182} Charts were created by theme and included index items which formed the subheadings for each theme. Interview respondents were randomly assigned a participant number which was used to identify their comments under each index item in the charts. All coroners were assigned a number preceded by ‘C’, while all non-coroners were assigned a number preceded by an ‘E’. Participant numbers follow all direct quotes in the text.

Mapping and Interpretation

The final step was to formulate an accurate and meaningful account of the data which addressed the research aims and objectives through descriptive claims about what coroners believe is their purpose, and normative claims about what other research participants believe is the purpose of the coroner. The data were collated in such a way as to: define concepts, map the nature and dynamics of phenomena, create typologies, find associations, seek explanations and develop new ideas and strategies.⁸⁵ In addition, data were presented to clearly reflect the inherent multiple constructions of reality, a step which was expected to be helpful in establishing that a single positivist or normative description of the coroner's purpose was not unchallenged, nor was it privileged above others. The identification of shared features of those who describe the coroners' purpose in a particular way also occurred at this stage.

Legal and jurisprudential content

Some of the legal and jurisprudential matters addressed in this study were beyond my expertise and experience. In several specific cases I consulted with members of the bar and legal scholars with respect to my interpretation of matters of public law, coroner law, human rights law, and legal theory. All advice was granted *pro bono*.

REFLEXIVITY

Reflexivity is described by Green and Thorogood as a critical component of rigorous qualitative analysis.²⁸³ It is intended to, "...account explicitly for subjectivity, in exploring how the context had an impact on the research and the data arising from it"^{283, p. 195} I was acutely aware of how my experience influenced the genesis of the research question itself, and of the way in which coroners interacted with me.

Any death investigation system can be understood, broadly, to include not only the principal investigator, but all of the constituent components of the system including: the coroner or medical examiner, those who provide administrative support to the coroner (*e.g.* the coroner's officer, the medical investigator), the police, the mortuary technicians, laboratory technicians, and the body removal service. For approximately ten years I worked as a forensic pathology technician (in a medical examiner's system), and as a pathology technician (in the morgue and the anatomic pathology department in an inner city hospital in Vancouver, as well as in the morgue and the embryopathology department in a children's hospital, also in Vancouver). The death investigation system in Vancouver is

overseen by the British Columbia Coroners Service (BCCS) which is a lay service - coroners are not required to have any particular experience and/or qualification. I have also worked for the body removal service which was contracted by the BC Coroners Service to remove bodies from scenes of death including those involving: homicide, suicide, accidents (including motor vehicle accidents), drug-related deaths, and deaths due to natural causes. The focus of my research for my Masters in Public Health (from the University of Cape Town, South Africa) was the psychodynamics of death investigation - a study which was carried out in collaboration with the Office of the Chief Coroner for Ontario in Toronto, Canada.

Having begun working in a medical examiner system I was able to witness, and participate in, the operation of a highly integrated medicalised system. The Chief Medical Examiner was required, under the Fatalities Inquiries Act (Alberta) 2000^{307, section 5(1)}, to be a certified pathologist, the Medical Investigators were all registered nurses^{###}, the histopathology lab and staff operated out of the Office of the Deputy Chief Medical Examiner, and the Office (which included the morgue, and the offices for the Medical Examiners and Investigators) also included epidemiologists, a photographer, and staff responsible for data management.

In 1999 I moved to Vancouver which has been described as, “home to one of the worst epidemics of human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) in the developed world”.^{309, p. 2} Both in my capacity as the Pathology Technician at St Paul’s Hospital and working in ‘body removal’ I spent the majority of my time working in and around, “...the poorest postal code in Canada”^{310, p. 96} dealing with the consequences of rampant drug use^{311, 312}, failing drug policy³¹²⁻³¹⁴, social marginalisation^{312, 315, 316}, police misconduct³⁰⁹ and, as is only now being discovered, poor police practice with respect to the protection of drug-addicted prostitutes in the Downtown Eastside (DTES)^{§§§§. 318} Despite the fact that illicit drug overdose deaths in British Columbia have been consistently high since deaths peaked in 1998 (N=417) the BCCS did not issue a Public Safety Bulletin addressing risks to illicit drug users until 5 May 2011.³¹⁹ I left Vancouver in 2003, only a few months before InSite (North America’s first safe injection

Medical Investigators are not required under the Act to be qualified registered nurses but, when I was working at the Medical Examiner’s Office they were, without exception, nurses. A recent advertisement for the position of Medical Investigator states, “[e]ducation and experience in nursing or a related medical field is preferred”.³⁰⁸

§§§§ Since the 1970’s and his arrest in 2002, Robert Pickton is thought to have murdered 49 women, most of them drug addicted prostitutes living in the DTES of Vancouver.³¹⁷

site)^{****} was established in an attempt to address the persistent problem of overdose deaths in the DTES.

The data for my master's thesis (*The Psychodynamics of Death Investigation: A Case Study of the Office of the Chief Coroner for Ontario, Canada*³²⁰) was collected in collaboration with coroners in Toronto. All coroners in Ontario are required, by statute, to be medical doctors.^{321, section 3(2)} Soon after I left Ontario it was discovered that Dr. Charles Smith, the head paediatric forensic pathologist at the Hospital for Sick Children in Ontario, had given 'erroneous expert opinion' leading to many wrongful convictions in the deaths of children on whom he had conducted flawed post-mortem examinations.⁷⁶ The Office for the Chief Coroner for Ontario faced extensive criticism over its management of paediatric death investigations in general, and its "completely inadequate mechanisms for oversight and accountability" of Dr. Smith in particular.^{76, p. 23}

I returned to the Medical Examiner's Office in 2004 for a few months before returning again to Vancouver. By the time I returned the BCCS had begun publishing Annual Reports and Statistical Reports, as well as publishing the occasional public safety bulletin, on their website.^{††††} However, still absent was a clear definition of the role of the service in preventing deaths and supporting public health and safety - that the service lacked a clear purpose would be noted in a 2011 audit of the system.⁸²

Thus, when I moved to London to begin my PhD, I arrived wondering what purpose a death investigation system served. When I subsequently came across the Third Report of the Shipman Inquiry, I found that Dame Janet Smith had asked precisely that question, particularly with respect to the system in England and Wales.

It was very unlikely, owing to my various roles in death investigation systems in Canada, that I would have been able to discover the answer to this question in Vancouver - coroners would have found the question puzzling coming from me, and the relationship I had with them would have made it difficult for me to assume a new role, that of a researcher. The opportunity to undertake this research in a different, yet sufficiently familiar, setting seemed ideal. For the most part, coroners in England and Wales are largely divorced from the more visceral aspects of the deaths they investigate. Coroners have not been required to view bodies since the passing of The Coroners (Amendment) Act 1926.¹⁴¹ Many coroners do not require their officers to attend scenes or post-mortems. It is my

**** <http://supervisedinjection.vch.ca/>

†††† <http://www.pssg.gov.bc.ca/coroners/publications/index.htm>

perception that by the time the details of the scene of death are filtered through the police and the coroner's officer, they are relatively sanitised, inevitably incomplete (insofar as only those details deemed important by the police officer and/or coroner's officer are passed on to the coroner), and entirely decontextualised from the grief, fear, and revulsion they may have inspired. Thus, I was in possession of knowledge and experience which coroners in England and Wales were not, and yet was sufficiently uninformed about matters pertaining to the system here that I could believably be seeking answers to the questions I knew I needed to be asked.

However, when I began this research the coroner system had just been the subject of two major reviews (the Luce Review and the Shipman Inquiry) and had been very publically criticised in both. The purpose, value and the very existence of the system had all been questioned in the course of these reviews. It was the opinion of both Tom Luce and Dame Janet Smith that the system was not fit for purpose and that it was in need of radical reform, reform: which, by the time I arrived in 2007, was looking unlikely to happen. This was the context in which all of the data for this project were collected. Coroners were being publically exposed for lacking a clear purpose, yet all but one coroner in my sample was able to provide me with a purpose when asked. It may well have been the case that, had I asked coroners to describe their purpose to me before these reviews took place, many of them would have unselfconsciously declared a purpose unnecessary. Now, however, coroners are undoubtedly struggling to make themselves relevant in the absence of any significant change to the system. I believe the context in which this research took place to be an important factor in framing this research.

I was aware of the fact that, in many respects, I have more extensive experience than the majority of the coroners with whom I spoke. I have also benefited from my experience working in different death investigation systems. In addition, as a public health student I am firmly committed to the public health system both in principle and in practice. Thus, it was necessary to constantly vet my own opinions and behavior during the course of this study in order to produce an objective, scientific and balanced piece of research.

LIMITATIONS OF THE RESEARCH METHOD

Scope of study

The coroner system does not operate in a vacuum. The policy and practice of death certification necessarily involves the coroner but will not be considered in any great detail

as it has been considered extensively elsewhere in: the 1893-4 Select Committee on Death Certification³²², the Wright Report, the Brodrick Report, the Luce Review, a 2003 report submitted to the Luce Review on behalf of the LSHTM²¹⁶, the Shipman Inquiry, the 2004 Home Office report²⁴³, the 2006 report of the Constitutional Affairs Select Committee^{51, 249}, the Government's response to the Shipman Inquiry³²³, and the 2007 Department of Health consultation (and response to consultation³²⁴) on Improving the Process of Death Certification²⁴⁷, as well as in the peer-reviewed literature.^{273, 325-345} Furthermore, I did not critique the recently implemented medical examiner system^{####} which is currently being piloted in Sheffield. As this system is in its infancy it is unclear if it will achieve its aim of providing a rigorous and unified death certification system for both burials and cremations in England and Wales. The new medical examiner system is, it would seem, the Government's response to Dame Janet Smith's 'Medical Coroner' and Tom Luce's 'Statutory Medical Assessor' both of which were intended to increase scrutiny of all deaths referred to the coroner. It was intended that the medical examiner system would be rolled out in stages beginning mid-2011³⁴⁶, thus, it is too early to assess what impact this might have on: the bereaved, physicians, funeral directors, the coroner and the registrar. It is also too soon to quantify: the reduction in the number of coroner's inquests, degree and frequency with which coroners avail themselves of the opportunity to consult with the medical examiners, or the number of cases referred back to the coroner for further investigation/inquest. The results of a pilot study titled *Improving the Death Certification Process: The Sheffield medical examiner pathfinder pilot*³⁴⁷ was published in 2008 and showed: a drop in referrals to the coroner from 46.6% to 36.0% ($p=0.0007$), and a drop in coroner-ordered autopsies from 10.6% to 6.0% ($p=0.0085$). Though, there were reductions in the percentages of the issuing of Form A, and 'no further action' recorded by the coroner's office, these changes did not achieve statistical significance ($p\geq 0.07$). A slight increase in the number of inquests from 3.5% to 4.3% was also not statistically significant ($p=0.517$).³⁴⁷

Representativeness and generalisability

There are some very clear limitations to this study, most notably in terms of selection bias. Coroners, in agreeing to be interviewed, were likely self-selecting such that the sample may

The 'medical examiner system' to be implemented in England and Wales beginning in mid-2011 is not the same as the medical examiner system as it is understood in North America. The system in England and Wales is intended to compliment, and not replace, the coroner system by giving coroners access to medical expertise and adding an additional means of scrutiny of MCCDs.

be biased in favour of those coroners more willing to participate in health research generally. This may have exaggerated the actual proportion of coroners who believe that public health to be their primary purpose. It also stands to reason that coroners who are resolute in their belief that public health is neither an important consideration, nor something they should be engaging with, may have chosen not to participate in this research. It is difficult to compensate for this possible source of bias; however, the data request was an attempt, in part, to establish how the non-responders and those who declined to be interviewed would respond to another public health request. Ultimately, therefore, there are questions as to the representativeness and generalisability of the sample.

Bias

Selection bias

There is one perspective which is conspicuously absent in this work - that of the bereaved. I very much believed that to approach the bereaved to request their participation in this project would be both an unnecessary and impractical intrusion given the circumstances under which they had come into contact with the coroner system. I had the opportunity to observe the bereaved while attending inquests; however, at no point did I speak with them about their experience and/or opinions, nor did I have ethical approval to do so. INQUEST has been a vocal advocate for changes to the death investigation system generally and has provided much testimony to the various reviews and consultations reflecting a general consensus among the bereaved that the system does not provide a meaningful service for families.

It is clear from our case work and in survey answers that very few people even know what an inquest is before they find themselves confronted with its reality - many confuse the term with the post mortem - the medical examination undertaken to determine cause of death. 75% of those surveyed knew absolutely nothing and the remaining 25% very little.^{348, p. 3}

INQUEST's 2002 response to the Luce Review *How the Inquest System Fails Bereaved People*³⁴⁸ includes information collected over the 21 years of INQUEST's existence^{§§§§§} as well as survey data from 130 families who approached INQUEST for support between 1997 and 2000. The report documents a general disappointment with respect to the inquest system

^{§§§§§} INQUEST was founded in 1981.

and its service to the bereaved. The report acknowledges a lack of research into the impact of the inquest process on bereavement and the anxiety and grief that it causes to the bereaved.³⁴⁸

In response to publication of the Draft Coroners Bill in 2006 the Minister of State for Constitutional Affairs convened a Bereaved People's Panel to provide scrutiny of the Bill in its current state.²⁵⁷ The Panel comprised 14 bereaved persons^{*****} who had recently come into contact with the coroner system - participants were asked to comment specifically on the Bill. Participants were not asked to respond to questions about what it is they felt the coroner was meant to do. Ultimately, therefore, this study makes very 'top-down' claims (and largely abstract claims) to an appropriate purpose for the coroner and does not give extensive consideration to the desires of individuals who use the service.

Confirmation bias

In addition, the fact that it was apparent from the recruitment letter that I was a public health student, doing research for a degree in public health, at a school of public health may have resulted in interview subjects placing disproportionate emphasis on the topic of public health.

ETHICAL ISSUES

All of the procedural requirements of the LSHTM Ethics Committee regarding ethics in general, and informed consent in particular, were observed. All interviewees who indicated that they would be willing to be recorded were provided with an information sheet (*viz.* **Appendix G**), and were asked to sign a consent form. Those who did not consent to be recorded, or those from whom a recorded interview was not deemed suitable, gave verbal consent in response to my research request in which I guaranteed their anonymity and confidentiality. All research subjects were informed that if they said something during the interview, and subsequently decided they did not wish it to appear in the transcript, the material would be deleted as per their request. Interviewees occasionally, while being recorded, indicated that something was, 'off the record' or requested that they not be quoted on something, in all cases the information that was subject to these impromptu conditions was not included in the thesis.

***** Panel participants were selected based on their level of satisfaction with the service such that the sample included individuals representing various levels of satisfaction.

Confidentiality

As per the stipulations contained in the *LSHTM Application to Conduct a Study Involving Human Participants*, and the subsequent ethics approval (*viz.* **Appendix J**), all data were stored on a password protected computer and on a removable drive encrypted using the BitLocker™ advanced encryption standard algorithm.

A transcriptionist was employed to transcribe some of the 45 recorded interviews. A suitable transcriptionist was sought from outside the study area as it was felt that someone from England or Wales might have, or might reasonably be expected to have, had dealings with a coroner, or a coroner's officer. Some of the non-coroner interviews were with people who are well known in England and Wales, therefore, it was felt that any transcription would have to be carried-out by someone unlikely to have previously come across these individuals, either in person or owing to media exposure. For this reason the transcriptionist was a native English speaker located in an area outside the British Isles and North America. All of the audio files were listened to initially for the purpose of transcription, and on a second occasion in order to confirm that there were no omissions or mistakes in the initial transcription. Following the checking of the transcripts the audio interviews were deleted.

Anonymity

Interview material was stripped of any identifying features pertaining to the coroner (*e.g.* names of the coroner and his/her colleagues, place names, places of previous employment) or to deceased persons, including information which might have been sufficiently remarkable so as to identify a deceased person. Information about well-publicised deaths was left in the transcript provided it was in the public domain and provided the coroner did not allude to having investigated the death or having presided over the inquest as this would identify the coroner in question - on several occasions transcript data were removed for this reason.

Chapter X: RESULTS

CORONER INTERVIEWS

Of the 105 senior coroners working in England and Wales in October 2009 all but one were invited to participate in an interview.* Of the remaining 104 senior coroners who were contacted: 58 (55.8%) did not reply[†], 34 (32.7%) initially agreed to an interview, 10 (9.6%) explicitly declined to participate, and 2 invitation letters (1.9%) were returned by Royal Mail.

Of the 34 coroners who initially agreed only 32 were interviewed.[‡] Of these, 31 consented to an interview under the proposed conditions (*i.e.* to meet for one hour and to be recorded), and one consented to meet but insisted in defining the parameters agreeing to a 30 minute meeting and stating that, “I am not prepared to have our conversations recorded under any circumstances”[C09]. Reasons given by the 10 coroners who declined to be interviewed included: insufficient time (N=5), imminent retirement (N=1), and an unspecified or general unwillingness to participate (N=4).

Gender and Length of Service

Of the 32 coroners interviewed 29 were male and 3 were female (9.7:1).[§] The lowest interval for length of service was 0-4 years, and the highest was 35-39 years. The lowest and highest intervals for male coroners were 0-4 years and 35-39 years. The lowest and highest intervals for female coroners were 0-4 years and 5-9 years.

Region

All regions within the study area were represented. Of the 32 coroners interviewed: 1 worked in the North East, 6 in Yorkshire & Humberside, 1 in the East Midlands, 2 in East Anglia, 2 in London, 4 in the South East, 4 in the South West, 3 in the West Midlands, 7 in the North West, and 2 in Wales.

Full-time versus part-time

There is currently an overlap, in terms of caseload, between full-time and part-time coroners. Some coroners may be considered part-time but have a higher number of

* I chose not to re-interview the one coroner with whom I had conducted the pilot interview.

† One coroner had been suspended for misconduct in March 2009 and, thus, would likely not have been inclined to reply.³⁴⁹

‡ One coroner retired before he could be interviewed and another expressed interest in being interviewed well after data collection had ceased and following consultation with his colleagues which, it was felt, would bias the interview.

§ Of the 105 senior coroners working in England and Wales in October 2009, 15 were women (7:1).

referred case as well as higher number of inquests than a coroner in another region who might be considered full-time. This may be a reflection of the perspective of the local authority, a response to the complexity of the case-load (*i.e.* in terms of the proportion of Article 2 inquests), or this may simply be a historical artefact. Of the 32 coroners interviewed 19 (59.4%) were full-time, and 13 (40.6%) part-time.

Qualification

Of the 32 coroners interviewed, 28 (87.5%) were legally qualified, 1 (3.1%) was medically qualified, and 3 (9.4%) were dually qualified.

Number of cases and inquests

The lowest interval for the estimated, self-reported number of referred cases in the previous year was 0 - 249, while the highest interval was 5,000+ cases referred. The lowest interval for the estimated, self-reported number of cases going to inquest in the previous year was 0 - 99, while the highest interval was 1,000+ inquests. The lowest and highest intervals for the estimated, self-reported number of referred cases in the previous year for full-time coroners were 2,000 - 2,499 and 5000 + referred cases. The lowest and highest intervals for part-time coroners were 0 - 249 and 3,500 - 3,900 referred cases. The lowest and highest intervals for the estimated, self-reported number of cases going to inquest in the previous year for full-time coroners were 100 - 199 and 1,000+ inquests. The lowest and highest intervals for part-time coroners were 0 - 99 and 400 - 499 inquests.

PURPOSE

All coroners were prompted to explain their purpose. Only one coroner did not believe a purpose was necessary and merely indicated that it was sufficient that, "...the state says there must be an inquiry" [C17]. The remaining 31 coroners indicated at least one purpose including: to fulfil the positive obligation under Article 2 of the ECHR; to provide 'closure', 'finality', 'peace', or 'understanding' for families; to rule out homicide; to investigate military deaths; to provide public reassurance; and to support public health and safety.

Often coroners defined a clear public health purpose without mentioning 'public health' *per se*. Some coroners would identify strongly with prevention of injury or death, safety promotion, contributing to mortality statistics and/or disease detection but would, when prompted, go on to disavow any responsibility to public health. As this was deemed to be

the result of a clear lack of understanding of public health, such responses were recorded as ‘public health’ regardless of whether the coroner would classify them in this way.

As coroners were asked to define their purpose in a semi-structured interview setting they were not restricted to providing a single answer nor were they asked to rank their responses in order of perceived importance. As such, some (N=19) coroners indicated one purpose, while others (N=13) mentioned two or more. None of the respondents listed more than three purposes. As coroners who listed more than one purpose generally indicated that the first stated purpose was either of primary or overriding importance the results have been tabulated (Table 1) based on the assumption that the first purpose indicated by coroners assumes a greater importance and/or that coroners identify more strongly with this purpose over others. All of the responses to the question of purpose are listed in Table 2 followed by the number of coroners who indicated such responses regardless of the priority given to the purpose.

Table 1: Percentage response by first or only stated purpose

First or only purpose indicated by coroners	No. of coroners	%	Cum. Freq.
Families	15	46.9%	46.9%
Public health & safety	6	18.8%	65.7%
Detect homicide	3	9.4%	75.1%
Article 2	3	9.4%	84.5%
Other	2	6.3%	90.8%
Reassurance	1	3.1%	93.9%
Military	1	3.1%	97.0%
Doesn't matter	1	3.1%	100.1%
TOTAL	32	100.1%[†]	100.1%[†]

[†] Percentage values have been rounded. As a result, the total percentage and the total cumulative percentage add up to 100.1%

Table 2: Percentage response by coroners by stated purpose

Purpose	No. of coroners referencing this purpose	% of coroners who referenced this purpose
Families	17	53.1%
Public health & safety	16	50.0%
Detect homicide	6	18.8%
Article 2	4	12.5%
Reassurance	4	12.5%
Other	2	6.3%
Military	1	3.1%
Doesn't matter	1	3.1%

Families

Of the 32 coroners interviewed 17 (53.1%) referenced this purpose and 15 (46.9%) identified providing a service for families as either their *first or sole purpose*. Some coroners made general reference to the purpose of providing a service for families without elaborating on specifically what it was families were to be provided with, just that the coroner's purpose is, "for the family" [C05]. Others described their purpose in terms of providing answers/knowledge/truth for families, while others described their purpose in relation to the grieving process (as providing closure/finality/peace). One coroner described providing a service to the family which would help them to prevent future deaths of family-members. One coroner believed that providing a service to families was a recent purpose for the coroner, one that did not exist in the past:

It used to be an absolute function; that the coroner is required to find out identity, or injury, or disease causing death...time, place and circumstances. That was what was required, and families were incidental. When I was first appointed if you had a family there, well they sat on the side, and if you spoke to them you were doing quite well. The whole modus has changed and families are now central to the whole system. And that really has been a shift in the last ten years. I'd always seen fulfilling my obligations under the

Coroners' Act, as being my job. That now is taken as read, [we've had to] expand the nature of the job. [C12]

Providing information

Some coroners identified their purpose as providing families with “answers” [C04], or “the truth” [C20]. One coroner stated his purpose was: “to tease out on behalf of families the facts which might not have emerged unless the systems were there” [C16].

Only one coroner emphasised that though she believed that the coroner's purpose was, in part, to provide a service for the family this did not include mollifying them or pandering to their wishes:

You will try at an inquest to find the truth. Sometimes a family are angry and bitter and upset and don't want to hear the truth. Or can't hear the truth because they've not yet reached that stage ...they're not ready. They haven't reached the stage where their mind is open to the truth; it's too clouded with hurt, and bitterness, and genuine lack of understanding. Um, and that would never prevent the coroner from saying, 'I'm sorry, I know you'll be disappointed by this but that's my decision'. [C20]

Aiding the grieving process

The coroner's purpose was described by some in relation to grieving: “the whole point is giving people closure” [C15], and the coroner is “there for the families...for them to get the finality they need” [C24], to “solve grief if at all possible” [C22], and to “get them through what's happened” [C21]. Families were described by one coroner as “looking to get peace from what happened” [C19], and the investigation was described as “a vital part of the grieving process” [C12].

One coroner expressed the belief that families would be unable to grieve without knowing what had happened:

OK, so your cat disappears, the whole time he's disappeared, OK, that's murder. Right, you don't know what's happened, he may be starving to death in someone's shed, somebody's maybe mistreat him, who knows? If you actually find him squashed on the road, OK, that's very sad but at least you know, all right, he's dead and that's what happened to him, he got squashed by a car, you know, you grieve. He's only a cat, all right, but you grieve. OK? Now can you imagine what it's like if you are a parent and that's your daughter? Imagine if you are a wife and that's your husband?

Unless you know what happened you can't grieve, you can't even start. So the whole point is giving people closure. [C15]

Helping families prevent further deaths

One coroner indicated that he felt it was his purpose to provide families with explanations which could help them prevent other deaths. The example provided referred to cases in which a genetic cardiac defect may have been the cause of death, prompting the remaining family members to take precautionary measures against, in this example, sudden arrhythmic death syndrome (SADS).

Public health & safety

Of the 32 coroners interviewed, 16 (50.0%) made reference to this purpose. Just under a fifth (18.8%) of coroners identified public health and safety either their *first or sole purpose*. Six coroners believed that they served a function comparable to that of a public health official. Of the 16 coroners who indicated that they believed facilitating public health and safety to be the coroner's purpose (or one of the coroner's purposes), 6 (37.5%) explicitly referred to prevention. Coroners referred to prevention either as an active role (*e.g.* one realised through writing Rule 43 reports), or a passive role (*e.g.* involving producing data for surveillance purposes). Though all 16 coroners couched their responses in terms of facilitating public health and safety there was no unanimous consensus with respect to the ways in which they realise this purpose.

Active prevention

Several coroners discussed their public health and safety role in active terms, stating their purpose was to, "...try to create a better world" [C29], and to "...prevent other deaths" [C11], to "...prevent natural deaths, [...] to prevent surgical deaths, [...] to prevent traumatic deaths" [C07]. One coroner described his purpose as such: "[t]he main reason that justifies my existence is to try to prevent further deaths of a similar nature" [C10]. Another, stated:

Obviously there are many other agencies which investigate deaths and in my view the function of the coroner is principally to investigate the circumstances of those categories of deaths with a view to seeking to identify circumstances which may cause future deaths and to try to prevent them. [C02]

Another coroner described his purpose by describing deaths in custody by way of example:

...simple things like changing roads, I mean, you do an inquest and look at a road and you think that maybe this road ought to be altered because of what you've heard. I do prison deaths, certainly changes took place in a number of our prisons following deaths. You know, simple things like taking the windows...instead of having iron bars they have plastic Perspex, whatever, to stop people hanging themselves on the bars, you know. So you go through a whole gamut of things. [C11]

One coroner felt that his role in supporting public health was realised through providing information to physicians in order to help them improve the clinical management of their patients:

...you can still learn a great deal from routine post mortems, which can be very useful in preventative medicine. And, I mean, we make sure that every post-mortem we do, a copy goes to the GP [...] because the GPs kept ringing up and saying 'I need to know what was going on', 'I mean I saw the superficial symptoms, I need to know what's going on underneath when I'm treating other patients'. [...] and that, I think, is a major thing. [C25]

Four coroners discussed Rule 43 reports when describing their purpose stating that through such reports they can, "...suggest ways in which [things] could be improved"[C31], and:

...we can write this Rule 43 report saying, 'at my inquest today I heard evidence that worries me', and 'that if something isn't done about the scenario in which this guy died other people are going to die in similar circumstances - I think you should know about this, I think you should do something about it'. [C13]

Passive prevention

Only 4 (25.0%) of the 16 coroners who identified themselves as purposed with facilitating public health and safety also discussed their role in terms of providing data for surveillance purposes. This represents 12.5% of the total sample of 32 coroners.

... you need information as to hazards, and organisations that might not be doing [things] properly. You need surveillance of health. You need general improvements in governments' managements, either locally or nationally. [C08]

One coroner referred to a remit to support surveillance, though more obliquely than his colleagues.

...I mean, clearly there is a public health issue in establishing whether people in ____ die of heart disease, or lung disease. And if there's a preponderance of lung disease what's that based upon; is it the fact that the atmosphere is no good, do we need to do something about it, if it's heart disease does it have to do with diet or whatever? [...] I facilitate others. In other words, I provide the information for other people - to take that away, analyse it, and make whatever decision they need to. [C03]

One coroner couched his description of the coroner's purpose in reference to suicide:

...the public needs to know, I would say, what the cause of death is, how many people are dying from a certain condition, or how many people are dying from suicide for example. I mean, I'm involved in efforts locally to try and reduce suicide, obviously in order to inform people who are looking at suicide prevention. I'm asked to say how many people are dying from suicide and what are the circumstances. And that information will help others to, you know, hopefully take measures which may be designed to reduce instances of suicide. [C18]

Detect homicide

Six coroners (18.8%) described their purpose as ruling out homicides or investigating suspicious deaths. Three coroners (9.4%) suggested that this was their *first or sole purpose*. Coroners described their purpose: as "...trying to pick up crime"[C29], to "...rule out homicide/foul play"[C21], to "...investigate suspicious deaths"[C02], and to "...weed out those deaths that are suspicious and need to be looked at from a criminal point-of-view"[C27].

If you go right back to basics, my job is to, number one, make sure that there are no suspicious deaths. If you take that in simplistic terms, my job is to make sure that murders are investigated.[C11]

Article 2

Of the 32 coroners interviewed 4 (12.5%) indicated that they felt that meeting the positive obligations under Article 2 of the European Convention of Human Rights was the coroner's purpose; three coroners (9.4%) stated that this was their *first or sole purpose*. The only purpose for which coroners were able to provide an authoritative source was Article 2. One coroner referenced "legal reasons" (*McCann v UK, etc.*) as purposing the coroner with the investigation of deaths owing to an action, or inaction, of the state:

Firstly, we have to exist for legal reasons, because we are the designated way of discharging the state's duty under Article 2** for any death that engages that - be it medical, custody, or whatever.

[C26]

Public reassurance

Of the 32 coroners interviewed 4 (12.5%) described allaying gossip/rumour and providing public reassurance was the coroner's purpose. Only 1 coroner (3.1%) mentioned this as the sole purpose stating:

Well, it's generally the text book definition, which is probably a good one, which is...which is to investigate suspicious deaths to allay public concern and also to allay the concerns of bereaved relatives.[C02]

Another coroner framed this response with respect to mental health:

Now, the difficulty with leaving [death] undealt with is that, be it a hospital, prison, nursing home, whatever, there will always be the suspicion - call it conspiracy theory or whatever you like - that people are being done in. [...] So if you were to justify it on those grounds, you can say that it exists to reassure society that untoward incidents are not going unchecked, that it is instilling confidence in people like the police, the ambulance service, doctors and nurses, as to what's going on. It is to some extent dealing with people's mental health and assuring of that. [C26]

Other

Two coroners (6.3%) gave answers which could not be definitively classified. One defined the coroner's purpose as, "sweeping up", "coping with all the bits that nobody else copes with" and "going around with the ash pan".[C12] The other responded that the coroner is "there as a nuisance" and that the coroner is meant "...to stir things up".[C30]

Investigating the military

One coroner (3.1%) gave what appears to be an outlying response when asked to describe his purpose. His response seemed to suggest that he believed that the coroner need not have a purpose as the law mandates that an inquiry take place in relation to certain types of

** This statement is somewhat misleading as coroners are not *the* designated way of discharging the state's duty under Article 2, rather, the inquest is *a* designated way of discharging the state's duty under Article 2. (*viz.* *R v Secretary of State for the Home Department ex parte Amin*, pp. 72-73)

deaths; yet, he discussed the coroner's purpose in terms of investigating military deaths. Ultimately, it was difficult to classify this response as no reference was made to Article 2, nor any other purpose that had been provided by the other 31 coroners.

No purpose

Only one coroner (3.1%) out of the sample of 32 indicated that he believed it irrelevant and unnecessary for the coroner to have a purpose stating simply that, "...the state says there must be an inquiry" [C17].^{††}

Negative statement of purpose

One coroner described her purpose in negative terms stating:

I think there are a number of areas where holding inquests can appear to be unnecessary and people may say, 'what is the point?'. I mean it's a very old jurisdiction and it does need to change. So for example where you have - I think it runs in parallel with the fact that you have many other agencies who investigate deaths - so sometimes, for example, I find that I hear a road traffic accident case and it's all been investigated up to the nines by a police investigator, and I sometimes think about what is the purpose of what I'm doing. Now, you get the odd case where actually despite the police investigation you do add something, but those are minority, a significant minority. And then you have cases which are investigated by the health and safety executive. Many hospital deaths, of course, you have an internal inquiry. I think from the point of view of the relatives of the deceased person the coroners service is perceived as being perhaps more independent. It's more available to a family to participate in a coroner's inquest than certainly in many internal hospital inquiries where they are just told what happened and here's the outcome. Um, the other sorts of inquests which sometimes appear pointless...I mean almost as a matter of history, we always hold inquest where there has been a mesothelioma death - I think those are utterly pointless. Many suicide cases don't seem really to me to perform any useful function. Cases where somebody has died as a result of the drug overdose, um, again I've done many of those inquests, I don't think in any case I actually felt it produced any useful information. And it's almost a matter of history or social mores as to what is viewed as being an illegal substance, and therefore unnatural, and a

^{††} The coroner whose interview was used to pilot the questionnaire also indicated that he felt it not germane to identify a purpose for the coroner. The pilot interview was not included in the sample of 32 coroners.

legal substance and therefore natural. I'm thinking of the difference between say cigarettes and alcohol, and then ecstasy on the other hand. I mean, it's a very fine line and it seems to me that in general, most cases, we don't get anything useful out of some of those drug deaths (and we do in _____ have a lot of them, because we have high proportion of drug users in places like _____) - we don't really get much use out of those.

NON-CORONER INTERVIEWS

All individuals approached consented to an interview. There was a general sense of frustration with the coroner system as a whole by all non-coroners with the exception of the two individuals from the Ministry of Justice who, as one might expect, were neutral in their opinion of the system as a whole. A selection of comments made by non-coroners regarding the coroner system follows:

- I occasionally deliver sessions on coroner training courses. And I have been on ones where pathologists or doctors are teaching [coroners] about disease and it really is at the level; 'a stroke is something that happens in the head', 'heart attacks happen in the chest'... **[E01]**
- _____ is a very good coroner and very good to work with. He is challenging but very good to work with. But, I have met one or two and, God! The idea that they have any kind of role in anything, something as important as this, is a bit scary. [...] As a citizen I find that a bit scary. **[E02]**
- Some coroners believe that everything that comes to them is right for a post-mortem. It is outrageous. And if it was a member of my family or something, I mean, I would pursue it really hard, if I didn't think it was justified. And they just do it. If you think of any work of medical practice where you said, you know we've got a similar consultant [in another region] and their rate for something is 20 percent; it's never accepted. It just could not be accepted in that sort of practice and you know there are those sort of disparities - which reflects the fact that you got all these different jurisdictions and some of them do things in very different ways and it's just balmy... **[E02]**
- And the [coroner I was talking to], he must be late 50s, he is a really good fellow he has been a coroner for about 25 years now. And so I was sort of being indiscreet, we were talking about what was going on [with the coroner for _____] and I was saying, '*ab the*

coroner's a so and so'. And he said to me, 'you know I've never met him'. 'I have been going through the training and all the meetings we have for 25 years [and] I have never met him'. How can that be? Okay, it's a reasonably small community: 25 years, you've never come across this person? No, they never come to any training...[E02]

- What does the coroner do? The coroner...the coroner's God. And let me tell you, I don't know who you've met yet but I'm sure when you've met them you'll understand why I say that. They are so important you wouldn't believe it. They make sure you know that.[E03]
- ...so they go off on a crusade. So [the coroner for ____] has started a crusade out in [____]. He's now come to [____] and he's not got any of that, so he's bizarrely gone off on another crusade of his own around police cars and accidents. So, you know, they end up, for me, they seem to lose the thread of why they're there because they get a personal interest in something and literally everything else can wait. You know, I've got some....on some of my work schedules I've got jobs that are still sitting on people's workloads here that have been waiting for years to be heard at coroner's court.[E03]

INQUESTS

Coroners' inquests are open to the public. Fifty inquests were attended including several which involved deaths that were the result of self-harm - only three of these (out of six) were ruled a suicide despite the fact that in the remaining cases it seemed patently clear that the death was the result of an intentional act. Two of these suicide verdicts were given by the same coroner. The reasons given in court by the coroner for not ruling the death a suicide (in all cases these deaths were given an 'open verdict') were: depression (which, in the opinion of the coroner, may have undermined the deceased's ability to form intent), and ingestion of alcohol (regardless of quantity) prior to the death which, again, was cited as possibly undermining intent.

Only one coroner met with the family of the deceased immediately prior to the inquest. During this meeting the coroner: offered the family his condolences; indicated what would happen at the inquest; explained family's rights during the inquest; and clarified that - barring any "surprise testimony" by witnesses - he would have to rule the death a suicide, stating, "I have to rule your son's death a suicide...because that's the truth" [C18]. The family, in this meeting, appeared grateful to the coroner, thanking him and repeatedly

assuring him that they understood the process, their rights, and the necessity of the verdict. One coroner, who was subsequently and informally interviewed, indicated that he felt coroners who met with families face-to-face, “should be shot”.

In one instance a very anxious and sobbing family member, who was sat next to me in the courtroom, appeared to be praying in the moments leading up the coroner announcing the verdict on a death that, based on the facts presented in court, was clearly the result of a suicide. When the coroner announced that he would render an open verdict, and not suicide, the woman appeared visibly relieved. The coroner, in this case, did not meet with the family prior to the inquest proceedings. In another instance, the father of a girl who had committed suicide made statements during the inquest imputing blame to the mother of the deceased (and her husband) but was quickly stopped by the coroner who pleaded that the families “stick to the facts at hand”. The witness statements in this case (including those of the police, the family physician, and a psychiatrist) were graphic and grisly. These statements appeared to greatly upset the family. Once the inquest had concluded the father stood up and turned to others present and repeatedly saying, “what was that for?” - a statement seemingly in reference to the inquest.

One inquest involving the death of a man from blunt force trauma (suffered following a fall that, the coroner postulated, was a consequence of alcohol inebriation regardless of repeated testimony to the effect that there was a defect in the staircase rendering it hazardous, that someone had fallen down the same stairwell and died on a previous occasion, and that no toxicology was requested), was ruled an accident by the coroner. There was no post-mortem in this case. Following his ruling the coroner, on record, warned of excessive drinking and made statements to the effect that low alcohol prices set by supermarkets were to blame for this and similar deaths. He then issued a disclaimer stating that he did, “not want to get political” followed by the statement, “we, as a nation, are drinking too much” [C32]. In conclusion the coroner referenced the faulty stairwell and suggested its speedy repair.

In another inquest which considered the death of an 84-year-old woman who was discovered dead in bed, the coroner stated that he would be rendering a verdict of death due to natural causes (owing to an “unspecified medical cause”) but specified that, “ten years ago I would have rendered an open verdict” on such a case [C32].

Another inquest considering the death of a 27-year-old man who died following a motor vehicle accident was ruled an ‘accident’ by the coroner who during the inquest (which the coroner’s officer conspicuously slept through) would not allow the investigating police officer to describe any of the circumstances of the death which might be distressing to the family. The coroner frequently interjected stating that the evidence was upsetting and, therefore, it was not necessary to recount it in court. When the family appeared distressed the coroner would stop and chat with them, asking them what their son did for a living, if he liked his job, and if he was good at it^{##}; this appeared to assuage their anxiety. The coroner concluded that the roadside barriers were inadequate and that the deceased (who was the driver of the vehicle) had been drinking.

DATA REQUEST

Of the 104 coroners initially approached to participate in an interview 58 did not respond, and 10 coroners explicitly refused to participate. All non-responders (minus the coroner who had been suspended), and those who refused to participate were mailed a written request for a sample of inquest data. The data request was thought to be reasonably simple: coroners were asked to provide all narrative verdicts rendered over a six month period. Of the 67 coroners approached for data: 31 (46.3%) did not respond; 15 (22.4%) sent the data as requested; 10 (14.9%) indicated that they did not have the resources to retrieve the data (1 coroner stated, however, that I could access the information at the court which I was told I was welcome to do); three coroners requested clarification about the data request yet did not respond once I’d clarified what it was I required; two coroners (3.0%) declined to send the requested information, one stating, “I am not prepared to disclose any details of [the relevant cases] to you: the information is not available to the general public”, and the other (via the coroner’s officer) that “[the coroner] notes your request but feels that your access to our records would not be appropriate because of the extremely sensitive and personal data contained therein”.^{§§} One coroner (3.0%) claimed to be too busy to send the data; one coroner (3.0%) declined to allow me to access the

^{##} This line of questioning, though apparently well intended and arguably effective in controlling the anxiety of the bereaved, was not relevant to the inquest and likely a contravention of the Coroners Rules 1984 which states that the, “proceedings and evidence at an inquest shall be directed solely to ascertaining [...] who the deceased was; how, when and where the deceased came by his death”.^{18. section 36(1)} The occupation of the deceased is information that is to be submitted to the Registrar under the Births and Deaths Registration Act 1953^{42, section 15} and the Registration of Births and Deaths Regulations 1987^{48, regulation 39 & Schedule 2 [Form 13]} and is, thus, a necessary question; however, questions as to the duration of the deceased’s employment and his job performance and or satisfaction are not permitted under the Coroners Rules 1984.

^{§§} The inquests, to which the data requests pertain, would have all been open to the public in accordance with Section 17 of the Coroners Rules 1984 which states that, “every inquest shall be held in public”.¹⁸

information on the basis that there was no suitable office space for me to examine the documents; one coroner (3.0%) directed me to the website for his region which includes access to the information I requested; one coroner (3.0%) asked to meet to discuss my research (but following said meeting, did not send the requested data); one coroner's officer (3.0%) indicated that the coroner had authorised my access to the data and that I should call to discuss the matter; and one coroner (3.0%) stated that it is not his practise to render narrative verdicts but attached inquest data for the time period regardless.

Of the 15 coroners who sent the data as requested: one (6.7%) sent the data within a week; nine (60%) sent the data within two weeks, and 12 (80%) sent the data within three weeks of date from which the request was sent. The two coroners (13.3%) who responded within four weeks had contacted me for clarification prior to sending the data which likely explains the delay. Only one coroner (6.7%) sent the data within seven weeks.

Open Verdicts

An 'open verdict' is described in Jervis as the verdict to be recorded, "[i]f there is insufficient evidence to record any of the other suggested conclusions *** ...".^{350, p. 316} A sample of open verdicts sent by coroners include:

- In the late hours of [date] the deceased, who was a pedestrian, sustained fatal injuries when in collision with a van being driven down [location].
- The deceased who had mental health issues and whose application for asylum in the UK had been refused, hanged herself at [location]...
- The deceased died as a result of a fire at his home....
- On [date] the deceased suspended himself with a ligature around his neck on the staircase at [location].
- [The deceased] died on [date] from plastic bag asphyxia.
- On [date] she took an overdose of [drug] and was later admitted to [location] where she died despite appropriate treatment. It is not clear what her intention was in taking the overdose. She had taken overdoses recently.
- [The deceased] died on [date] from heroin toxicity.

*** Those being: natural causes, industrial disease, dependence on drugs/non-dependent abuse of drugs, want of attention at birth, suicide, attempted/self-induced abortion, accident/misadventure, disaster the subject of a public inquiry, execution of sentence of death, lawful killing, open verdict, unlawful killing, and stillbirth.

- On [date] the deceased was found deceased on a mattress in the bedroom at her home. A note was at the scene. (COD: Toxic effects of [drug A, drug B & drug C]).

Narrative Verdicts

The ‘narrative verdict’ was intended as means through which the coroner (or the jury) could meet obligations under Article 2 of the ECHR to elaborate of the circumstances of a death more so than would be possible with a standard short-form verdict (*viz.* R. [on the application of Middleton] v West Somerset Coroner, pp. 70-72). It has become common, however, for coroners to render narrative verdicts in cases that do not involve state agents. Thomas *et al* (2008) state that narrative verdicts should be used to indicate: “failures which caused or increased the risk of death/which amounted to breaches of Article 2”; “matters which assist in achieving the purpose of the inquest, for example, ensuring accountability”; “systemic failures”; and “matters which increase the risk of death in future”.^{50, p. 310} Thomas *et al* acknowledge that despite the intended uses of a narrative verdict, “[t]here is no set procedure in relation to how coroners will decide upon what type of verdict they will leave to the jury or consider themselves”.^{50, p. 317} Recording a narrative verdict rather than documenting a short-form verdict is problematic for the calculation of mortality statistics as mortality data is typically based on the short-form verdict.^{16, 50, 351} A sample of narrative verdicts sent by coroners include:

- [The deceased] died from natural causes, namely dilative cardiomyopathy, a condition which was undiagnosed during her life.
- Natural causes aggravated by the non-dependant use of cocaine.
- [The deceased] died from injuries received in a road traffic collision. He was riding a cycle and was unlawfully killed on impact with a motor car being driven dangerously by a driver who had been drinking, was uninsured and had no driving licence.
- Dependant use of alcohol.
- Natural causes aggravated by self-neglect.
- [The deceased] died at [location] from injuries sustained in a road traffic collision on [location] Road after losing control of his vehicle.
- [The deceased] hung himself by the neck using a piece of aerial cord padded with socks from the loft hatch at his home at [location] [...] [The deceased] died as a result of the consequences

of asphyxia caused by the hanging. The question of intent in relation to the hanging is unclear.

- The deceased died as a consequence of an overdose of [drug], there being insufficient evidence to establish his intention to the required standard.
- [The deceased] died when he hanged himself in the bedroom of his home when no other person was present in the house. There was no evidence to demonstrate whether his action was intended to cause his death or whether his death was the unintended consequence of a deliberate experimental action.
- [The deceased] hanged himself when the balance of his mind was disturbed. An opportunity to render assistance to him as a missing and vulnerable person and potentially avert his actions was missed because an appropriate system was not in place to identify missing and vulnerable people in the police control room.
- The deceased died as a result of ingesting an excessive quantity of prescription medication at a time when he had been drinking heavily.
- Died of an inflicted gunshot wound whilst suffering from anxiety and alcohol dependency, treatment for which had been intermittent due to the requirement for his own co-operation which was periodically absent.

No short-form verdicts would have accompanied these narrative verdicts. The final six of these verdicts would have to be coded by the ONS as 'accidents'. The ONS is often forced to code these deaths as 'accidental' in accordance with the requirements for coding underlying causes of death as detailed in the World Health Organization's International Classification of Disease (ICD).³⁵²

Chapter XI: DISCUSSION

In this chapter I discuss coroners' responses to the question of purpose. The discussion will be done in the order of frequency the responses were reported from the survey. The focus is on understanding coroners' responses, describing why they may be problematic as policy and in practice. In addition, the incompatibility of these purposes with other putative purposes is illustrated suggesting that any multi-purposed system (such as those proposed by both Tom Luce and Dame Janet Smith) will have to be considered carefully given how coroners' purposes are currently being put into practice. This chapter concludes with a discussion of the limitations of the present study.

CORONERS AND THEIR UNDERSTANDING OF PURPOSE

It was generally the case that, when asked to describe their purpose, coroners referred to their statutory duties to establish the identity of the deceased and how, when and where the deceased has died. When prompted to describe a reason for establishing these facts all coroners were able to provide an answer; however, the answers were varied and inconsistent. Answers to the question varied; however, it did not appear that there was any factor (*i.e.* gender, full/part time, lawyer/physician) inherent to the coroners themselves that could account for the discrepant responses. The responses fell into seven categories: providing a service/closure for families; facilitating public health and safety; detecting homicide; public reassurance; meeting the obligation of Article 2 of the ECHR; acting as a check on the military; and defining a purpose was not necessary. Two coroners' responses could not be classified and may simply have represented confusion about the question being asked or the inability, on the part of the coroners, to describe their purpose.

Providing a service to families

The purpose most frequently-cited by coroners was to aid families of the deceased. This notion that coroners exist to provide a service to families has been expressed by others. The MP for Beckenham, while advocating the abolition of the Chief Coroner as per the Public Bodies Bill (2010), stated: "I am quite taken by the idea that we [...] have independent coroners who talk on behalf of the families and say some things [that government] do not like".^{275, col 247}

Undoubtedly providing a good service for families is important and improving the system in this regard was one of the primary recommendations of the Luce Review and the Shipman Inquiry. But as a defining purpose of the coroner it is problematic given how coroners go about realising the purpose. For example, it has been suggested that coroners

not infrequently avoid distressing families with a suicide verdict and that, “open verdicts, or those of accidental death or misadventure are often used instead”.^{4, p. 135} It has also been suggested that nebulous and inconclusive narrative verdicts are being used to the same end, “in an effort to protect the feelings of family members”.^{13, p.6}

A non-coroner research subject described a typical problem with respect to this practice:

[In one case] somebody who was known to be a problem heroin user... There was nothing mentioned on the death certificate about whether they'd done toxicology or not. There was nothing mentioned on the death certificate about the fact that they were known to be a heroin abuser, nothing at all...just 'unknown cause'. Another thing the coroners will say, they sometimes think of themselves as helping families with bereavement. And I think that's not their job at all, but some of them think it is and still don't want to write down something that will make the family unhappy. So, they don't want to write down 'drug misuse' if they don't have to. **[E01]**

In my experience attending inquests, very few likely suicides were given a verdict of suicide, and the application of the standard of proof appeared inconsistent. Suicides that seemed demonstrably so were frequently given open verdicts owing to the fact that the deceased had been depressed (as ‘the balance of his/her mind was disturbed’), implying the inability to form intent. Coroners clearly believed that such deaths could not, beyond a reasonable doubt, be ruled a suicide.

Similarly, it has been suggested that coroners will rule a drug overdose as an accidental death in order to avoid distressing the family with a potentially stigmatising verdict.⁴ The fact that coroners are given the latitude to decide whether deaths are natural or unnatural leaves open the possibility that deaths owing to chronic addiction (*e.g.* alcohol dependency) may, in the interests of not distressing a family by requiring an inquest, be referred back to physicians as ‘natural deaths’, such that the physician may simply sign a MCCD.

Also, it is not uncommon for unhappy families to be present at inquests where I have witnessed coroners ‘negotiating’ (often between physicians and the deceased’s family) the particulars that appear on a death certificate. In one instance the negotiation went on for some time, with the coroner playing the part of the intermediary, only to make what seemed to be a trivial change in the MCCD. In this instance the mere appearance of a negotiation seemed both to empower and placate the family with no objection from the

physician (who, however, was vocal about the insignificance of the change). The deceased's widow, who had shown a considerable degree of animosity towards the medical witnesses, subsequently indicated that she was satisfied with the outcome. One non-coroner research subject (an epidemiologist) stated that coroners believe this process is "cathartic", and that "it makes everybody feel better" [E01].

A non-coroner research subject (a barrister in private practice who has acted as an advocate for families at inquests) reported that, on more than one occasion, a coroner has requested a private meeting with him in advance of an inquest to ask him which verdict the family would prefer. On every occasion, after stipulating the family's preference, the coroner ruled in accordance with the family's wishes. [E04]

There is nothing wrong, in principle, with coroners identifying their purpose in terms of service to families; however, if one of the few means whereby they provide families with a service that gives them 'closure', 'finality' or 'peace' is to adapt the verdict in order to minimise their distress, this purpose is to the detriment of the greater good as it may undermine the goal of better public health by failing to record properly causes of death which represent identifiable health related social trends and currents.

The legality of coroners acting in the interests of the family

Legislation, legislative instruments, and case law permit a certain degree of latitude in the coroner's judgments. However, it is the opinion of Tom Bingham* that:

The rule of law does not require that official or judicial decision-makers should be deprived of all discretion, but it does require that no discretion should be unconstrained so as to be potentially arbitrary.^{353, p. 54}

Yet the actions of coroners often do appear arbitrary, in terms of both how they see their role and how they execute that role, as illustrated by their various statements of purpose and varying use of verdicts. As much of the legislation governing coroners is vague and enabling, this may account for some of the differences in practice from one region to the next. The fact that, for example, suicide verdicts vary significantly from one coroner jurisdiction to the next suggests an arbitrary application of the law (or, perhaps, and arbitrary understanding of what the law requires). The fact that some coroners believe

* Incidentally, Lord Bingham presided over: *R v North Humberside & Scunthorpe Coroner ex parte Jamieson*, *R v Secretary of State for the Home Department ex parte Amin*, and *R v Her Majesty's Coroner for the County of West Yorkshire ex parte Sacker* (viz. Case Law, pp. 61-73).

their purpose in applying the law is to provide a service for families, while others may understand their purpose differently, seems to suggest that the discretion afforded coroners under the law is being applied in a manner that could only be considered both inconsistent and arbitrary.

One coroner stated that: "...the statutes set out what I can and can't do. But it gives us free reign as to how we run our inquests within the legalities that are set out" [C24].

Delivering one verdict when another verdict might be more accurately rendered must be considered evidence of either an area of law that is sufficiently vague as to provide no clear guidance, or it is evidence of a practice that is contrary to the intention of the law. If the intention of the law (*i.e.* the purpose of the legislation) is unclear, there is no standard against which to judge the legality of this practice.

When I asked coroners (who had indicated that they believed their purpose to involve providing closure/finality/peace for the family) whether families could request that an inquest not be held, or if the coroner could request that an inquest be foregone if the deceased had no family, all responded that this could not be done. This suggests that, although coroners may feel their purpose is to provide for families, they accept that they must do so within the confines of the law. The fact that some coroners are providing open verdicts in an attempt to satisfy families suggests that they believe this practice to be permissible under the law.

Acting in the interests of the family as a threat to impartiality

Regardless of whether or not coroners are properly to be considered judges, judicial officers, or quasi-judicial officers, the fact remains that they currently fulfill a judicial function. It is, in part, owing to this judicial status that the importance of the coroner's independence is so frequently emphasised. However, independence is not generally considered sufficient to ensure that judicial officers fairly apply the law. Judicial impartiality is essential to the judicial function.

Impartiality is required by various international resolutions for the protection of judicial independence including the Latimer House Principles³⁵⁴, the Bangalore Principles of Judicial Conduct³⁵⁵, and the United Nations Basic Principles on the Independence of the Judiciary which states that:

The judiciary shall decide matters before them impartially, on the basis of facts and in accordance with the law, without any

restrictions, improper influences, inducements, pressures, threats or interferences, direct or indirect, from any quarter or for any reason.³⁵⁶

Article 6 of the ECHR also requires the impartiality of legal tribunals.¹⁹⁷ The requirement that the law be applied by an unbiased tribunal is a requirement under UK, and European Law. Therefore, the fact that some coroners believe their purpose to be advocating on behalf of families is a clear statement of bias.

The appeal of a Divisional Court's dismissal of a request for judicial review of the Marchioness coroner's decision not to resume an inquest following the completion of criminal proceedings, was based on the coroner's appearance of bias *against* a family member.³⁵⁷ The appeal was successful as the coroner's apparent bias was deemed to represent a "real danger of injustice".³⁵⁷ Lord Bingham noted that for coroners there is a higher standard of impartiality:

[I]f anything [the coroner's] central and dominant role in the conduct of an inquest might be said to call for a higher standard [of impartiality] since those interested in the proceedings are, to an unusual extent, dependent on his sense of fairness.³⁵⁷

Mental health

Despite the fact that some coroners believe that their involvement with the family of the deceased is beneficial to families' mental health, some evidence appears to contradict this claim. A 2003 report, *How the Inquest System Fails Bereaved People*, produced by INQUEST reflected a longstanding and widespread dissatisfaction with the coroner system with respect to families.

The Coroner's inquest has become an arena for some of the most unsatisfactory rituals that follow a death - accusations, deceit, cover-up, legal chicanery, mystification; everything but a simple and uncontroversial procedure to establish the facts.^{348, p. 3}

The report indicates that, "...families have frequently described the experience as one that adds to, rather than diminishes, distress and that it marginalises them leaving them with more questions than answers".^{348, p. 3} A further study of individuals who had been bereaved by suicide described several research subjects as having been significantly traumatised by the inquest process.³⁵⁸ The study indicated that families were, "...particularly disturbed by the judicial atmosphere, media activity, the invasion of privacy, and giving evidence" in addition to, "exposure to graphic evidence, delayed inquests, confiscated suicide notes and

the inquest's failure to provide explanation and deal with blame".^{358, p. 1033} In a 2010 letter to the editor of the BMJ an anonymous author described the traumatic death of a partner and the series of events which followed including a failed attempt to communicate with the coroner:

I contacted the coroner's office on two occasions asking to speak to him and was told this was not possible. On the second occasion, without warning, the results of the postmortem examination were read out to me over the phone by someone clearly unfamiliar with medical terminology. [...] For me the painful memory of that day will last a lifetime. I believe it could have been handled so much better. [...] We may not choose the manner of our dying, but death should not deny us our rights or our dignity. Could not communication, common sense, and, above all, compassion prevail?^{359, p. 481}

There have been many suggestions for reform which would address some of the aspects of the system which are known to cause distress to families. For example, both Tom Luce and Dame Janet Smith suggested that public inquests are, in many cases, not warranted and that they cause increased distress to families. One coroner commented on the distress caused by suicide inquests stating:

...very often at a suicide inquest I acknowledge that my existence does nothing but extend the grieving period and [that] 'I will leave you now and get out of your hair - you can hopefully move forward having gotten this out of the way'. But it's acknowledged, by me certainly, that that is an intrusion into the family's grief. It may give them certain allowances, and it may give them a facility to ask questions, it may give them an opportunity to participate in the death, as it were, but it's not always helpful for them. [C12]

Another coroner acknowledged the distress caused to families owing to the presence of the media at the inquest:

[Suicide inquests] also upset families so much because they get reporters at inquests and they report these cases and it upsets them greatly. I get this hostility at a suicide inquest with the family, 'what's that reporter doing sitting there?' I say 'I'm awfully sorry I can't ask them to leave, it's a public hearing'. Why can't they be in private? I don't mean a secret inquest, but one where all the interested parties can come to but not the media. [C02]

These accounts seem to suggest that there are certain features of the inquest system which are inherently distressing for families, thus, coroners who identify their purpose as providing a service to families may feel they should do so in response to the anxiety caused to families by the system itself. However, the therapeutic effects of such a gesture are questionable.

Moreover, if indeed it is the coroner's purpose to aid in the grieving process, it is unclear why the coroner should be required to be legally qualified as, surely, there are other qualifications better suited to someone purposed with providing closure, finality or peace to the bereaved.

Public health surveillance and research

Beyond the obvious fact that rendering open verdicts (or oblique narrative verdicts) presents problems for public health generally, and mortality surveillance in particular, the belief that the purpose of the coroner is to provide a service for families poses other problems for public health. For example, literature indicates that families often consent to tissue donation for the purposes of research, that they find "comfort" in knowing that they could help others and that the opportunity to donate tissue on behalf of the deceased is "empowering".^{360, p. 372} Bruce Winick, in his work on therapeutic jurisprudence, has also emphasised that there is therapeutic value in allowing people to make choices.³⁶¹ This raises the question why (given that so many coroners identify their purpose as that of providing a service for families) it is not the practice of more coroners to ask families if they wish to be contacted by the NHS Blood and Transplant Authority for the purposes of discussing tissue retention.

Public health and safety

The second most frequently cited response to the question of purpose was that the coroner is, in effect, responsible for contributing to public health and safety. Although precisely half (N=16) of coroners indicated that they believed public health and safety to be one of the coroner's purposes, only 18.8% (N= 6) identified this as the first or only purpose. Whether acknowledged by coroners or not, how coroners operate affects public health in a number of ways. For example, information on cause of death produced by coroners influences regional, national and worldwide mortality statistics that are used by governments, public health officials and researchers, to name a few, in causal and descriptive research, for early detection of public health threats (surveillance), and to

monitor trends. Coroners' willingness to participate in public health research studies (and, conversely, their resistance to participation) can aid or hinder efforts to find answers to public health problems; and their handling of Rule 43 cases as well as the recommendations coroners make, may or may not help to bring about the desired effect of preventing further deaths. Whether the present coroner service contributes to or detracts from public health and safety is discussed below with respect to cause-specific mortality data, public health research, and coroner recommendations (*e.g.* Rule 43), and communications with the media. The role of the coroner in a fourth area (*i.e.* tissue donation) is relevant to a discussion of the public good and is, therefore, also mentioned.

Cause-specific mortality data

Routine mortality surveillance in the UK is the responsibility of the ONS. Causes of death are coded in accordance with the rules and conventions of the International Classification of Diseases (ICD).³⁵² The ICD coding guidelines are extremely strict and do not allow the coder to infer information that is not stated explicitly by the coroner or physician. The underlying cause of death includes the mechanism of death and intent. Intent is defined by the ICD in terms of the intention of the initiating act (*e.g.* it is not germane to know whether the deceased intended to die, only that they intended to cause themselves harm, or that they carried out the act with the understanding that it would cause themselves harm). The categories of intent for deaths from injury or poisoning as allowed by the ICD are: accident/unintentional, intentional self-harm, assault, event of undetermined intent, legal intervention, operation of war, or complication of medical or surgical care. It is not possible to code a death under one of the categories of intentional self-harm as defined by the ICD if, for example, the coroner either fails to indicate that there were drugs involved or classifies the death as an accident. Thus, the ability of the ONS to accurately code causes of death is entirely dependent upon the accuracy of the cause of death as recorded by the coroner or physician.

The difficulty and complexity of assigning a cause of death was illustrated by a comment from one coroner:

You'd be surprised how often somebody's thought of taking their lives who actually die from natural causes. It may well be the excitement of preparing to take his own life that caused his heart to fail [...] but he hasn't caused his death, you see. **[C15]**

The present study has made a number of observations that indicate that attribution of cause of death by coroners can be inconsistent, arbitrary and frankly inaccurate. A number of factors have been identified that adversely influence cause-of-death determinations including: (a) no clear understanding or consensus on what constitutes an unnatural cause of death and hence the jurisdiction of the coroner, (b) inconsistent practices among coroners, (c) incomplete information collected by coroners, (d) avoiding verdicts which coroners believe upset families, (e) over-reliance on narrative and open verdicts, and (f) delay in reporting. Each of these is discussed further below.

Natural vs unnatural causes of death

Confusion about the distinction between natural and unnatural death is a relatively modern phenomenon. In medieval times two rather straightforward distinctions defined what constituted a natural and an unnatural death. The first medieval definition of a ‘natural death’ was intended to differentiate between physical/organic (*i.e.* natural) death and a civil (*i.e.* social) death; referring to loss of status resulting, for example, from taking holy orders or becoming an outlaw.⁹⁴ The second distinction was between violent and non-violent deaths and in this context, according to Havard, “the medieval mind considered any death which was not violent as natural”.^{94, p. 41} Early inquest data from the thirteenth and fourteenth centuries documenting investigations held on prisoners who had been deprived of food and water indicates that these deaths were inevitably ruled as having resulted from natural causes as they had, categorically, not been the consequence of violence.[†]

Neither the term ‘natural’ nor ‘unnatural’ are defined in the legislation despite the fact that both the Registration of Births and Deaths Regulations 1987⁴⁸ and the Coroners Act 1988³⁴ use the term ‘unnatural’ to define the coroner’s jurisdiction. The common law, however, offers some clarification as to the distinction between ‘natural’ and ‘unnatural causes’. In *R v Poplar Coroner ex p Thomas*¹⁶¹ (*viz.* p. 63) it was the opinion of the Court of Appeal that a death due to a natural disease process (*i.e.* asthma) was not made ‘unnatural’ by the late arrival of the ambulance. In *R v Birmingham Coroner ex parte Benton*³⁶² the court ruled that a child who was suffering from a fatal medical condition had died of natural causes owing to the fact that he was suffering from irrevocable life-threatening condition and, moreover, that the medical intervention (whether unsuitable or insufficient) could not render the

[†] Clearly the notion of ‘structural violence’ did not exist in medieval times. It is a modern concept attributable to sociologist Johan Galtung and has only recently (in the early 1990’s) been popularised in the works of Paul Farmer. Regardless of how strong a predictor of mortality structural violence might be, coroners rarely investigate such deaths as they are the result of complex historical, cultural, economic and social forces.

death unnatural. In *R v HM Coroner for Inner North London ex parte Touche*¹⁹² (*viz.* pp. 63-64) the Court ruled that a death that would not have occurred were it not for some culpable human failure should be deemed to have come about unnaturally. Despite this clarification by the courts, coroners often struggle with the distinction between ‘unnatural’ and ‘natural’ deaths. Coroners differ in their understanding of the distinction both when assuming or declining jurisdiction, and when rendering verdicts at inquest. The difficulty in distinguishing unnatural from natural causes of death when the definition is essentially a tautology, was expressed by one coroner who said:

Court of appeal defined [unnatural] and they said, ‘an unnatural death is a death which is unnatural’[...] if you apply that then you get deaths occurring now which we call unnatural, and 20 years ago you think were natural, and vice versa. So at the moment we treat deaths from lung cancer caused by smoking as natural. It’s quite natural for someone to smoke a cigarette and then die from lung cancer. We think at the moment that if you take heroin and you die as a result that’s unnatural. I’m talking about what the public call natural and unnatural. Now I reckon in 20 years time that would be the other way around, I reckon 20 years’ time somebody who dies from lung cancer, we’d probably be holding an inquest as we’ll say, ‘how on earth does that happen?’ Heroin deaths would be so numerous, that we’d just be saying, ‘ah, I can’t hold an inquest for that, that’s natural’. **[C15]**

When I inquired about how this coroner would return a verdict on cases of swine flu he responded that he uses the distinction between natural and unnatural for the purpose of providing public reassurance:

Once swine flu really gets a grip, then that’s natural. So, I’ve held three swine flu inquests so far. And my staff say, ‘well why are we hold[ing] an inquest, it’s just flu really’. And my answer is, at the moment to die from swine flu is unnatural, unusual. In each of the three cases we have held - and they were all right at the beginning when it first happened - it turned out that the swine flu was a very minor part of the death, if any part at all. All of them had very significant underlying diseases which could have killed [them] at any time. Now that did, I believe, the public a lot of good. Because people know, well this is what’s happening. It’s not this huge problem at the moment, all right, they got all these things. So again what we’re doing is to say, ‘here is something unnatural, the public as well as the individuals need to know what it is’. **[C15]**

I also asked how the coroner decides when to stop defining deaths as unnatural:

That's the whole beauty you see, because if you keep things simple and you have simple people like me actually in the community, not some high court judge, or some judge of appeal or anything like that, just an ordinary bloke, I know whether a thing has become natural because I know what the people next door to me are talking about, I know what they're saying in the pub, I know what the schools are saying. And if I get it wrong they'll tell me pretty damn quick. OK. If I start sitting there holding inquests that people think shouldn't be held or saying 'this is unnatural' when everyone else in _____ thinks it's natural they'll tell me very, very quickly...all over all the newspapers, you know, 'coroner not fit to be coroner' and all this sort of stuff, you know. And that's what it should be. [...] Until I believe it's a non-issue. **[C15]**

Another coroner indicated that "some coroners" define unnatural deaths liberally in order to increase their salary:

...as a part time jurisdiction I get paid on the bodies that I deal with so if I suddenly decide I wanted every lung cancer related death, you know, every person who's been in hospital in the last two years reported to me, I'd double or triple my salary. And you'll find some coroners do that. **[C04]**

Another coroner raised the issue of alcohol deaths and drug deaths stating:

Alcohol is another issue. Somebody dies from alcohol, liver disease, that's normally regarded as a natural cause and you could say it is not natural to kill yourself through excessive drinking. You could kill yourself through drug overdose it's not a natural cause. So there is a grey area. **[C18]**

Also, given that unnatural deaths require the coroner's involvement, coroners who may be overworked, under-resourced, or understaffed may feel inclined to try to reduce the number of unnatural deaths by pressuring physicians to not mention certain features of a deceased person's recent medical history in order to avoid having to classify the death as unnatural. This possibility was raised during the Shipman Inquiry specifically with respect to deaths following femoral fracture.⁵ If physicians indicate that a death was preceded by a femoral fracture on the MCCD then the coroner is obligated to intervene as the death could, therefore, have resulted from a fall, rendering it unnatural. If the coroner can convince a physician not to document the femoral fracture then the coroner need not become involved. A clinical epidemiologist gave evidence to the Shipman Inquiry claiming

that, “this sort of action has the effect of rendering completely unreliable statistics for excess mortality following a fractured femur”.^{5, p. 167} Ultimately, the unnatural *vs* natural distinction, though necessary for deciding the coroner’s involvement, may be: used as a means of social reassurance; reinforcing social or religious dogma (*e.g.* by rendering deaths ‘unnatural’ which are thought to have been brought about through illegal means, or which are felt to be socially or morally undesirable), or used as a means to increase or decrease the coroner’s case load. This undoubtedly distorts mortality statistics.

Inconsistent practices among coroners

In a 2000 study entitled *What is a natural cause of death? A survey of how coroners in England and Wales approach borderline cases*, Roberts *et al* asked coroners to provide a verdict for sixteen scenarios which included a cause of death and, in most cases, described scenarios, “common in clinical practice”.^{191, p. 367} The study found that there was considerable variation in the way coroners returned verdicts on borderline cases. The lowest degree of agreement was found in scenarios describing a death resulting from a combination of trauma and natural disease. The two scenarios describing deaths as a consequence of HIV infection returned very different decisions: one involved a man who acquired HIV through homosexual activity (92% of coroners judged this to be a natural death)[‡], and a woman who acquired HIV through injection drug use (23% of coroners judged this to be a natural death). Another source of confusion involved deaths due to CJD; in one case the infection was thought to be acquired through a past injection of human growth hormone (27% of coroners judged this to be a natural death), and in the other it was thought to have been acquired through eating beef burgers (63% of coroners judged this to be a natural death). The authors concluded that the possible consequences of variations in coroners’ approach to borderline causes of death include: confusion for medical staff, distress to family members of the deceased, and “gross distortions of national and regional mortality statistics”.^{191, p. 373}

The fact that the practice of coroners varies greatly between regions was mentioned in both the Luce Review⁴ and the Third Report of the Shipman Inquiry⁵ and was frequently cited as problematic in the ongoing debate about the abolishing of the position of Chief Coroner.^{15, 275, 363, 364} That variations in coroners’ practice are likely distorting area differences in the incidence of suicide has been established by Carroll *et al* (2011)³⁶⁵ and Gunnell *et al* (2011).¹⁶

[‡] It is perhaps concerning that five coroners indicated that they deemed deaths from HIV to be unnatural if the infection was acquired through homosexual sex because “homosexual activities are not natural”.^{191, p. 371}

In addition concerns about variations in practice have been raised with respect to drug-related deaths by Stanistreet *et al* (2004)³⁶⁶ and the Advisory Council on the Misuse of Drugs (2000).³⁶⁷

Some of the problems posed by inaccurate and inconsistent coding practices were discussed by one of the non-coroner research subjects:

...there are staggering differences between different coroner's areas, for example, the coroner that [...] the coroner who covers the area that includes King's Cross has never given a verdict of drug misuse or drug dependence.[§] [...] But we don't use their verdict to count deaths from drug misuse because we know their verdicts are dodgy at best. [...] I mean we still miss them - I mean if they don't put anything about the drugs down we miss them - but if they put on the death certificate that any of the drugs that are in the schedule of misuse of drugs are on the death certificate then it's a drug misuse death and they're split up into ones where you have a suicide verdict, and an accident verdict. We actually completely ignore the drug misuse and drug dependence verdict and just call them accidental poisonings because basically they're so - the use of them by different coroners is so completely bizarre that it would be meaningless. So the indicator that we use for deaths from drug misuse is actually only acute poisonings. So it's acute poisonings with any drug that's in the schedule of misuse of drugs, whatever the verdict. [E01]

Limited information collected by coroners

An article that appeared in a June 2010 issue of *Mental Health Practice* criticised the practice of coroners not collecting potentially relevant demographic data on suicides:

Coroners have maintained that they will not collect details of ethnicity unless it is relevant to the inquest proceedings [but] if you don't collect this information, how do they know it is not relevant.^{13, p. 6}

The 2011 DEMOS study concluded that, "...some coroners currently choose not to include relevant health information within their inquest records, which are frequently the main input to Primary Care Trust's (PCT's) suicide audits.^{17, p. 14} The study, which involved conducting qualitative interviews with coroners, cited one coroner as saying, "I don't think

[§] That some coroners will not rule a death as being the result of drug-use was a finding of the 2000 report by the Advisory Council on the Misuse of Drugs which noted that: "[a] surprising problem is that there are coroners working in high drug prevalence areas who will never certify a death as related to drug misuse".^{367, p. xviii}

coroners should have to put more detail in because they are there to make sure a death is recorded in the proper way, and nothing more”.^{17, p. 59} With respect to the possibility of assisted suicide another coroner stated that, “[t]here have been many cases where I had suspicions, but I would not see it as my specific job to delve into it. If I had no option then I would, but you might say I didn’t want to know”.^{17, p. 62}

In addition, it has been suggested that coroners’ focus is too concentrated on the events which happened late in what might be a long and complex chain of causation. It is often the case that an event which may appear, temporally, to have precipitated death (*i.e.* it was the last event to occur before the deceased died) was only incidental in terms of causation. This is a problem, in particular, when coroners focus disproportionately on measures taken by medical staff to treat someone who is in immediate and irreversible threat of dying from another cause; for example, one respondent in the present study stated:

I think one of the problems with the coroners system is that the concentration is all on what happened at the last minute. [...] So the concentration is all on what happened, you know, if somebody came into hospital. One of the premises is that most people die, I think, because they’ve accumulated so many illnesses and organ failures that they can’t recover from them all anymore. So it’s often quite complicated trying to work out all the things that went wrong. And what we want for statistics is always that underlying cause. And the other things are nice extras. A lot of other people want the complications. They want the ‘anaesthetic error’, the ‘drug error’, the ‘health care associated infection’. **[E01]**

Avoiding verdicts which coroners believe upset families

It has been suggested that coroners avoid rendering certain verdicts in order to avoid adding to a family’s distress.^{4, 13, 14, 16, 17} This has been referred to as a, “misplaced regard for the feelings of the people left behind”.^{14, p. 5} It is my perception, having attended many inquests, that deaths that are manifestly suicides are often given open or narrative verdicts to avoid distressing families who, incidentally, are often in attendance at the inquest. In one instance I found the ‘open verdict’ utterly bewildering as the deceased had, prior to drowning herself, sent text messages to her family to inform them of her intention to do so.

One coroner discussed reluctance to classify deaths due to drug abuse:

When I was first appointed - shouldn’t be saying this - when I was first appointed, um, I had a number of families who did not like

the term ‘misuse of drugs’ or ‘abuse of drugs’. And it seemed to me at that time that in reality people who died of an overdose of heroin, it was probably an accident wasn’t it, in the ordinary sense of the word, they weren’t intending to kill themselves. So, it’s an accident. Until the Drug Action Team came to see me to say, ‘You know, _____, our funding is suffering here’. [C20]

A non-coroner research subject described some of the problems with this type of practice:

We did a cohort study of problem heroin users...flagged by the [National Health Service Central Register] and got a composite of their death certificates. You know, we...it was all very anonymous, we didn’t know who they were in the beginning, but eventually we knew this cohort were all not just users of drug treatment facilities, but problem heroin users (*i.e.* they had lots of complications). [...] But quite a substantial proportion of those with the post-mortem; all we got as the cause of death was just ‘unknown cause’...that was it. Known to be...somebody who was known to be a problem heroin user. There was nothing mentioned on the death certificate about whether they’d done toxicology or not.** There was nothing mentioned on the death certificate about the fact that they were known to be a heroin abuser. Nothing at all...just ‘unknown cause’. [E01]

Another coroner acknowledged avoiding suicide verdicts out of concern for families, one stating that:

I personally don’t like the verdict ‘suicide’. I think it’s old fashioned, I think it lacks compassion for the family who’s survived, I think it tempts insurance company dealers because they’ll avoid the policy if they can... [C21]

And, another long-time coroner stated that, “I never return a suicide verdict for a young person [...] I don’t think they’re capable of making up their own mind”. [C05]

Over-reliance on open and narrative verdicts

Related to the issue of avoiding distressing verdicts, discussed above, is over-reliance on narrative and open verdicts rather than attempting to assign a cause of death. Narrative verdicts allow the coroner to avoid making a statement as to intent rendering it impossible to establish if a substance was self-administered or if there was a deliberate intent to self-

** It was noted in the 2000 Advisory Council on the Misuse of Drugs Report that coroners are inconsistent in their requesting of confirmatory toxicological testing of suspected overdose deaths.³⁶⁷ In some cases it was found that coroners failed to note whether toxicology was taken or not.

harm. Such deaths must, therefore, be coded as accidents.³⁵¹ The ONS has estimated³⁵¹ that most narrative verdicts categorised as accidental poisoning or accidental hanging were actually suicides “as many are likely to be”^{365, p. 2}, resulting in a 6% underestimation of the suicide rate for 2009, or 7 deaths per million per year.³⁵¹ The study did not, however, address the problems posed by open verdicts.³⁵¹

In early 2010 I met briefly with a researcher working with the National Mental Health Development Unit (a joint DH and NHS programme)^{††} on research studies of suicide in the UK for the purpose of preventing future deaths. He acknowledged that the evidentiary standard for establishing intent in cases of self-harm is higher than for most other verdicts^{‡‡} (*i.e.* the death must be proven *beyond reasonable doubt* rather than on the *balance of probabilities*), yet it was his opinion that even when the death is held to the criminal standard of evidence, many more deaths are afforded open or narrative verdicts than is warranted.

One coroner acknowledged the challenges these ambiguous verdicts pose for coders:

So a lot of the confusion arises because the Department of Health statistical data on suicide is based on a balance of probability type test and they come to coroners saying ‘we’d like to access your records because we’re doing a suicide survey’ and we have to spend a fair amount of time saying ‘yeah, but it’s not good just looking for suicide, you need to cover all the open verdicts and all the accidentals because they may well include what you would regard as suicide but what in law I can’t because I cannot be sure that they had a settled intention to end their life that day and it wasn’t something went wrong, or a misjudgement, overdose, or whatever. **[C13]**

In two recent articles, Gunnell *et al* (2011) and Carroll *et al* (2011) have established that the increasing use of narrative and open verdicts in deaths for which the cause is ostensibly suicide is undermining calculations of the rate of suicide overall^{16, 365} and clouding comparisons of rates among localities.³⁶⁵

^{††} The research participant wished to remain anonymous and preferred not to be quoted directly.

^{‡‡} Suicide and unlawful killing are the two verdicts for which the criminal standard of evidence are required.

Though coroners suggest that the use of narrative and open verdicts reflects the correct application of the law, the study by Carroll *et al* found that there is significant geographic variation in their use with some coroners returning 50.3% ‘other’ verdicts.^{§§}

Delay in reporting

The timeliness of routine surveillance data is critical to identifying outbreaks of infectious diseases (*e.g.* pandemic influenza, bio-terrorist agents), or spikes in incidence of suicide (*e.g.* in aggregate, by location, or by method), accidents (*e.g.* owing to an influx of tainted drugs, a new substance of abuse, or deaths owing to occupational risk) or other categories of death which may share an underlying cause representing a new or increased risk to human life. The timely recording of mortality data is required in order to disseminate information upon which to act in the interests of prevention and control. The average time from the date at which the death was reported until the conclusion of the inquest is presented in Figure 5.^{***}

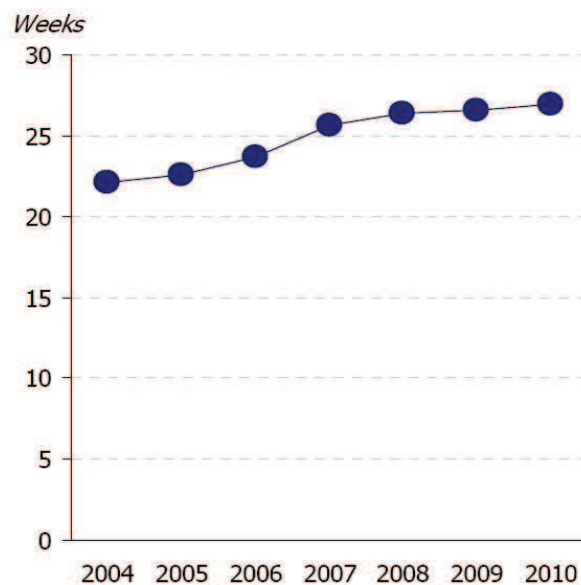


Figure 5: The estimated average time taken to process an inquest (2004-2010). Reprinted from: *Coroners Statistics 2010*, Ministry of Justice Statistics Bulletin, 2011.

^{§§} ‘Other’ verdicts included both narrative and open verdicts. An attempt was made by the authors to consider only narrative verdicts but, “...the MOJ only receive data on the breakdown of ‘other’ verdicts from around three quarters of coroners and these data are of varying quality, making the estimation of narrative verdicts at this level difficult”,^{365, p. 2}

^{***} In July 2011 five Teesside MPs called for the resignation of the Teesside coroner claiming that the average waiting time from a death to the inquest in 2010 was 43 weeks.³⁶⁸

One non-coroner research subject described the problems posed by slow reporting as follows:

So things like the flu deaths... The Cabinet Office is having this huge fuss saying ‘we must know every day at 3 o’clock in the afternoon how many people died’, and *they have to have that!* And we’ve tried to explain to say ‘look, you know when these things go to the coroners, as they did in the last flu thing (all the kids deaths were referred to coroners. Why? Who knows? They might have been unnatural for some reason) not a single one of them was registered within 6 months’. So, (laughs)... [E01]

Public health research

One of the means whereby public health issues can be understood and addressed is through public health research. A features of public health research is that it affords a multi-disciplinary perspective on matters traditionally addressed through a single academic tradition.³⁶⁹ In this way, it develops or contributes to generalisable knowledge and to our understanding of theories, principles, or relationships, while also addressing specific matters relating to threats to public health. Thus, supporting research is, beyond contributing to routine surveillance, an opportunity for coroners to support a public health mandate. Additionally, research requiring a nation-wide, population-level perspective would require support of all coroners in order to not introduce sampling bias which may distort results. A public health and safety purpose arguably requires unanimous agreement in order to be effectively realised.

Considerable frustration has been expressed over coroners’ apparent reluctance to participate in or contribute to public health research. The researcher working with the National Mental Health Development Unit on research studies of suicide in the UK that I met with in June 2010 expressed intense frustration at the unwillingness of coroners: to support research studies by recording demographic and health information which could be used to identify risk factors for suicide, to provide information on suicides upon request (regardless of whether the information had previously been presented as part of a public inquest), and to alter their practice of avoiding distressing families by rendering open or nebulous narrative verdicts,

A 2011 report titled *The Truth about Suicide*, published by the independent think tank DEMOS, sought to establish what proportion of those who committed suicide in England had a terminal or severe physical illness which may have been a factor in the suicide. The

article was based, in part, on qualitative semi-structured research with coroners. The findings of these interviews included the following:

- Coroners vary in the extent to which they record information on physical illness in suicide inquest records. Therefore, inquest records may not accurately reflect the deceased person's health status and PCTs may be underestimating the scale of the problem.
- Coroners vary in the extent to which they are willing to cooperate with other agencies performing local suicide audits.
- Several coroners indicated that they deliberately avoid probing into suspected cases of assisted suicide, often for fear of causing problems for the friends and family left behind. This suggests that the actual number of assisted suicide cases is also likely to be higher than official records suggest.^{17, p. 13}

An article in the June 2010 issue of *Mental Health Practice* claimed that coroners would not provide access to their records when asked to do so by those collecting data for legitimate research.¹³

Cooperation with researchers requesting interviews or the completion of survey questionnaires

The response rate of coroners in the present study and other similar studies may be taken as an indication of their willingness/unwillingness to participate in public health-related research. Of the 104 senior coroners approached to participate in the present study: 58 (55.8%) did not reply, 34 (32.7%) initially agreed to an interview, ten (9.6%) explicitly declined to participate, and two invitation letters (1.9%) were returned by Royal Mail.

Though few studies have employed a method involving approaching all senior coroners in England and Wales to request their participation in an interview or to complete a survey, some research studies which employed a comparable approach are useful for comparison. A 1998 study carried out on behalf of the Home Office³⁷⁰ involved posting survey questionnaires to each of the 148 coroner regions in existence at the time; questionnaires were completed on behalf of 118 (80%) regions^{†††}, representing a significantly higher response rate than for the present study. A survey of how coroners in England and Wales approach 'borderline' natural cause of death cases was carried out in 2000¹⁹¹ and involved posting a questionnaire to each of the then 143 coroners; 64 coroners (44.8%) completed

††† As coroners may have jurisdiction over more than one region one coroner's response might have been considered on behalf of several coroner regions.

and returned their questionnaires to the research team, leaving 79 (55.2%) non-responders. Another survey-based study was carried out in 2000 to assess how coroners and pathologists understood the role of the registered nurse in the coroner's enquiry.³⁷¹ The survey was sent to the 134 coroners working in England and Wales at the time. Of the 134 coroners approached for this study 72 (53.5%), "finally participated"^{371, p. 351} leaving 62 (46.5%) non-responders. In a 2011 study addressing the links between suicide and terminal or chronic illness, 82 coroners' offices were asked for contact details; 6 refused to give out contact details or could not be contacted, 76 obliged.¹⁷ Of the 76 coroners asked to participate in a short single semi-structured interview 42 (55.3%) did not respond, 19 (25%) declined and 15 (19.7%) agreed to an interview.¹⁷

The non-response rate for the present study (55.8%)^{###}, the 2000 study of 'borderline cases' (55.2%)¹⁹¹, the 2000 survey involving registered nurses (46.5%)³⁷¹, and the 2011 study of suicide and terminal or chronic illness (55.3%)¹⁷ are surprisingly consistent.

Cooperation with researchers requesting data

Requesting that a coroner agree to an interview, or requesting completion of a survey questionnaire, may present challenges involving scheduling, venue and confidentiality. Thus, one might expect that these methods of data collection may elicit a different response rate than that of a request for data already held by the coroner and accessible when time and resources permit. Thus, in an attempt to test the claim that coroners will not provide inquest data for research purposes, I requested inquest data from 67 coroners - only 15 (22.4%) coroners complied with the request. Though many coroners either failed to respond (46.3%) or claimed to not have sufficient resources to provide the data as requested (14.9%), only two coroners (3.0%) refused to disclose the information on the grounds that the information is: "not available to the general public" and "extremely sensitive and personal". Coroners who opted to send data did so in compliance with the specifics of the request. Of those who sent data, all responded within seven weeks of the request; over half (60%) sent the data within two weeks. Limited resources were also cited by 14.9% of coroners as a reason for not sending the data - is important to acknowledge that this cannot necessarily be interpreted as an unwillingness to do so. Ultimately, the responses to the data request suggest that many coroners are, in fact, willing to provide data for research purposes (and will do so promptly), though some may simply lack the

Calculation is for passive (58) non-respondents. The non-response rate including both active (10) and passive (58) non-responders is 66.7%.

resources to do so. However, a considerable number of coroners explicitly decline to provide data, or are unwilling to respond to such requests. Moreover, coroners are not listed under Schedule I of the Freedom of Information Act 2000 and are therefore not subject to Freedom of Information requests.³⁷²

The 2011 DEMOS study methodology included eliciting (by way of a Freedom of Information Request) data on suicides from PCTs. In instances where PCTs were unable to provide the requested data some offered an explanation for their inability to do so. Five PCTs indicated that they, “had difficulty communicating with the local coroner’s office to collect information for their suicide audit”.^{17, p. 15} The PCT for Stoke-on-Trent was unable to provide the number of suicides in that district for any of the five years prior to the Freedom of Information request stating that, “poor communication with the coroner’s office had prevented local auditing procedures that had been set up from being carried out effectively”.^{17, p. 47} Sandwell PCT also commented that, “they had not yet (despite repeated efforts) managed to secure access to the coroner’s patients’ records in order to audit the deaths effectively”.^{17, p. 47} Finally, the NHS Northwest London reported being, “...unsuccessful in their efforts to get the required data from the coroner’s office”.^{17, p. 47}

A non-coroner research subject described this problem as follows:

I mean [coroners] say in the meetings about reform that they want to identify patterns and trends so that they can make recommendations that will prevent future deaths. And they need to understand that in order to do that they have to record things in a consistent way and you have to have the basic public health and epidemiological information about populations at risk. I mean, they really think that they are going to drive down the suicide rate because they’ll see three cases and they’ll write to the local PCT and say, ‘under the Rule 43 thing, you must do something about this and you are now required by law to write to me within a year to say what you’ve done about it’. [...] But at the same time, *the very same ones*, if they’re asked to cooperate with the PCT’s compulsory suicide audit don’t have time to do it, don’t think it’s their job and won’t even record verdicts consistently enough for the PCT to be able to tell which deaths were suicides. And they don’t understand that *that’s* the problem! **[E01]**

This unwillingness to share information seems, in some cases, to be a matter of a coroner's policy as physicians have also reported having difficulty obtaining information from coroners. One of the Rapid Responses published in the BMJ in response to the article *Autopsies - why families count too*³⁵⁹ a consultant paediatrician notes that, "...it is our experience that Coroners frequently do not inform us of the results of post-mortems, and our attempts to gain this information is often frustrated".³⁵⁹

Cooperation with requests to participate in an ongoing prospective studies

In response to an increasing concern about the sub-clinical level of vCJD in the population and the associated risk of iatrogenic transmission of the disease from asymptomatic donors via blood transfusions, contaminated plasma products, surgical instruments, dental procedures and transplanted tissue, the Spongiform Encephalopathy Advisory Committee (SEAC) advised the DH that it was very important to establish the prevalence of subclinical vCJD infection in order to assess the risk of transmission, determine the efficacy of current precautionary measures, and determine if further measures are necessary to reduce the risk of human-to-human transmission.¹² Following a prolonged correspondence between the Chief Medical Officer and the Secretary of the CSEW the coroners declined to participate on what I argue are entirely spurious grounds. The issues surrounding the coroners' refusal to participate are considered at length in three of the publications included as part of this study (*viz.* **Publications Two, Three and Four**). Ultimately, the refusal of the CSEW to support the research methodology speaks to the fact that coroners may not be amenable to implementing new protocols for the purpose of supporting public health research.

Coroner recommendations and communications

The Coroners and Justice Act 2009 requires that coroners avail themselves of Rule 43 (*viz.* pp. 56-58) in cases where:

[A]nything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future [and] in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the coroner must report the matter to a person who the coroner believes may have power to take such action.^{43, schedule 5, section 7}

Rule 43 reports have been published bi-annually by the Ministry of Justice since July 2009.¹⁷⁵⁻¹⁷⁹ The most recent report was published in May 2012 and covered the period between 1 April 2011 and 30 September 2011 during which time coroners in England and Wales published 210 Rule 43 reports.¹⁸⁰ For this period, hospital deaths elicited the greatest proportion of Rule 43 reports (36%, N=75), followed by road deaths (12%, N=26), deaths involving community healthcare and emergency services (11%, N=24), mental health related deaths (10%, N=21), and deaths in custody (7%, N=16).¹⁸⁰ The number of reports issued over the six month period by coroner region varied from 0 to 13. Rule 43 reports were issued by only 54% of coroner regions.¹⁸⁰

There have been some attempts to determine the value of coroners' recommendations. In a 2003 article *Coroners' recommendations: Do they lead to positive public health outcomes?* Bugeja and Ranson outlined some of the problems associated with the way coroners formulate and distribute recommendations including, for example, widely reported or sensationalised deaths may result in media focus on the culpability of individuals which may detract from prevention messages or opportunities for system-wide improvements; insufficient developments in technology to address risks; competing matters which may take priority over a coroner's recommendation; limitations relating to budget or resources; or a coroner's recommendation may simply exceed the cost benefit of the offending agency.¹⁸¹

A further article addressing occupational death investigation by Bugeja *etal* similarly identified limitations of coroner's recommendations to prevent workplace fatalities, these included:

[C]oroners' lack of knowledge or training in public health, policy development and injury prevention; the paucity of resources to identify or examine known risk and contributory factors comprehensively, evaluate system failures and the effectiveness of countermeasures; and the lack of time, expertise and resources required to consider the potential implications for similar workplaces comprehensively.^{373, p. 2}

In a 2010 study of coroners' recommendations following fatal heavy vehicle crashes in Australia Brodie *etal* suggested that: "...recommendations should reflect the theoretical frameworks of injury causation, prevention and public policy making to systematically examine contributing factors, rather than a single cause".^{183, p. 141}

A recent article by Bugeja *et al* (2011) questioned whether the medico-legal death investigation system drew on, or was informed by, scientific principles of injury prevention in the formulation of coroners' recommendations.⁶¹ The aims of the study, carried out retrospectively using databases containing coroner reports in the State of Victoria, Australia, were to quantify coroners' recommendations and to examine the nature of the recommendations in accordance with public health injury causation and prevention. The study found that, "[o]verall the coroners' recommendations were not systematically consistent with public health principles".^{61, p. 6} The authors speculated that:

Coroners interpret their function of formulating recommendations to be limited to identification and statement of a countermeasure [...] Given that the qualifications and training requirements for coroners are primarily legal, not public health, it is reasonable that they may not appreciate the potential value of recommending interventions that identify risk or contributory factors and target the population at risk.^{61, p. 7}

Finally, it was the opinion of Tom Luce that many suicide inquests are unnecessary and that "...publicising of means and locations of suicides may contribute to further deaths involving the same means and location".⁴ It has been well established that publicising suicides may, in some cases, have imitative effects.³⁷⁴⁻³⁷⁶

It is not at all surprising that coroners were divided on whether or not they felt Rule 43 reports had any positive impact. Some coroners felt that Rule 43 reports were an important part of their work, one stating, "I mean if I don't [write Rule 43 letters] what is my point? [...] If I can't actually make a difference, if all I'm doing is processing, you know, what's the point?" **[C03]**

Some coroners acknowledged that in many cases they lack the expertise to make judgements about what should be done but that Rule 43 was nonetheless a useful tool for bringing matters to the attention of those who could address them:

I do use Rule 43 quite extensively, but I think we have to be extremely careful. We're not experts in road engineering, we're not experts in medicine, in fact, we're not experts in anything. Sometimes it is as plain as the nose on your face what is wrong and what needs doing. You've heard expert evidence at your inquest and you can pass on that information. But I think Rule 43 ought to be used in a way that it is designed, to draw people's attention to potential dangers for them, then to satisfy you that

they've considered and balanced everything and made a decision based on science, or whatever, as to what needs to be done. So for instance I can hold an inquest and it's absolutely plain that the cause of the death was ice on an un-gritted road. I can bring that to the attention of the road authorities, [but] it's not for me to say that road should be gritted... [C27]

Conversely several coroners did not believe that Rule 43 letters were effective in preventing future deaths stating that agencies do not respond, or they simply choose not to implement changes:

But technically and under the law, the person to whom the letter is sent could turn around and respond in this way; 'I have received your letter...end of story'. Or, 'up yours'. [C31]

I think [the coroner has] the power to effect a change but that's a strange political power isn't it? It's not a power that should be invested in a coroner. It's a power that should be a political ability of society. [C12]

Some coroners were unsure about the efficacy of such letters:

Um, do I get a satisfactory [response]?... Just let me think for a minute. My initial reaction is to say no. But that's not wholly accurate. I.....some....I receive satisfactory responses probably about a third of the time. I find government departments difficult to deal with.^{§§§} They're quite defensive I think. Rule 43s in police and prison deaths are quite successful...by and large. [C20]

It was interesting that many coroners, particularly those in small communities, prefer to contact relevant authorities informally rather than writing a Rule 43 letter. Seven coroners indicated that informally notifying the relevant authority was their preferred method of addressing public health and safety concerns:

In a city situation where there is no sort of personal contact. That may be the right thing to do. In _____ I will meet the Prison Governor at almost all the functions, so it's a bit awkward having castigated him to death, and sent letters, to then say 'Hello Joe!' It's not easy to do. I prefer to publicly not embarrass people but to privately make them well aware of what I am thinking. So persuasion is the way I prefer to do it. But it's a personal style, I'm

^{§§§} Four coroners expressed frustration at sending Rule 43 reports to government departments. All claimed that government tends to respond indicating that they will not address the issues raised in the report.

not saying other persons are wrong, but then I've got a much more personal style probably more than most coroners. [C30]

The whole purpose of Rule 43 is to stop the deaths occurring in similar circumstances. I mean, I think I can make more progress through the back door, sometimes, and sometimes the people I'm talking to are people I used to work with. [...] So I can just ring somebody up and say, 'Fred!!!' [...] If I want to do anything involving the public authorities, say local authority, then I'll just ring them up and say look, you need to solve this. [C04]

Six coroners indicated that it is often the case that by the time the inquest occurs the responsible authorities or agencies have already addressed the problem, negating the need for a Rule 43 letter:

Well I used to do it a lot more than I do now because many of our deaths have been so investigated by the time we get to a court that changes have already taken place. And, that's again one of the things with coroner's court is that you are forcing people to do stuff. If you take a prison death, by the time it comes to us there has been a prison and probation ombudsman investigation, and so many of the recommendations have already been put in place. Or, there is a serious review in the hospital and so sometimes, by the time you come to court, things have taken place. [C11]

Five coroners felt that the media coverage of an inquest is sufficient to shame organisations into taking steps to prevent future deaths. This was described as being particularly effective in small communities:

If you are the coroner of a rural community where, for the local press, the most exciting thing that may happen for them is when they come and hear you talking about a tractor that's fallen over...or a cat that's climbed a tree. Then that will hit the newspaper and everybody locally will read the local paper so that the information will be disseminated and the council will have to do something about it. [C10]

It is clear that coroners who do not appear to be acting in the interests of public health (*i.e.* they do not write Rule 43 letters) may, in fact, be doing so either informally, or by relying on the deterrent effect of the inquest, or through the dissemination of information through the local media. It is difficult to assess the efficacy of the active measures taken by coroners to prevent future deaths; however, several coroners were of the opinion that changes made in response to their recommendations had saved lives.

Tissue donation

Not all coroners routinely ask families if they wish to be put in touch with the NHS Blood and Transplant Authority (NHSBT). Though I did not ask coroners if it was their practice some indicated that they preferred not to:

Because....because the bereaved are vulnerable and the coroner is a big authority power figure to a lot of people and....I simply do not believe that it is right for the coroner to use his or her office to do something that to some might feel...might be...might create some degree of pressure. [C20]

One coroner indicated to me that, though many of his colleagues would not ask families their wishes with respect to tissue donation, it was his practice to do so. He indicated that other coroners were also asking the family's wishes in this respect.

Ruling out homicide

The investigation of homicide, manslaughter (both voluntary and involuntary) and infanticide are the responsibility of the local police authority. Since the passing of The Coroners (Amendment) Act 1926¹⁴¹ the coroner is obligated to adjourn inquests on such deaths until the conclusion of the criminal proceedings. As per the Criminal Law Act 1977¹⁵⁹, "...the purpose of the proceedings shall not include the finding of any person guilty of the murder, manslaughter or infanticide; and accordingly a coroner's inquisition shall in no case charge a person with any of those offences".^{159, section 56(1)} In cases of suspected homicide, manslaughter, corporate manslaughter, and infanticide, the coroner is notified by the police (via a completed report of sudden death form) that a death has occurred. The coroner will then open an inquest and subsequently adjourn it pending the outcome of a police investigation.^{****} Once the police have completed the investigation and, if necessary, following all relevant criminal proceedings, the coroner may resume the inquest.^{†††} Thus, it is not the coroner's mandate to *investigate* cases of homicide, manslaughter, corporate manslaughter or infanticide; that is the responsibility of the police.

**** As is required under section 16 (*Adjournment of inquest in certain cases*) of the Coroners Act (1988)

††† The coroner is afforded the discretion to resume the inquest or to simply notify the registrar as to the necessary particulars. If the Crown Court has concluded a substantive hearing it is "unusual" for an inquest to be resumed.³¹ If the coroner decides to resume the inquest in such cases Section 16(7)(a) of the Coroners Act (1988) states that, "the finding of the inquest as to the cause of death must not be inconsistent with the outcome of the relevant criminal proceedings".³⁴ It is "generally regarded as illogical to interpret [the 'cause of death'] as meaning anything other than the *whole* [original emphasis] of the findings of the inquest".^{31, p. 104}

When coroners refer to their purpose with respect to homicide (and manslaughter, *etc.*) they are not suggesting that it is their job to *investigate* homicides - as that is patently untrue - they are suggesting that they believe it their purpose to *identify* homicides that may not have been identified previously by the police; *i.e.* they act as a 'safety net' to identify suspicious deaths that may have been overlooked.

The nature of 'hidden' homicide

In *The Detection of Secret Homicide*, Havard suggests that this (*i.e.* the detection of 'secret homicide') is the, "main purpose of a modern medico-legal investigative system".^{94, p. xiv}### However, Havard notes that the majority of homicides are carried out covertly and that the real danger is in those that are, "...accompanied by an attempt to get the death certified and registered, and to get the body disposed of through normal channels as a natural death".^{94, p. xiii}

Though it is impossible to know how many murders escape detection, Harold Shipman did provide us with some sense, not only of the ease with which homicide can be carried out (and the relevant systematic checks circumvented), but also of the scale. That Shipman was able to kill 215 of his patients without the coroner being involved is in itself troubling; that two of those cases were referred to the coroner, but did not warrant any suspicion, suggests that those cases which elude police are likely to elude the coroner as well. One police officer noted that, "...I mean, it doesn't happen very often, where the police investigate something and then it's been missed, but picked up by the coroner".[E05] Though two coroners indicated that they had, in the past, referred cases back to the Criminal Investigation Department (CID), initiating further investigation of a death by the police, neither indicated that any such deaths had turned out to be homicides. One coroner, however, indicated that she often identifies cases of negligence and that this happens "all the time"[C20]. It is unknown how many cases of manslaughter and infanticide are uncovered following referral from the coroner.

For coroners to effectively realise the purpose of identifying homicides, they would have to scrutinise those deaths that have failed to raise the suspicion of the police and presumably those deaths which a potential murderer has intended to disguise as natural deaths, as Harold Shipman did. Since coroners generally use the distinction between 'natural' and

Havard goes on to note that a medico-legal death investigation system, "is also of considerable service to the community [as] the determination of the exact cause of death in unexplained cases has often led to the disclosure of previously unsuspected hazards to the public health...".^{94, p. xiv}

‘unnatural’ to decide whether to assume jurisdiction, they are failing to assume jurisdiction over precisely those deaths that are most likely to be ‘hidden homicides’.^{§§§§}

It was precisely Dame Janet Smith’s conclusion that what is needed is, “...a person specially trained to investigate non-suspicious deaths [and] the investigation of non-suspicious deaths should be carried out by the coroner’s investigators”.^{5, p. 20} The medical examiner system (*viz.* pp. 94-95 & p. 178) was government’s response to this proposal; however, the coroner’s investigators were not incorporated into the Coroners and Justice Act 2009 in the form envisaged by Dame Janet Smith.

It is not possible to quantify the extent to which these suspicious deaths are being overlooked and there is no means to measure the effectiveness of the coroner in detecting hidden homicide. If there is no means to quantify this, there is no way to determine if scrutiny by the coroner is an effective means of identifying these ‘hidden’ homicides. Moreover, a coroner system charged with being a ‘safety net’ to detect criminal cases potentially missed by the police, will operate in a manner that is likely to come into conflict with another stated purpose of the coroner, namely to provide a service to families. The frustration of working under competing purposes was expressed by one coroner:

Government really can’t make its mind up. On the one hand they went along with Dame Janet, who said that never ever again must there be another Shipman. To which my response is, in that case you must have a post-mortem with toxicology for every single death because how can you ever be sure without. And it’s no good to do an ordinary [post-mortem] because it would just show, you know, natural diseases; you need to look for the morphine, or other drugs. On the other hand government were saying, we’ve done far too many post-mortems in this country we’re not nearly as nice enough to relatives’, we need to take relatives’ concerns into account and to reduce the numbers - ‘you’re going to be touchy feely’, ‘you’re gonna be nice to relatives’. Well make your mind up government, what do you want? If you want to be nice and touchy feely that’s fine I’ll be nice and touchy feely. But don’t be surprised if we get lots of missed homicides. [C13]

^{§§§§} It was the opinion of Norman Brodrick that, “...our general conclusions are the risk of secret homicide occurring and remaining undiscovered as a direct consequence of the state of the current law on the certification of death has been much exaggerated”.^{3, p. 30}

Information from which to identify homicide

If it is indeed the coroner's purpose to identify missed homicides (or other suspicious deaths), the system of reporting and scrutinising these deaths not identified as suspicious by the police is not suitable to facilitate this purpose.

The information upon which this initial vetting of cases is based is, in large part, collected and collated by the police. The information contained on the sudden death report forms is what was observed and deemed to be of interest by the police. If the police have decided that the death is not suspicious, or if they have failed to recognise clues that would suggest otherwise, then the report will reflect this determination. Dame Janet Smith described this sort of *a priori* judgement as "a self-fulfilling prophecy".^{5, p.21} In other words, if the police believe a death not to be suspicious, then they are describing what they see (*i.e.* a non-suspicious death) in their report to the coroner. The coroner is, therefore, basing his or her scrutiny of a death (for the purpose of identifying homicide), in part, on a description of a non-suspicious death.

The Shipman Inquiry reviewed a sample of sudden death report forms completed by police officers from the Greater Manchester Police and discovered that there were, "very variable standards of investigation and reporting", that "it was clear that officers often had no idea why the death has been reported to the coroner" and, consequently, the information contained in the reports, "did not focus on the issues of real relevance to any subsequent coroner's investigation".^{5, p. 19}

Scenes of death that are not deemed suspicious (*i.e.* those that do not require that the police notify a special investigative unit) are generally not attended by anyone with a specialisation in death investigation, as a 'patrol officer' will not likely have any training in death investigation and, even if the coroner's officer were to attend, they are also not often trained in death investigation.*****

In cases where someone has died in hospital, if the case has not immediately been referred to the police, the point-of-contact for a physician would be the coroner's officer. The

***** A small number of coroners require that their coroner's officers attend scenes. They may, in this sense, attend in the capacity as an investigator. Only one coroner of 33 interviewed required that his officers attend scenes (though only during office hours). As there is little in the way of training for coroner's officers it is unclear how many have formal death investigation training. Dame Janet Smith found the lack of training of coroner's officers concerning stating that, "[t]he service provided by coroner's officers is currently of variable quality. For too long, they have been expected to perform tasks requiring the application of skills which they do not possess and in which they have not been trained".^{5, p. 19}

coroner's officer may try to convince the physician to sign a death certificate, or they may pass on information about a death to the coroner.^{††††}

If a death is identified as suspicious by the police then the post-mortem is performed by a Home Office accredited pathologist.³⁷⁷ When deaths are not deemed suspicious by the police those undertaking post-mortem examinations on behalf of the coroner may not be trained in forensics, or even pathology.⁵ The standard of coroner requested post-mortems is variable and it is often the case that once a possible cause of death is detected (*e.g.* occlusion of a coronary artery that *could* have been a cause of death) no further examination is carried out.²⁶⁶ Neither toxicology, nor histology is routinely requested.²⁶⁶

Training of coroners to identify homicide

The majority of coroners in England and Wales are legally qualified and have no formal medical qualification. The Coroners and Justice Act 2009 states that all coroners appointed subsequent to the implementation of the Act must be legally qualified; those who are medically qualified will only be considered if they hold a legal qualification as well. Coroners are also not obligated to undergo any training upon assuming their office, though some training is offered through the Coroners' Society of England and Wales. Regardless, coroners are not required to have any training in forensic science in general, nor are they required to have any training in identifying suspicious deaths in particular. Coroners are not required to have any particular legal background (*e.g.* all of a coroner's professional legal experience could be in the field of shipping law, or intellectual property law) from which one might expect there to be some transferable skill with respect to identifying homicide 'at the starting gate'.^{††††}

Vetting police practice and procedure

Many coroners spoke about referring cases back to the police owing to an insufficient preliminary investigation or incomplete documentation of the circumstances of a death. This suggests that, though referrals back to the police may not be identifying homicides, they may be an invaluable means of quality control of police procedure, and may offer a

^{††††} One physician described referring a death to the coroner as such: "[The coroner's officer] didn't seem to understand the medical language, he seemed a little bit dozy, to be honest. Not very much on the ball and a bit of a waste of time, sort of, referring through.... I'm sure it's fine for kind of routine ones. I mean, because even in, I don't know, even in causes of death which have been a little more tricky to kind of unpack, you know, I'm not sure the coroner's officer would have the expertise to help us out there. I think [he] was sort of mainly agreeing with what we were saying" [E06].

^{††††} Generally, when a coroner refers a death back to the police it is done prior to the inquest or, as one coroner put it, "at the starting gate" [C20].

mechanism through which a standard of police investigation is ensured. This possibility was indicated by a Detective who stated that:

...sometimes [coroners] might just not be satisfied with certain parts of the investigation or might think to themselves, actually it's not obvious from the [police report] what the answer to that question is - even though it may have been investigated, just the way it's been articulated or reported by police officers. The coroner might want something to be just looked at in a little more detail, and is well within his or her right to come back to the police and say 'I'm not gonna deal with this yet because I think there's some other lines of inquiry that you might want to consider'.

[E05]

Several coroners, however, indicated that when the police fail to record relevant details about a death it is often impossible to recognise that information has been omitted. The identification of shortcomings in the police investigation of non-suspicious deaths may often fall on the coroner, yet none of the coroners interviewed identified their purpose in these terms.

Thus, although the stated purpose of identifying homicides - and other suspicious deaths not identified by the police - is unlikely to be fully realised in practice, the coroner may serve to ensure an appropriate degree of scrutiny is afforded each death by the police. Though ensuring that the police properly investigate deaths may be an invaluable contribution on behalf of the coroner, this still leaves the question of the coroner's purpose unanswered. Thus, the coroner may serve to ensure a high standard of death investigations...but for what purpose? Further, given that referrals back to the CID happen, in the vast majority of cases, prior to the inquest, the purpose to identify homicides seems to then raise the question of the purpose of the inquest in cases where neither the police, nor the coroner, have any reason to suspect that the death was due to homicide, manslaughter or infanticide. Currently the majority of inquests are held on deaths that have not been identified as suspicious.³⁷⁸⁻³⁸¹

The proposed medical examiner system

In 2004 a position paper, *Reforming the Coroner and Death Certification Service*, was published by the Home Office.²⁴³ This document outlined plans to implement a medical examiner service staffed by medical practitioners, who would be appointed by regional Directors of Public Health, who would screen all deaths and either refer them to the coroner, or confirm the cause of death with the first certifier and subsequently authorise burial or

cremation.²⁴³ The proposed medical examiner system would undergo some significant changes in response to the Department of Health consultation *Improving the Process of Death Certification*²⁴⁷ (and the consultation response³²⁴); though the position of medical examiner was ultimately incorporated into the Coroners and Justice Act 2009.^{43, section 19} The medical examiner is intended to scrutinise a large number of deaths (up to 75% of all deaths²⁷³) and would, "...have full access to medical records and would be empowered to discuss the circumstances of the death with the doctor signing the MCCD and with the family of the deceased".^{324, p. 1} As the medical examiner will be vetting the majority of deaths (and will have access to more information about a death than would the coroner) they will likely be in a better position to identify cases of homicide not identified by the police. Thus, the few cases which coroners are currently referring back to the CID, may be identified by the medical examiner once this system is implemented in April 2013.³⁸²

Article 2 of the ECHR

Article 2(1) of the ECHR states that, "[e]veryone's right to life shall be protected by law" and that, "[n]o 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 this penalty is provided by law".¹⁹⁷

The definition of Article 2 inquests

The British common law has interpreted Article 2 to impose upon the state the positive obligation to investigate deaths when individuals have been killed as a consequence of the use of force by state officials (*viz.* *McCann v UK*, p. 68) for the purpose of ensuring that the state is held properly accountable (*viz.* *Jordan v UK*, pp. 69-70). In addition, the state must take reasonable steps to avoid risks to life about which they knew or ought to have known (*viz.* *Osman v UK*, pp. 68-69); Article 2 requires that these deaths are also the subject of effective investigation. In *R (on the application of Middleton) v West Somerset Coroner* (*viz.* p. 70-72)^{§§§§§}, Lord Bingham concluded that the coroner's inquest is, in some cases, sufficient to meet the positive obligation under Article 2 provided that the statutory requirement to determine 'how' the deceased died be interpreted as 'by what means and in what circumstances'. Despite these definitions of the circumstances in which the procedural obligation under Article 2 is invoked, coroners do not agree on precisely what constitutes an Article 2 case. One coroner stated that, "some of my colleagues don't agree [on what

§§§§§ The Middleton case was decided in 2004 which, in the case of coroners who responded that they believed the coroner's purpose to involve Article 2, suggests that they may have given a different response to the question of purpose had they been asked prior to 2004.

constitutes an Article 2 case] - we had a forceful discussion about this about fifteen months ago, ten of us at a training session". [C17]

He went on to describe an Article 2 case as follows:

Well [an Article 2 case involves] state intervention, that's the basis. But what is state intervention? Because state intervention could be the police, a government organisation...it isn't the National Health Service [...] I took several decisions last year; I must have done three or four, involving health service cases. I had Article 2 representation because I insist on full argument by all parties as to whether I should have Article 2 or not. On a National Health Service case I turned it down, every one that they did, I turned it down and nobody appealed me. So, either I'm getting it right and [other coroners] are wrong, or [advocates] haven't got the guts to appeal me. [C17]

And another described Article 2 cases as such:

Um, an article 2 case to me...is a death...no let's see if I can get a precise legal definition here... well, clearly death in custody is an Article 2. A death with police involvement is, to me, an article 2. [...] Might just be a police chase or something... That's an Article 2 case. A death...let me think...a death of someone who is detained under the Mental Health Act is an article 2. [...] Is the state involved to the degree that the death potentially happened, in part, because the risk of it doing so was not recognised and appropriate precautions were not taken. [...] If there is a sufficient system failure by an organ of the state, in effect, is potentially grossly negligence - I would treat that as an Article 2. A hospital death can be...but rarely [...] There needs to be something within the system operated by the state that has a direct causative link with that death, potentially, for me to treat it as an Article 2. [C20]

Yet another coroner believed that the issue of detention was key to defining Article 2 stating that only if an individual died while being detained, would the death be subject to an Article 2 inquest. Three coroners indicated that their procedure for Article 2 cases is largely the same as for non-Article 2 cases; "...those of us who do the job properly conduct inquests in such a way that there isn't that much difference anyway". [C20] Others indicated that the scope of the inquiry is narrower when deaths do not (according to their own definition) engage Article 2. Again, this speaks to an arbitrary and somewhat haphazard interpretation and application of the law which itself reflects not only the lack of formal definition of the circumstances under which an Article 2 inquest is engaged but also

the lack of uniformity of practice among coroners. This is not only problematic for the rule of law but, it could be argued, it undermines the purpose identified by some coroners to provide public reassurance. If similar cases are being treated differently then this has the potential to undermine the public's trust in the legitimacy of how such inquests are being conducted.

In addition to the fact that there is disagreement among coroners as to the definition of an Article 2 case, there is also disagreement as to the temporal definition of an Article 2 case with respect to the amount of time after which an individual ceases to be in the care of the state, that the death ceases to engage the Article 2 obligation.

Now [coroners] will say they do all sort of different things. They are required by law to investigate deaths that are sudden and of unknown cause...[as well as those which] occur in prison, or police custody, or are unnatural. Now, the first two of those are matters of fact - you can say whether somebody was in police custody or not when they die. Though, in fact, it's slightly flexible...or *soon after their release*. There is no definition of what *soon* is. [E01]

The purpose of the Article 2 inquest

In *R v Secretary of State for the Home Department ex parte Amin* (*viz.* pp. 72-73) the purposes of the investigation into an Article 2 case were established:

The purposes of such an investigation are clear: to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others.³⁸³

Thus, it was the opinion of Lord Bingham that the positive obligation under Article 2 was itself a means to achieving other purposes, those being: exposing culpable and discreditable conduct, allaying rumour, and facilitating public health.

Increasing the possibility of an Article 2 violation

Article 2 of the ECHR “imposes an obligation on States to take appropriate steps to safeguard the lives of those within their jurisdiction” (*viz.* for example, *L.C.B v The United Kingdom*³⁸⁴ and *Öneriyildiz v Turkey*³⁸⁵).³⁸⁵ The public health system is one of the components of the state responsible for “reduc[ing] the amount of disease, premature death, and

disease-produced discomfort and disability in the population”, thereby fulfilling this obligation.^{369, p. 145} Epidemiology, the basic science of public health, is “the study of the distribution and determinants of health states or events in specified populations” for the purpose “inform[ing] appropriate public health action”.^{386, p. 3} In short, public health systems are mechanisms through which states “take steps to safeguard the lives of those within their jurisdiction”.³⁸⁵

The primary means through which the risk, and risk factors of premature death are assessed is through mortality statistics. The increasing use of narrative verdicts, in both Article 2 as well as ‘regular’ inquests, has been implicated in obscuring cause-specific mortality statistics.^{16, 351, 365} One of the non-coroner research subjects described the problem with narrative verdicts as follows:

Since Middleton [coroners] don’t like giving...they used to give short form verdicts which were things like: ‘suicide’, ‘unlawfully killed’, ‘accidental death’, ‘open verdict’. They don’t like doing that anymore. Now they do a narrative, a description of all the events that happened.***** And so I can get three pages of description about how often somebody was checked on in their cell, whether the prison had a policy about assessing suicide risk, whether that policy was filed, how often people had to have training, all sort of things. But it doesn’t tell me whether the person killed himself or not! So, ‘found dead in his cell’ - doesn’t say whether he was alone in his cell, doesn’t say whether somebody else could have killed him! There’s reams of stuff and nobody is saying, ‘he actually harmed himself intentionally’. So we can’t count it as a prison suicide. [E01]

***** An example of just such a narrative verdict is as follows (note the absence of a definitive statement as to whether or not the deceased killed himself, whether the coroner believed he was able to establish intent on behalf of the deceased, or whether or not someone else may have been involved in the death): “In the main _____ was friendly and polite apart from episodes involving ‘smashing up’ cell. Deceased was not forthcoming in relation to their mental state on admission or during prison stay. Did not want to be moved to prison X. Information available in respect of an inmate’s current and previous mental health status is kept in medical and prison records. Further information is in a pre-sentence report by the probation service. Minimal time was spent with the prisoner and it appears that a full assessment of mental state was never undertaken. Relevant information was only used when the prisoner was seen by a member of staff. There appears to be insufficient communication between departments responsible for prisoner and a lack of follow-up procedures [or] records of communications. Information only seems to be used in isolation. A prison officer contacted a duty governor with deceased’s concerns about the transfer to prison X. Information was available within medical records, the records of events kept in the normal location, the segregation unit and any risk assessment that had been recorded. It appears that discussions took place within the observation, classification and allocation department in respect of _____’s concerns regarding the transfer but no alternative seemed appropriate. Allegedly no documents were reviewed at that time”. The cause of death was recorded as “hanging”.

Such nebulous narrative verdicts may be undermining the ability of the state to accurately determine risks to human life which it is obligated to address as per the common law interpretation of Article 2 of the ECHR. Some coroners may be failing (owing to incomplete recording practices or unwillingness to upset families) to record certain facts about deaths which, when analysed in aggregate, may demonstrate significant risks to life for which there may be practical and effective interventions. This possibility suggests that, though coroners may believe their purpose is to fulfil the positive obligation under Article 2 to subject deaths that may have been perpetrated by the state to effective scrutiny, they may, paradoxically, be increasing the likelihood that the state will fail to meet other positive obligations required by Article 2.

Training

It is the opinion of Thomas *et al* (2008) that in complex Article 2 cases the requirement that coroners have five years' experience in legal or medical practice in order to qualify them for appointment "is unlikely to equip them with the necessary skills and knowledge" to preside over such inquests.^{50, p. 369} Though the coronial inquest is one of the means through which the state may discharge its positive obligation under Article 2, there is no definition of the types of Article 2 cases (in terms of complexity or contentiousness) which might better be investigated by another authority (*i.e.* a 'senior judge').⁺⁺⁺⁺ It was suggested in the Luce Review that more challenging cases should be heard by "suitably trained Circuit Judges" or "suitably prepared High Court Judges" in acknowledgement of the fact that in some instances coroners may not be suitably qualified and/or experienced to preside over such cases.^{4, p. 101}

Public reassurance

That coroners' inquests provide public reassurance was acknowledged by Umfreville in 1761 in his *Lex Coronatoria* in which he stated:

Yet Coroners, to remove the public Suspicion, have heretofore taken Inquisitions in such Cafes, and *Murder*, for Want of a Proof of *Englebery*, hath been affeffed upon the Hundred, in Cafes of fudden Death, and Perfons "*subito mortuis*" ...^{1, p. 208}

⁺⁺⁺⁺ In an attempt to assess whether Article 2 cases are resulting in a greater number of judicial reviews I approached the Ministry of Justice to request data on the number of successful judicial reviews of coroners - which might provide some basis/metric to help establish if coroners are correctly applying the law in general, and with respect to Article 2 cases in particular. The Ministry, however, does not collect such data.

Undoubtedly, the public nature of the coroner's inquest has the effect of providing some assurance that a death is not being ignored and, as was considered above, the inquest may serve to educate and demystify a cause of death that might otherwise be misunderstood, and which might be the cause of a considerable amount of unwarranted concern and anxiety among the public.

The biggest threat to the capacity of the coroner to provide reassurance is the seemingly arbitrary application of the law (*e.g.* not ruling the correct cause of death out of concern for families), the lack of a clear purpose, and the variable levels of service across the country as noted in the Luce Review⁴, the Shipman Inquiry⁵, and by various organisations which advocate for families.^{348, 364, 387-389} The haphazard application of the law as well as the variable service standards among coroners' jurisdictions is one of the reasons most often cited for the re-introduction of the position of the Chief Coroner following its abolition under the Public Bodies Bill (2010).

With respect to coroners who believe public reassurance synonymous with allaying rumour, it seems contrary to this purpose to render ambiguous or open verdicts on death that are manifestly from another cause. This practice, far from allaying rumour, seems more likely to inspire it.

Ultimately, the fact that there is no agreement on the purpose of the coroner (leading to disparate practices and often arbitrary application of the law) is itself undermining the purpose of the system to provide public reassurance.

Other

Two coroners struggled to provide a clear statement of purpose. As this may have been a consequence of the way in which the question was phrased, I did pursue a more definitive answer by rephrasing the question. In both cases this did not result in coroners clarifying their statements. These responses will not be considered at length in this discussion as it may simply be the case that neither coroner was unable to think of a purpose at the time the question was asked.

Military

One coroner spoke of his purpose in terms of acting as a check on the military. It seems likely that this was an attempt to describe a purpose best classified under Article 2 of the ECHR but the coroner preferred to describe his purpose solely by way of this particular

example. As such, his response is likely to be addressed in the above discussion relating to Article 2 of the ECHR.

Coroners need not have a purpose

It was suggested by Tom Luce that the coroner system in England and Wales was not “fit for purpose in modern society” clearly implying that the lack of a modern purpose was responsible for problems with the coronial system.^{4, p. 16} It was also a recommendation of the Luce Review that the general public be informed as to the purpose of the proposed system, suggesting that it would be, thus, necessary to have one. Likewise, Dame Janet Smith suggested that coroners felt that the fact that the inquest has “...no defined purpose which the public can understand leads to difficulty and unrealistic expectations”.^{5, p. 214}

In addition, as this study shows, disparate understandings of purpose coupled with a legislative framework which affords the coroner a significant degree of latitude, are enabling disparate practices which have been implicated in this study and others as one of the problematic aspects of the current system. Thus, it is argued, that a statement of purpose to which coroners are mandated to pursue is the only means to assure any uniformity of practice in the system. The suggestion that coroners need not have a purpose is not helpful for coroners, Government, and the public, all of whom would benefit from a clear understanding of the purpose of the coroner as well as from consensus.

LIMITATIONS OF THE PRESENT STUDY

One of the challenges in carrying out this study was that of understanding how the media attention and on-going policy reforms would affect the data provided by coroners. It was difficult to control for day-to-day events with which one could expect coroners to be familiar.

Media attention

Media coverage of coroner reform was not always positive and can reasonably be expected to have had some impact on how coroners and others behaved during interviews. In addition, media coverage did at times over the course of the data collection, focus on individual coroners who had been subject to: some degree of public criticism^{7, 9, 10, 368, 390}, judicial review^{391, 392}, or disciplinary measures over matters of conduct.^{349, 393, 394} It is, therefore, difficult to determine whether respondents’ interviews were an accurate

reflection of their own attitudes and beliefs, or were simply a reaction to recent events which may have not received favourable exposure in the media. It was also reasonable to assume that these events may have affected the way respondents felt about this research project and, perhaps, about me as a researcher - particularly in the wake of the debate over the government's failed vCJD survey with which the Coroners Society of England and Wales had opted not to cooperate (*viz.* **Publication One:** *Coroners and the Obligation to Protect Public Health: The case of the failed UK vCJD study*). Once again, an attempt was made to understand the interviews in light of recent media attention by raising these issues during the interviews in order to assess whether the issue(s) in question seemed to be a matter of concern for the respondent, or to prompt interviewees to explicitly acknowledge this to be the case. Ultimately, however, it was difficult to assess the impact of conducting research in the midst of an on-going and uncertain policy process and fluctuating media attention.

Changing policy environment

The fact that the reform of the coroner system was occurring while I was conducting my research posed certain challenges. For the most part I was fortunate in that the on-going reform offered the opportunity to observe the policy process as it happened, rather than doing so retrospectively. However, the relentless production of new information was often difficult to keep up with and it was not unusual for me to write lengthy analysis on one aspect of, for example, the Coroners and Justice Bill only to have the section in question disappear in subsequent drafts. The publication *Reform of the Coroner System: A potential public health failure* (*viz.* **Publication Two**) in which a colleague and I outlined various failings of the Bill - was sent out for peer-review when the Bill was in the House of Commons Committee Stage but was only published online in March 2010 - four months after the Bill received Royal Assent.^{####} Ultimately, the amount of time spent trying to operate in such a 'dynamic' research environment could have been put to better use had this study not been concurrent with so much change.

Difficulty in accessing information

Finally, information to support this thesis was repeatedly requested from the Ministry of Justice. The Ministry does not collect routine data on the coroner system nor is it necessarily willing to release what limited information it does have. This fact was raised

The Bill received Royal Assent on 12 November 2009.³⁹⁵

publically in the House of Commons on 25 October 2011 by the Labour MP for Stoke-on-Trent with reference to the costing estimates for the Chief Coroner.^{§§§§§§}

§§§§§§ “On that point about costings, does [the Hon. Gentleman] know that the Royal British Legion, INQUEST, [Cardiac Risk in the Young] and a whole host of other organisations, along with Members, have repeatedly tried-whether through parliamentary questions, freedom of information or whatever-to get the information from the Ministry of Justice, yet at every opportunity, it clams up and refuses to give the detailed figures?”^{275, col. 428}

Chapter XII: CONCLUSIONS

FRUSTRATION OF PURPOSE

Coroners were created for a clear purpose, that being to contribute to the royal coffers. Every duty they had was pursuant to that purpose: from treasure trove, to declaring forfeiture, to holding inquests on bodies. The coroner system, as it was in the early 12th century, was entirely fit for purpose. There is no question, however, that this purpose no longer exists. Even the coroner's jurisdiction over treasure trove - a vestigial duty to be sure - makes no contribution to Her Majesty's Treasury.*

Beginning in the mid-18th century the documentary evidence suggests that there had been longstanding problems with the office of coroner owing to: corruption¹⁰⁴, misconduct^{1,396}, and a general lack of a "warranted doctrine", "theory" or "perceptive instruction" of the office.^{1,p.v} By the early-19th century John Jervis himself acknowledged that the office had fallen into the hands of those, "...incompetent to the discharge of even their present limited authority" and was in need of "restoration". Yet Jervis was resolute in his belief that the office, "undoubtedly contain[ed] the germ of vast public utility".^{397,p.v} The literature clearly documents: an ongoing disillusionment with the coroner, repeated calls for coroners to adopt a public health role, and numerous questions as to the coroner's qualifications, jurisdiction and, of course, the coroner's purpose.

The fact that the coroner is still with us after over 800 years cannot be construed simply as evidence of the necessity of the office as it exists today - especially when one considers that: there are few mechanisms through which to abolish it; there has been relatively little political will to do so; and, arguably, at least some of the coroners duties have to be carried out by someone. Likewise, the fact that the legal profession has had a foothold in this occupation for centuries should not be a testament to the appropriateness of this arrangement. Nor can it be said that the office of the coroner - in its current incarnation - is a necessary feature of civilised society: it does not exist in this form on the Continent; it has come under such great scrutiny in North America such that many jurisdictions have replaced the coroner with a medical examiner (or some other derivation thought to be preferable to the colonial form); Scotland has never had coroners (operating instead under a procurator fiscal system); and, there are other systems of death investigation which have proven themselves better suited to the needs of modern society. Ultimately, therefore, it would be illogical and unscientific to assume that the coroner is a necessary feature in any

* Rather the contrary actually as the British Museum is required to buy artefacts, at the current market value, from finders should it wish to acquire them.

jurisdiction. The question of whether or not to keep the coronial system was addressed by Dame Janet Smith who concluded that the system should be retained provided that it would be subject to, “...radical reform and a complete break with the past, as to organisation, philosophy, sense of purpose and mode of operation”.^{5, p. 489} Thus, despite asking the normative question, ‘what should the purpose of the coroner be?’ and the ensuing question, ‘what changes can be made to actualise this purpose?’ I do not assume that the coroner system needs to exist in England and Wales, owing to either its longevity or its suitability to the duty of effectively and efficiently investigating death. However, the new legislation, in the form of the Coroners and Justice Act 2009, leaves the system largely unchanged. England and Wales will - barring sudden and drastic changes to the new legislation - be served by a coroner system for the foreseeable future. Thus, any practical suggestions presented at this point in time must be made assuming (and accepting) that the coroner system is here to stay. The coroner, for the time being, must be taken for granted and we must turn to the question at hand, that being: *what should the purpose of the coroner be, and what changes can be made to actualise this purpose?*

The question as to an appropriate purpose for the coroner, as posed in this thesis, reflects precisely the question as considered by Robert Wright, Norman Brodrick, Tom Luce, Dame Janet Smith, and others who were tasked with suggesting reform of the system. Though all of the modern reviews posited several aims and purposes of the coroner, or specifically of the inquest, these aims and purposes were not obtained from canvassing coroners themselves and do not tell us how coroners view their role in society. This thesis demonstrates that:

- There has been a long-standing debate (beginning in the 19th century) about the role of coroners with respect to public health;
- coroners, for the most part, identify strongly with a single purpose - albeit that purpose varies from coroner to coroner;
- the current and future legislation governing coroners is sufficiently vague as to allow the coroner a significant leeway in the exercising of his/her duties;
- even when coroners agree on a purpose they often operate to that end very differently;
- the way in which coroners attempt to achieve the purpose with which they identify is largely ineffective;
- many coroners do not genuinely understand how to best pursue the purpose with which they identify;

- coroners are often not qualified or trained to properly realise the purpose that they believe they should pursue;
- some of the purposes that have been suggested in the various reviews of the system are not mutually compatible given how coroners go about realising these purposes;
- there is currently little in the way of oversight and accountability in the system;
- and, despite the continuing consultation on the secondary legislation (*i.e.* the Coroners Rules) and the recently published Coroners Charter, it appears unlikely that the service will be defined in terms of a single defining purpose.

Coroners in England and Wales do not agree on their purpose. This is problematic owing to the fact that evidence suggests that coroners are carrying out some of their statutory (and occasionally non-statutory) functions in a manner proscribed by the purpose they believe they serve. Some of the purposes identified by coroners are being served in a manner that undermines other purposes. This is the case, for example, when coroners render open verdicts to mollify families and, in doing so, undermine public health efforts to quantify causes of death; or when inquests are held (in the name of providing a service for the bereaved) in cases where the public nature of the of the inquest is likely to be embarrassing, stigmatising, or generally distressing for the bereaved.

Even when coroners agree on a purpose they often operate to that end very differently; as a result these variant practices have an impact on measurements of health nationally.¹⁶ In addition, case law is interpreted differently by different coroners; for example, there is a considerable difference of opinion on what precisely constitutes an Article 2 case.

The current and future legislation governing coroners is sufficiently vague as to allow the coroner a significant leeway in the exercising of his/her duties. Interviews with non-coroners suggest that coroners may afford disproportionate time and energy to the investigation of certain types of deaths in which they develop a personal interest[†] (*e.g.* military deaths, accidents involving police cars, deaths involving mental health issues). It is not uncommon for coroners to disregard the legislation (*e.g.* Section 22(1) of the Coroners Act 1988 - 'Removal of body for post-

[†] Coroners tend to describe being 'interested' in a certain categories of death "I am quite interested in mental health issues for example [...] some coroners have an interest in military areas". [C18] Non-coroners tend to describe this interest as "going off on a crusade" [E02] One non-coroner indicated that coroners define natural/unnatural (in order to decide if they should assume jurisdiction) based on what they are "interested in" (implying a personal interest). [E01] A recent report on suicide in Britain described the problem of inconsistent detail being recorded following inquests: "...the level of detail provided varies depending on the individual coroner's approach and interests"¹⁷, p. 75

mortem examination³⁴⁾ and, though they may be arguably justified in doing so, the fact remains that there is no practical mechanism for discouraging this practice: notwithstanding egregious violations of the legislation. Coroners also have the means to impact the policy process through coercion: many coroners reported using this tactic to ‘shame’ recipients of Rule 43 letters into addressing the concerns raised in the letter or in cases where coroners made recommendations (which is done despite rules to the contrary - Section 36(2) of the Coroners Rules 1984). This tactic can also be used to pressure local authorities to comply with coroners’ request for resources.³⁹⁸

There is currently very little in the way of oversight and accountability in the system. Provisions in the Coroners and Justice Act 2009 for a Chief Coroner, Deputy Chief Coroners, the Medical Advisor to the Chief Coroner, and Deputy Medical Advisors to the Chief Coroner were to be overturned by the Public Bodies Bill (2011); however, on 22 November 2011, after much advocacy on behalf of various interest groups (including: INQUEST, the British Medical Association, the Royal British Legion, Cardiac Risk in the Young, Victim Support, and the Royal Mencap Society), government agreed to remove the position of Chief Coroner from the Bill, thus ensuring that coroners will, for the first time, have a leader in the form of a Chief Coroner. On 22 May 2012 the Ministry of Justice announced that the Lord Chief Justice, following consultation with the Lord Chancellor, had appointed His Honour Judge Peter Thornton QC to the position of Chief Coroner for England and Wales.²⁸¹ Judge Thornton is expected to take up his new post in September 2012.²⁸¹

Despite the on-going consultation on the secondary legislation (i.e. the Coroners Rules) and the Coroners Charter it appears unlikely that the service will be defined in terms of a single defining purpose. The system will remain much the same as it was under the 1988 legislation, which itself was merely a consolidating act based largely on the Coroners Act 1887. The draft charter consultation requests comment on improving a pamphlet distributed through coroner’s offices titled *A Guide to Coroners and Inquests*.³⁹⁹ It is proposed that the Guide and the Charter be published as one document and that the Guide include statements as to the coroner’s purpose. However, the purposes indicated in the draft remain problematic, contradictory (in the way they are realised by coroners), and not binding. The consultation responses were published on 15 December 2011 and included little in the way of comment on the coronial purpose beyond the suggestion that the final version of the Charter make clear that the purpose of the inquest is not to provide the foundation for a civil suit.²⁷⁸ As

such, there is still no explicit statement of purpose for the coroner. *The Guide to Coroners and Inquests and Charter for Coroner Services* was published in April 2012.²⁷⁹

Public health as a defining purpose

It might be argued, particularly in relation to experience in other jurisdictions (as outlined in Chapter I), and that the absence of clarity as to the purpose of the coroner as has become clear from the historical survey (as described in Chapters II-V), and together with the material collected from current surveys (as detailed in Chapter X), that the coroner's office should have one overriding purpose, that of facilitating public health. However, one cannot assume that specifying a purpose to support public health is sufficient; coroners need to understand why this purpose is appropriate, why pursuing others is not, and how to operate pursuant to a public health purpose while providing a meaningful and compassionate service for the bereaved, and while providing assurance to the public that deaths will be subject to appropriate and effective independent scrutiny. The coroner's responsibility to meet the positive obligations under Article 2 of the ECHR is not an end unto itself, its purpose is to protect public health and provide public assurance.

Further, the public needs to be made aware of the coroner's purpose; this, it would seem, would help reduce the confusion and disappointment many bereaved families feel with the inquest process, and help them understand the multitude of means through which the coroner can assist in ensuring that premature deaths are prevented in the future.

Also, it has frequently been said about the coroner system that it is "neglected".^{4, 249, 348, 400} Evidently this neglect is manifest in the fact that many matters pertaining to coronial law, including the question of the coroner's independence, are yet to be clarified and are, arguably, in urgent need of further consideration by legal scholars.

Chapter XIII:
RECOMMENDATIONS

What follows is a series of recommendations that are possible within the current legislative framework or which would require minimal legislative amendments. The recommendations call for a formal reorientation of purpose and the means to achieve this purpose.

PUBLIC HEALTH AND THE FUTURE OF DEATH INVESTIGATION IN ENGLAND & WALES

Dame Janet Smith suggested extensive reform stating that her recommendations would call for a new service, one “...barely recognisable as the offspring of its parent”.^{5, p. 489} Several of the respondents interviewed for this thesis lamented the fact that neither Dame Janet Smith’s proposed system, nor the changes proposed by Tom Luce, were implemented, believing these changes crucial to improving the system. However, the recommendations from both reviews were deemed too costly and were passed over in favour of more moderate changes. The new legislation, in the form of the Coroners and Justice Act 2009, leaves the system largely unchanged. England and Wales will - barring sudden and drastic changes to the new legislation - be served by a coroner system for the foreseeable future. Thus, any practical suggestions presented at this point in time must be made assuming (and accepting) that the coroner system is here to stay. The coroner, for the time being, must be taken for granted and we must turn to the question at hand, that being: *what should the purpose of the coroner be and what changes can be made to actualise this purpose?*

Incorporate the coroner system into one of the branches of government

The current relationship between coroners and the Ministry of Justice does not include mechanisms for their regulation or control. A relationship with the Ministry is necessary only insofar as coroners require “administrative support” and in circumstances where the legislation requires the action or approval of the Secretary of State.^{31, p. 12} Moreover, it has also been said that the, “...provision of these services is carried out in such a way that the coroner remains unconstrained in both actions and decisions”³¹ and that the coroner has “...a responsibility to the Crown rather than to government”.^{31, p. 13} Therefore, it cannot be said that coroners are a component part of the Ministry, subject to the normal oversight and accountability afforded its other constituent bodies.

Coroners are empowered to produce accurate accounts of deaths, within the parameters of the relevant legislation, for the purpose of informing those agents of the state whose function it is to collate and interpret data produced by coroners, and to formulate policy in the interests of protecting the public’s health and safety. In this sense, coroners are

responsible for contributing to the functions carried out by the executive. Yet, as the vCJD study (*viz.* pp. 90-93) illustrates, when the Department of Health attempted to define how coroners might best contribute to the public good coroners were not willing, nor were they legally required, to assist. Coroners are, thus, relied upon to facilitate the work of the executive without being responsible to it. There is no way, then, for the executive to define for coroners the most effective way to carry out their duties leaving the executive impaired, rather than empowered, by coroners.

Were coroners to be brought fully into the executive branch of government, as is the arrangement in all coroner jurisdictions in Canada for example, they would be subject to accountability to Parliament and the judiciary. In addition, coroners would be subject to internal accountability and would be held accountable to the mandate of the Ministry. Ministries also have established systems of oversight. Moving coroners into the executive might also serve to standardise their access to resources, and afford them appropriate training and support.

On the other hand, the argument against such a move is that coroners would not benefit from operating as part of the judiciary which offers a relatively stable environment, as the judiciary is not subject to the changes resulting from shifting political priorities or changes in government. Any changes in coroners' policy or procedure would likely result in changes, however minimal, to the data coroners produce. This presents challenges to those organisations that rely on coroner data who must control for any changes in the way the particulars of deaths are established or reported.* Additionally, the coroner system would benefit from a more transparent appointment system, as is currently offered by the Judicial Appointments Commission.

However, incorporating coroners into the judiciary risks putting too much emphasis on the judicial aspects of coroners' work, and may leave them relatively divorced from the public health system.

As can be seen, there are pros and cons to either re-alignment. Ultimately, coroners and the public would benefit from the system being fully and formally drawn into either the

* An example of the confusion resulting from policy changes (and consequent changes in recording and reporting methods) is the implementation of the National Crime Recording Standard (NCRS)/Home Office Counting Rules (HOCR) by the Home Office in 2002/2003.⁴⁰¹ This change in crime recording and reporting procedure renders *direct numerical comparisons* of crime statistics before and after the NCRS was introduced meaningless.

executive or the judiciary as their current, ambiguous status is not offering appropriate mechanisms for regulation and control.

Formalise the purpose of the coroner as a facilitator of public health

The principal recommendation emerging from this thesis is that coroners, or those in a position to govern coroners (*i.e.* a Chief Coroner, the Lord Chancellor, or the Lord Chief Justice), should formalise the fundamental purpose of the coroner as an agent of the state who, like all other state agents, is responsible for the health and welfare of the people and who is tasked with supporting and facilitating public health. Other purposes deemed appropriate to the position, though important in their own right, must be necessarily subordinated to the cause of protecting public health. This purpose need not require legislative amendment as the current legislation, though not prescriptive, is suitably enabling to allow this mandate to be exercised to the necessary extent.[†] However, making the coroner's purpose clear, conspicuous and immutable would be necessary in order to render the service properly accountable.

Reports and recommendations produced by coroners should be evidence-based and based upon best practice. Coroners would benefit from being incorporated into efforts to counter emerging threats to human health, front-line disease surveillance systems, and should be capable of operating as part of the response to complex emergencies. Further, coroners would need to be accountable to the purpose of supporting public health, and must be supported in pursuing this purpose in terms of resources, training and oversight. Secondary purposes, though important, are appropriately sublimated to the purpose of public health. Supporting public health must necessarily be the purpose of the coroner, not merely the purpose of the inquest, and must be applicable to all of his/her functions. Coroners need to be disavowed of the notion that their purpose is solely to investigate Article 2 cases, that they are to act as a check on the military, that they are meant to rule out homicide, or that they are meant to mollify and pander to the bereaved and their advocates. The system would benefit from a formalised statement of purpose, for example that envisaged for the coroner system in New Zealand in the 2000 Law Commission Report:

[†] The problem posed by the absence of any statutory purpose for the coroner was formally raised by Mr. Michael Burgess, the coroner for Surrey, while giving evidence to the Constitutional Affairs Committee in 2006 with regard to the legal framework of the service. In addressing the question of the coroner's legal framework Mr. Burgess stated that, "...it is necessary to understand what the coroner's function is and currently in statute that is not clear. All we have got is that we are to hold inquests and those inquests are expected to find certain things as proved or not as the case may be",²⁴⁹, p. 25

Protecting the lives of its citizens is a primary function of the State. Its processes for investigating sudden death ideally should be geared to finding the causes and eliminating them for the future, while respecting the sensibilities of the family in its grief.^{64, p. xi}

The following recommendations for changes in policy and practice may help to reorient the system such that it might be optimally pursuant of public health.

Move the service from the Ministry of Justice to the Department of Health

As Buse *et al* (2005) have pointed out, other ministries whose policies have an impact on human health, “tend to be absorbed with their own sectoral policy issues rather than concerned to contribute to a government-wide set of health policies”.^{402, p. 92} Arguably the Ministry of Justice exercises its mandate in the interest of the public good generally; however, the Ministry’s mandate to, “...protect the public and reduce reoffending, and to provide a more effective, transparent and responsive criminal justice system for victims and the public”⁴⁰³ may not be sufficiently consistent with a public health mandate to provide appropriate accountability. Furthermore, the MoJ may not give sufficient priority to public health or to the implications of its policies/practices on public health in its broadest sense.

The coroner system has changed ministries three times over the last five years. It has been under the purview of the Home Office (until 2005), the Department for Constitutional Affairs (from 2005 to 2007), and the MoJ (from 2007 to present). It would appear that: an inappropriate ethos (*i.e.* one which emphasises criminal justice and not public health), lack of resources, operational support, and relevant institutional networks makes the coroner system’s placement in that ministry problematic and may be contributing to the system’s confusion of purpose and, in certain circumstances, its inefficacy and inefficiency.

Regardless of the fact that coroners generally describe themselves as judges or “independent judicial officers”^{31, p. 12, 350, p. 10}, the legislation[‡] does not substantiate this claim. Since 2005 there have been three opportunities to codify a judicial (or a quasi-judicial) status of the coroner, yet this has not occurred; thus, the claim that coroners should be overseen by the MoJ owing to the fact that it is the ministry responsible for administration of Her Majesty’s Courts and Tribunals Service (and therefore for the judicial arm of government) is spurious. That some coroners instead describe themselves as ‘quasi-judicial

[‡] Neither the Constitutional Reform Act 2005, or the Coroners and Justice Act 2009 mention coroners at all. The Tribunals, Courts and Enforcement Act 2007⁴⁰⁴ makes a singular reference to the soon to be abolished (as per the Coroners and Justice Act) Coroner for Queen’s Household but does not define or imply that the coroner who holds this position is, by virtue of holding that office, a judge.

officers' does not itself necessitate a link with the MoJ as many quasi-judicial bodies (*e.g.* tribunals[§]) operate outside the auspices of the MoJ.⁴⁰⁶

It would seem, therefore, that a more appropriate ministry into which a suitably mandated coroner service could be best situated would be one responsible for public health (*i.e.* the Department of Health in England, and the Department of Health and Social Services in Wales). Additionally, given that one of the challenges faced by the coroner system, as identified in both the Luce Review^{**}, and the Shipman Inquiry^{††} is the fact that the service is in many regions under-resourced, it seems reasonable to move the system into a ministry with a sizeable annual expenditure budget^{‡‡} and one with access to resources which might, under the current arrangement, be duplicated at the expense of the coroner's operating budget. Both the Luce Review and the Shipman Inquiry suggested that the coroner service become a national service^{§§}; however, the Coroners and Justice Act 2009 legislates that the system will remain locally administered and that coroners continue to be funded by local authorities. The Department of Health not only has access to resources but would also be able to fund, and otherwise support, a public health mandate. In addition, the MoJ is expected to cut £1.6 billion (a -23% percentage change in real terms) from its budget by the fiscal year 2014-2015 as part of the Coalition Government's austerity plan.⁴⁰⁸ Conversely, funding for the DoH is to increase over the same period (a +.04% percentage change in real terms).⁴⁰⁸ Include the coroner system as part of government's new strategy for public health

On 30 November 2010 the DoH published a White Paper titled *Healthy Lives, Healthy People: Our strategy for public health in England* and in it proposed "a radical shift in the way we tackle public health challenges".^{409, p. 2} An update of the White Paper was published in July 2011 in which Government re-iterated that this new approach to public health needed to

§ The Family Health Services Appeal Unit⁴⁰⁵ of the NHS Litigation Authority is one such example.

** The Luce Review identified the following as one of the critical defects of the system: "[t]here is a general lack of resources and support [in the system] - for example to provide coroners with premises for inquests - or in some cases even a minimal amount of secretarial and administrative support".^{4, p. 18}

†† Dame Janet Smith described the service as, "in some places appear[ing] to have been run on a shoestring"; she goes on to suggest that, regardless, the system does not provide good value for money.^{5, p. 516}

‡‡ The total departmental expenditure for the NHS (which comprises only part of the DoH budget) was nearly 100 billion GBP in 2009-2010; by way of comparison, in 2009-2010 the departmental groups responsible for: education had a total expenditure of 57 billion GBP; defence had a total expenditure of just under 37 billion GBP, and justice had a total expenditure of just over 9 billion GBP.⁴⁰⁷

§§ Dame Janet Smith suggested that coronial death investigations, "...should be provided by means of a unified national Service, centrally governed and operating through regional and district offices".^{5, p. 490} Independent of the findings of the Shipman Inquiry, the Luce Review included a similar recommendation: "the service should be reformed into two national jurisdictions, one for England and Wales, and one for Northern Ireland".^{4, p. 21}

be afforded “real political priority” acknowledging that “public health has a clear priority” and should be seen as “a core part of business across Government”. Though many coroners would disagree, they do comprise part of the apparatus of the state and, in that sense, are government officials. Thus, this responsibility for public health, as described in the White Paper, can be understood to apply to them as well. As the public health system in England, and in the devolved nations, is currently the focus of substantial reform (as per the 2010-2011 Health and Social Care Bill⁴¹⁰) perhaps now is the most opportune time for the coroner system to formalise their purpose to operate as part of the new public health system.

In addition, the Health and Social Care Bill^{***} includes amendments to the National Health Service Act 2006⁴¹¹ which outline the Secretary of State’s duty as to the protection of public health. This amendment includes a fundamental statement of the Secretary’s duty to protect public health:

2A Secretary of State’s duty as to protection of public health

- (1) The Secretary of State must take such steps as the Secretary of State considers appropriate for the purpose of protecting the public in England from disease or other dangers to health.
- (2) The steps that may be taken under subsection (1) include—
 - (a) the conduct of research or such other steps as the Secretary of State considers appropriate for advancing knowledge and understanding^{410, section 8}

The Bill also suggests additional changes to the National Health Service Act 2006 requiring co-operation in relation to public health functions:

^{***} As per the 8 September 2011 version of the Bill (the version that was sent to the House of Lords from the Commons).⁴¹⁰ The Lords’ First Reading was 8 September 2011. The Second Reading is scheduled for 11 October 2011.

247A Co-operation in relation to public health functions^{†††}

- (1) This section applies to any body or other person that exercises functions similar to those of the Secretary of State under section 2A (whether or not in relation to the United Kingdom).
- (2) The Secretary of State must co-operate with the body or other person in the exercise by it of those functions.
- (3) If the Secretary of State acts under subsection (2) at the request of the body or other person, the Secretary of State may impose charges in respect of any costs incurred by the Secretary of State in doing so.
- (4) The body or other person must co-operate with the Secretary of State in the exercise by the Secretary of State of functions under section 2A.
- (5) If the body or other person acts under subsection (4) at the request of the Secretary of State, it may impose charges in respect of any costs incurred by it in doing so.^{410, section 57}

Clearly, had the coroner system formally accepted a public health mandate and, had these provisions been in place, it would have been unlikely that the Coroners' Society of England and Wales would have been able to decline to participate in the vCJD survey (*viz.* **Publications One, Three & Four**), as to do so would have been unlawful. The CSEW's concern that the survey would be costly to administer would have also been addressed by Section 247A(5) of the Bill.

Public Health England

Healthy Lives, Healthy People calls for the creation of a new, "...dedicated, professional public health service" called Public Health England (PHE) which is to be established as part of the DoH and which is tasked with, "...strengthen[ing] the national response on emergency preparedness and health protection".^{409, p. 8} Public Health England is intended to be locally

^{†††}The Explanatory Notes that accompany this section of the Bill describe this section as follows: "*Clause 57 - Co-operation with bodies exercising functions in relation to public health.* 598. This clause requires co-operation between the Secretary of State and other people or organisations engaged in public health protection activity. This could include circumstances when the Secretary of State's activity takes place overseas and co-operation between the Secretary of State and other organisations is required to help control the spread of infectious disease, or the release of harmful chemicals into the environment. The intention is to make sure that the system works in a co-ordinated and coherent way to deal with threats to public health. This clause also provides for co-operation between the devolved administrations in Scotland, Wales and Northern Ireland and the Secretary of State". 599. The clause inserts a new section 247A into the NHS Act. New section 247A imposes a reciprocal duty of co-operation on all individuals or organisations, including the Secretary of State, who carry out health protection functions similar those of the Secretary of State under new section 2A of the NHS Act. 600. Under subsections (3) and (5) of new section 247A, the Secretary of State and individuals or organisations would be able to charge for the costs of their co-operation, on a costs recovery basis, when it is requested"^{412, clause 57}.

delivered and headed by Directors of Public Health (DsPH) whose role within local government will include, "...ensuring that all decision makers locally understand public health issues".⁴¹³ It has been proposed that the DsPH, who are currently employed by the Primary Care Trusts (PCT), will be employed by the Local Authorities. Since it represents a considerable conflict of interest to have coroners working under PCTs this seems an opportunity to incorporate coroners into the proposed public health system without compromising their independence from the NHS.

In addition, public health funding for the new public health service is to be ring-fenced^{408, 409} which may represent an opportunity for coroners to stabilise their occasionally precarious financial position with the Local Authorities. Although this is perhaps the most promising development through which to operate a new coroner system, PHE is still in its formative stages and it is therefore not possible to fully develop a model through which coroners could operate as part of this system.

On 2 November 2011 the House of Commons Health Committee released its report addressing the future of public health in England.^{414, 415} The Select Committee emphasised that PHE must be both visibly and operationally independent of Ministers.⁴¹⁴ This independence is a central theme throughout the report and, should PHE be established based on this principle, the independence of the coroner (were coroners to become part of PHE) from government could be assured.

Engage coroners in public health surveillance and research

There is a considerable body of literature addressing the capacity of death investigation agencies to participate in: disease and injury surveillance^{12, 74, 416-444}, emerging infectious disease sentinel surveillance^{416, 437, 445-448}, bioterrorism surveillance^{428, 447, 449-451}, and public health research.^{416, 452} It should become standard practice for coroners to participate in public health surveillance and research for which their participation is requested on behalf of government, or by reputable academic institutions.

In addition to the provisions in the Health and Social Care Bill 2010-2011 requiring the co-operation of, "any body or other person that exercises functions similar to those of the Secretary of State" in the exercise of the Secretary of State's proposed functions, the Bill outlines the Secretary of State's duty as to research^{410, section 57}:

1D Duty as to research

15“In exercising functions in relation to the health service, the Secretary of State must have regard to the need to promote—

- (a) research on matters relevant to the health service, and
- (b) the use in the health service of evidence obtained from research.”^{410, section 5}

This provision would, thus, require that the Secretary of State promote research. The powers to secure co-operation from other bodies would presumably extend the duty as to research to such bodies making it unlikely that coroners, were they to formally acknowledge that they “exercise functions similar to those of the Secretary of State under section 2A” could refuse to participate in research if their participation was requested by the Secretary of State.^{410, section 57}

Participation in public health research needs to become the norm and should properly be considered integral to the coroner’s remit. Furthermore, it has been said that “...one of the problems with the coroners’ system is that the concentration is all on what happened at the last minute”**[E01]**. If coroners are going to record meaningful information about deaths the information contained in the coroner’s records should necessarily be broader in scope so as to paint a more complete picture of the proximate cause of death. Coroner’s records need to be made available to researchers with a legitimate interest - the legitimacy of the researchers’ interest should not be assessed by individual coroners, rather, there must be someone in the system who can review and authorise such access to information. In addition, the system would benefit from increased funding for post-mortem testing, including: bacteriology, seriology, and histology.

Provide in-service training in public health

Several coroners described their purpose in terms that were entirely consistent with any meaningful definition of public health, yet denied having any public health role. Ideally, coroners could be required to attend training in: carrying out investigations in order to maximise the utility of the resultant information for public health, proper recording of information pertaining to the investigation, and the importance of their contribution to public health. The lack of mandatory or sufficient training for coroners has been identified as significant problem in both the Luce Review and the Shipman Inquiry. Implementation of training requirements for coroners was, for example, supported by: the Constitutional Affairs Committee²⁴⁹, the Home Office²⁴³, the Bereaved People’s Panel²⁵⁷, the Department

for Constitutional Affairs²⁴⁵, and the British Medical Association²⁵⁰. One of the duties of the Chief Coroner is to be the oversight of training for coroners (*viz.* the Coroners and Justice Act, Section 37).

Develop and formalise a code of ethics for coroners

Currently coroners in England and Wales operate in the absence of a code of ethics. There is nothing statutory, or otherwise, to guide their conduct beyond the vague provisions under which a coroner may be dismissed under the Coroners Act 1988 (*viz.* Section 3) and the Coroners and Justice Act 2009 (*viz.* Schedule 3, Section 13). The Guide to Coroners and Inquests and Charter for Coroner Services does not make sufficiently explicit the coroner's duty to protect human life, it is also unclear to what degree the Charter is legally binding.²⁷⁹ Other coroner systems have developed codes of ethics which are easily accessible to anyone wishing to understand the ethical framework within which coroners are expected to function. Section 6 of the Code of Ethics for Coroners in Ontario reads:

Coroners shall accept their share of professional responsibility towards society in relation to matters of public health, health education and legislation affecting the health and well-being of the community.⁸⁰

Likewise, Section 9 of the *Code de déontologie des coroners* in Québec states:

Le coroner doit témoigner, dans l'exercice de ses fonctions, d'un constant souci du respect de ses devoirs de protection de la vie humaine.^{81##}

Of interest to this work is the fact that few formal definitions of the constituents of a profession would include coroners, in their present incarnation, in England and Wales.⁴⁵³⁻⁴⁵⁶ Larson (1977) defines the characteristics of a profession which she suggests can be understood to include: "...professional association, cognitive base, institutionalized training, licensing, work autonomy, colleague 'control', code of ethics".^{455, p. 208} That a code of ethics can be generally considered an essential feature of any profession speaks to fact that this is a necessary, albeit not sufficient, component of the system should coroners wish to establish their occupation as a profession.

Increase public awareness of the coroners' mandate

The general public needs to understand what the coroner does. Evidence suggest that much of the disappointment with the current system stems from a misunderstanding on

In the performance of his duties, a coroner shall show constant concern to respect his duties toward the protection of human life.

behalf of the public about what exactly it is that they should expect from the coroner, the coroner's officers, and the inquest.^{348, 358} The Coroners Services Public Accountability Action Group submitted, at length, to the 2006 Constitutional Affairs Committee: the submission revealed, "...a high degree of suspicion about the workings of the coronial system, alleging secrecy, arbitrary decision making, lies and illegality"^{249, p. 51} A formal acknowledgement of the coroner's duty to public health and safety, in addition to a more general commitment to transparency, may address some of these concerns. Additionally, given that coroners may feel pressure to assuage the grief of families, it would be beneficial for the coroner not to be confronted with this type of expectation or to perceive that the expectation exists. The Office of the Chief Coroner for Ontario makes explicit and conspicuous their 'motto' (*i.e.* "we speak for the dead to protect the living") on their website⁴⁵⁷ as well as at the beginning of the latest Annual Report (*i.e.* The Patient Safety Review Committee 2010 Annual Report⁴⁵⁸) which begins with the statement, "[t]he motto of the Office of the Chief Coroner for Ontario speaks to the importance of learning from each and every death to try to prevent similar deaths in the future"^{458, p. i} The mission statement of the OCCO is also included at the beginning of every Annual Report:

The Office of the Chief Coroner for Ontario serves the living through high quality death investigations and inquests to ensure that no death will be overlooked, concealed or ignored. The findings are used to generate recommendations to help improve public safety and prevent future deaths in similar circumstances.⁴⁵⁹⁻⁴⁶¹

Similarly, the *Québec Bureau du Coroner* makes its motto (*i.e.* "*nous cherchons à protéger des vies humaines*"^{§§§}) explicit on its official webpage⁴⁶² and in its latest strategic plan⁴⁶³, and explicitly states the organisation's mandate in the preamble to the plan:

Rechercher de façon indépendante et impartiale les causes et les circonstances des décès obscurs ou violents, de manière à contribuer à la protection de la vie humaine, à acquérir une meilleure connaissance des phénomènes de mortalité et à faciliter la reconnaissance et l'exercice des droits ****^{463, p. 7}

The website for the *Québec Bureau du Coroner* also explicitly states its responsibility to provide information for scientific research and acknowledges that government and other

§§§ We seek to protect human lives.

**** To research the causes and circumstances of obscure and violent deaths in an independent and impartial way, while contributing to the protection of human life, acquiring a better understanding of the phenomena of dying and aiding in both the recognition and application of rights.

organisations require information generated by the coroner for research and prevention purposes.⁴⁶²

One of the recommendations of the July 2011 audit of the British Columbia Coroners Service was that the Service “communicate information on the purpose, role, goals and priorities of the agency” to the public.^{82, p. 21} Ultimately, it is important that the public is disavowed of the notion that the coroner assigns blame, that the inquest is meant to provide the foundation for a civil suit, and that the coroner advocates on behalf of the bereaved.

Contextualise coroner law as a substantive component of public health law

Coronial law is a non-autonomous area of law. It can be understood as a component of several other areas of law. Much of the case law relating to coroners in England and Wales is contextualised in human rights law. The reasons for this are beyond the scope of this work to discuss; however, it would likely help to clarify the coronial purpose if coronial law were considered in the context of public health law. Public health law has been defined as:

The study of the legal powers and duties of the state, in collaboration with its partners (*e.g.* health care, business, the community, the media, and academe), to ensure the conditions for people to be healthy (*e.g.* to identify, prevent, and ameliorate risks to health in the population), and the limitations on the power of the state to constrain for the common good the autonomy, privacy, liberty, proprietary, and other legally protected interests of individuals. The prime objective of public health law is to pursue the highest possible level of physical and mental health in the population, consistent with the values of social justice.^{464, p. 4}

The World Health Organization’s publication *Developing a Framework for Public Health Law in Europe* emphasises that public health law, “...is intended to create an environment in which the promotion of public health goes hand-in-hand with the protection of individual rights and the general principles of equity and justice”.^{465, p. 8} The law empowers coroners to collect information about mortality which can be used to: suggest and/or support interventional measures; understand infrastructural effectiveness and efficiency; and determine the negative/positive impact on the health of the population of incidental laws, rules, and regulations. In this sense, coroner law should be seen as a substantive component of public health law. And, in turn, coroner law should be seen as key instrument in addressing public health challenges.

Modify or implement specific practices to support a public health orientation

Provide a short-form verdict for all narrative verdicts

That the practice of rendering narrative verdicts is hindering the collection of mortality data has been well established.^{16, 17, 35, 351, 466} If we accept that the coroner's purpose is to facilitate public health which, by definition, includes a commitment to prevention, then obscuring data which would otherwise be used in the prevention of death seems contrary. Recent case law (*viz.* *R on the Application of Middleton v West Somerset Coroner*, pp. 70-72) has encouraged the use of narrative verdicts in cases which require that the coroner elaborate on the question 'by what means and in what circumstances' a death occurred. Regardless of the intention of the stipulation in the Middleton ruling that narrative verdicts be used in cases when the death in question involves a matter of public concern, coroners are increasingly using narrative verdicts as an alternative to short form verdicts in cases where the cause and circumstances of death might be multi-factorial or otherwise complex.¹⁶ The degree to which individual coroners avail themselves of the opportunity to record a narrative verdict varies, and this may give the appearance of variance in cause-specific mortality between coroners' jurisdictions.^{16, 351} There has been a considerable increase in the use of narrative verdicts overall (*viz.* Figure 6) since 2001 a trend which, if continued at the same rate, will have a statistically significant effect on mortality statistics - most notably in the case of intentional self-harm.³⁵¹

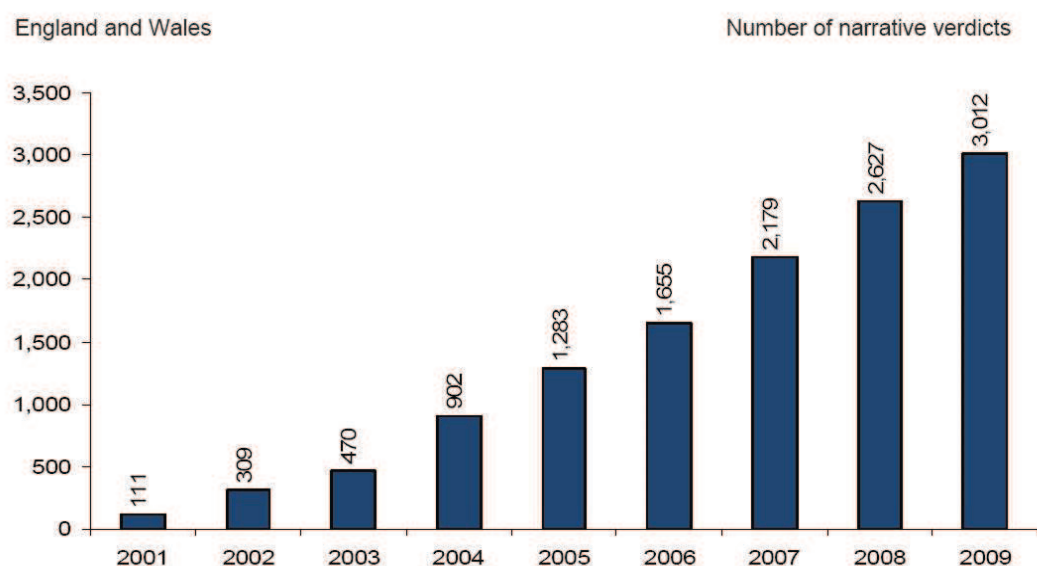


Figure 6: Number of narrative verdicts: by year of death registration, 2001-2009. Reprinted from: Hill C, Cook L. *Narrative verdicts and their impact on mortality statistics in England and Wales*. Health Stat Q. 2011 Spring(49):81-100.

One possible means to mitigate the problems caused by narrative verdicts is to require that they be accompanied by a short form verdict.¹⁶ In addition, their use needs to be standardised in terms of which cases warrant a narrative verdict, and they should not be used as a means of avoiding a definitive decision on the cause and/or manner of death.

Limit or standardise the use of open verdicts

Regardless of whether a person could fully form intent (because they were depressed, fatigued, inebriated, mentally ill *etc.*) the fact that their actions brought about their own death is meaningful from a public health perspective. Masking these deaths with an open verdict, or a nebulously worded narrative verdict, is unlikely to help prevent such deaths in the future - the more that is known about these types of deaths the greater the evidence-base from which to define policy priorities and to formulate effective interventions.

As the degree to which open verdicts are used has been shown to vary considerably between regions^{191, 467} it would seem that it is not the standard of proof alone that is determining which deaths are ruled suicides; it is also the whim of the coroner and his/her interpretation of the law. This variation in practice not only has the effect of masking causes of death, but also of making it difficult for epidemiologists to control for this effect. If coroners are to continue to render open verdicts then everyone would benefit from a common understanding of when their use is appropriate. Additionally, it would be helpful if, in cases where open verdicts are rendered, a sufficient amount of detail about the circumstances of the death were included in the Coroner's Inquisition form (in Section 3: Time, place and circumstances at or in which injury was sustained) such that researchers could establish that the death was manifestly a suicide. These records should also be made available upon request to government agencies and those conducting legitimate research. It would also be helpful if coroners could indicate on the form why the death was not considered to have met the standard of proof to be ruled a suicide in order to allow future audits to establish if open verdicts are being used consistently. Periodic analysis of open verdicts is likely the only way to ascertain which variables are determining whether the coroner rules the death a suicide or an open verdict. Finally, the practice of trying to assuage the grief of a family by rendering an open verdict and/or approaching advocates to ask which verdict the family would 'prefer' should cease, regardless of the circumstances.

Implement a National Coroners Information System (NCIS)

It would be advantageous for coroners, and those who rely on the data they produce, to

have access to a consolidated information sharing system. The system as it operates in Australia may provide a practical model upon which to base a system in England and Wales. The NCIS in Australia is intended to assist coroners in investigations and to provide information concerning fatalities to researchers and government agencies in order to, "...assist in the development of community health and safety strategies".⁴⁶⁸ Currently, in order to obtain detailed information about deaths, researchers and government agencies must approach individual coroners and request access to information - this is time-consuming, inefficient, and provides incomplete data (as not all coroners will agree to give access to data - this has been identified as a serious concern for national suicide audits, for example¹⁷). In addition, the fact that currently no information is available about a death until the inquest has concluded has been identified as problematic by the ONS.⁴ Late reporting compromises timely identification of mortality trends and, in turn, compromises efficacious interventions - a NCIS could be established allowing coroners to enter information as it becomes available such that it could be accessible by other agencies in a more timely and efficient manner.

Implement an audit system

Empowerment of the Lord Chancellor (under section 18(1) of the Coroners and Justice Act 2009 to "make regulations requiring a registered medical practitioner, in prescribed cases or circumstances, to notify a senior coroner of a death of which the practitioner is aware" would allow the coroner system to conduct passive public health surveillance in certain vulnerable populations. The Coroners Act (Ontario) 1990 requires that when a person dies while a resident in a long-term care home in Ontario the individual in charge of the care home must give notice of the death to a coroner.^{321, section 10 (2.1)} The coroner will investigate if any of the conditions under section 10 of the Act are suspected (*e.g.* if it suspected that the individual has died as a consequence of violence, misadventure, negligence, or died suddenly or unexpectedly): in addition, the coroner investigates every tenth death (known as 'threshold cases' which are investigated regardless of whether the coroner has investigated any intervening deaths) in such facilities. The mandatory reporting form for such deaths including provision for identifying threshold cases is included as **Appendix K**. Such passive surveillance may potentially identify: outbreaks of infectious disease, failures in the standard of care, medical mismanagement, injury, negligence, abuse, suicide, or homicide. This type of regular reporting and routine investigation may also act as a deterrent to those who might otherwise victimise the target population.

In her *Third Report* Dame Janet Smith suggested that coroners in England and Wales undertake random audits of deaths.⁵ Since systematic samples are prone to bias (*e.g.* due to intentional mis-reporting, or because malicious acts could be carried out based on whether the victim was likely to be the 10th reportable death) a random sample would be preferable. The proportion of deaths to be randomly sampled could be based on the capacity of the system to investigate the additional cases. As is suggested below, the number of inquests should be reduced in, for example, suicide cases (*i.e.* suicides that do not occur in custody) this would reduce the case-load such that random audits would be possible. If the system acknowledges that its purpose includes the prevention of future deaths then, in terms of opportunity cost, reducing suicide inquests and instituting an audit system would arguably represent a greater contribution to prevention - particularly given that many suicide cases are not, after a lengthy investigation and inquest, even recorded as such (*i.e.* they are given ‘open verdicts’ or ‘narrative verdicts’). In addition, audits of, for example, state-operated care homes would represent a pro-active commitment to identifying and preventing deaths at the hands of state agents (as is required under Article 2 of the ECHR).

Abolish the coroners’ jurisdiction over treasure

It is impossible to make any sweeping statement of purpose - particularly when the purpose is that of supporting and facilitating public health - whilst the coroner is still responsible for investigating treasure trove. The jurisdiction of the coroner over treasure also confounds formalisation of the coronial purpose. The repeal of the coroner’s jurisdiction over treasure was recommended by the Luce Review^{†††}, however, jurisdiction was maintained in the form of a Coroner for Treasure and Assistant Coroners for Treasure in the Coroners and Justice Act 2009. This will, when implemented, have the effect of absolving all coroners from having to investigate treasure trove in favour of appointing a single coroner (and assistant coroners) to carry out this function. Regardless, it is an antiquated practice which is incompatible with a public health mandate and, it is reasonable to assume, a source of confusion for the public. Unfortunately, many coroners enjoy enquiring into treasure and describe this responsibility as “fun” and “interesting”. The responsibility for treasure trove should, however, be turned over to the Department for Culture, Media and Sport, The British Museum/National Museum of Wales, or to an independent arbitration office which could also resolve disputes regarding ownership.

††† The Brodrick Report (1971) indicated that coroners should continue to enquire into treasure trove but only, “...until comprehensive legislation is introduced to deal with the whole question of the protection of antiquities”³, p. 350.

Limit public inquests in certain types of cases

It has been suggested that there is little or no public interest in inquests into certain types of deaths and consequently there is no justification for a public inquest in such cases.^{4, 5, 249, 358, 469} Suicides, provided they do not qualify as Article 2 cases, are frequently cited as the type of death in which there is little or no public interest. Dame Janet Smith, in her testimony to the Constitutional Affairs Select Committee on coroner reform, indicated that deaths involving children might also be unnecessarily distressing to the bereaved if such deaths were subject to public scrutiny.⁵¹ Clearly, there is no public interest in accidental deaths in which there was an autoerotic component. It is my experience that road traffic deaths are either unnecessarily gruesome when described at inquest or, when the coroner attempts to limit the amount of information presented during inquest out of concern for the bereaved, the amount of information divulged could hardly be said to satisfy the public nature of the inquest, were one to presume that there was, in fact, a public interest in such deaths. In none of the death investigation jurisdictions in Canada would such deaths would be subject to a public inquiry unless they occurred in custody or unless the circumstances were so exceptional that a public hearing was deemed necessary.

With respect to suicide inquests it has been suggested that, “[u]nlike other inquests which may directly result in legislative change or preventative public health measures, it is more difficult to arrive at a modern day purpose for the suicide inquest”.^{358, p. 1033} The current public nature of suicide inquests is not only unlikely to contribute to public health and safety but also, it has been suggested, may undermine public health by traumatising the bereaved.³⁵⁸

Michael Burgess, the coroner for Surrey and former Coroner of The Queen’s Household, stated before the Constitutional Affairs Select Committee that, were public inquests forgone in cases in which there was assumed to be no public interest, he estimated the consequent reduction of inquests in his region would be approximately 40%.⁵¹ Given that coroners have recently refused to participate in public health initiatives on the grounds that they do not have time^{11, 12}, this potential reduction in public inquests would likely reduce the time required to investigate such deaths. Additionally, reducing the number of inquests negates the need to arrange court facilities, as well as other time-consuming logistical matters required of a public inquest. Increasing efficiency and effectiveness in handling deaths for which there is unlikely to be a public interest would allow the coroner to

concentrate on other tasks which would represent a greater contribution to public health. Inquests into certain types of deaths may not be the best use of limited resources.

Dame Janet Smith included among her conclusions to the *Third Report* the suggestion that, with the exception of cases in which there is a demonstrable public interest (*e.g.* deaths in custody), coroners should have the discretion to decide whether a public inquest should be held.⁵ However, in order to properly guide this discretion, and subject it to appropriate constraints, there must exist a legislative test of such discretionary powers. One of the tests used to establish if discretion is being used appropriately is to, “...go behind the words which confer the power to the general scope and objects of the Act in order to find what was intended”.⁴⁷⁰ In *R v Minister of Agriculture and Fisheries ex p Padfield* (1968) Lord Reid, in considering whether the discretionary power of a former Minister of Agriculture and Fisheries had been exercised in accordance with the law, stated that:

Parliament must have conferred the discretion with the intention that it should be used to promote the policy and objects of the Act; the policy and objects of the Act must be determined by construing the Act as a whole and construction is always a matter of law for the Court. In a matter of this kind it is not possible to draw a hard and fast line, but if the Minister, by reason of his having misconstrued the Act or for any other reason, so uses his discretion as to thwart or run counter to the policy and objects of the Act, then our law would be very defective if persons aggrieved were not entitled to the protection of the Court. So it is necessary first to construe the Act.⁴⁷⁰

Thus, given that it seems that there is general disagreement as to the purpose of the coroner and, by extension, the Coroners Act 1988 the Coroners and Justice Act 2009^{###}, it seems unlikely that, without first discovering the purpose of the coroner, it could rightfully be said that there exists a mechanism for guiding and constraining the coroner’s discretion. Incidentally, many federal Acts in Canada include an explicit statement of purpose (*e.g.* the *Canada Consumer Product Safety Act*^{§§§§}) or, alternately, a declaration of principle (*e.g.* the *Youth Criminal Justice Act*^{*****}) where the principles are intended to extend beyond the act and

^{###} Only Part I of the Coroners and Justice Act 2009 relates specifically to coroners.

^{§§§§} The purpose of the Act is to, “protect the public by addressing or preventing dangers to human health or safety that are posed by consumer products in Canada, including those that circulate within Canada and those that are imported”.^{471, section 3}

^{*****} The Declaration of Principle included in the Act is as follows: “The following principles apply in this Act: (a) the youth criminal justice system is intended to, (i) prevent crime by addressing the circumstances underlying a young person’s offending behaviour, (ii) rehabilitate young persons who commit offences and

describe the purpose of the system as a whole (e.g. the ‘youth criminal justice system’⁴⁷²). Therefore, until the matter of the coronial purpose is resolved it might be advisable to limit the coroner’s discretion generally, and with respect to the holding of inquests in particular.^{††††}

Finally, it has been suggested in this thesis and elsewhere that coroners are ruling suicides as ‘open verdicts’ or that they are rendering ambiguous ‘narrative verdicts’ in an attempt to mollify families; were the public inquest foregone, coroners might have less contact with families and, as a result, might be more inclined to rule suicide as the cause of death as they may not feel pressure to rule otherwise.

Increase oversight and accountability

The lack of consistency in the service, the absence of standards, the inadequate training for coroners and coroners’ officers, and the complexity of the appeal system (*i.e.* judicial review is currently the only route through which to formally challenge a coroner’s decision) have long been implicated as part of the problems with the current coroner system.²⁻⁵ There is currently no system of oversight and/or accountability of coroners beyond judicial review and the statutory power afforded the Lord Chancellor and the Lord Chief Justice to dismiss a coroner for inability^{††††} or misbehaviour.^{34, section 3(4)} Oversight in some form is pivotal in order to drive up standards, to enforce them, and to require that they be delivered uniformly across the service. Though the Coroner and Justice Act 2009 empowers inspectors of court administration to inspect and report on the operation of the coroner system to the Lord Chancellor^{43, section 39(1)} it is again unclear how this mechanism is meant to ensure oversight or accountability in practice.

The fact that increased oversight and accountability may potentially: mitigate the anxiety of the bereaved; ensure consistent, timely, meaningful and accurate investigations; and facilitate public health interventions and research has been raised at length elsewhere.^{4, 5, 11, 12, 30, 245, 272, 273, 348, 473} However, there are other compelling reasons for instituting an effective system of oversight and accountability into the system.

reintegrate them into society, and, (iii) ensure that a young person is subject to meaningful consequences for his or her offence in order to promote the long-term protection of the public’.⁴⁷²

†††† The Explanatory Notes to the Coroners and Justice Act 2009 includes a vague statement of purpose applying to the entire act and which is as follows: “The purpose of the Act is to establish more effective, transparent and responsive justice and coroner services for victims, witnesses, bereaved families and the wider public”.^{37, section 14}

†††† This section is worded “incapacity or misbehaviour” in the Coroners and Justice Act 2009.^{43, section 13(1)}

The National Audit Office (NAO) is another organisation for which independence is crucial to its legitimacy. The NAO is governed by an advisory Board which is supported by a Leadership Team which includes the Comptroller and Auditor General who oversees the NAO. The reports of the NAO are also subject to external audit by academics at Oxford University and the London School of Economics and Political Science - the external audit is carried out to provide the necessary academic scrutiny and to demonstrate that the NAO is “prepared to learn lessons from independent experts”.⁴⁷⁴ Thus far there is no proposed mechanism of independent oversight for the purpose of reviewing Rule 43 reports or the public health recommendations contained therein.

Establish an oversight council

Despite the government’s recent decision to retain the position of Chief Coroner^{§§§§§}, no announcement has been made about the future of the Ministerial Board which was proposed by government as a means to provide oversight and accountability of the coroner system *in lieu* of a Chief Coroner. The Ministerial Board was to provide “oversight of the non-judicial aspects of the coroner system” and to “provide a direct line of accountability on these matters to Parliament”^{275, column 259}. It is unclear how, precisely, this board would function to provide oversight.

One of the recommendations of the Goudge Inquiry into Paediatric Forensic Pathology in Ontario was that a Governing Council be established to enhance oversight and accountability of the Office of the Chief Coroner for Ontario.⁷⁹ The council comprises up to thirteen members^{*****}, including at least three members of the public, and is responsible for making recommendations regarding financial resource management, quality assurance, strategic planning, performance measures and accountability mechanisms, public complaints, and general matters pertaining to compliance with the Coroners Act (Ontario) 1990.⁴⁷⁵

§§§§§ As well as the Deputy Chief Coroners, the Medical Advisers to the Chief Coroner, and the Deputy Medical Advisers to the Chief Coroner.

***** “The Council is composed of the following: 1. A person who has retired as a judge of any federal, provincial or territorial court. 2. The Chief Coroner (non-voting member). 3. The Chief Forensic Pathologist (non-voting member). 4. A person nominated by the Minister. 5. The Dean or Associate Dean of an Ontario medical school or a person who teaches full-time at an Ontario medical school. 6. A person employed under Part III of the Public Service of Ontario Act, 2006 who is nominated by the Minister of Health and Long-Term Care. 7. Two persons employed under Part III of the Public Service of Ontario Act, 2006 who are nominated by the Attorney General. 8. Two persons, each of whom is a president, chief executive officer or other senior administrator of an Ontario public hospital. 9. At least three members of the public”.⁴⁷⁵

It is still unclear what form the government's Ministerial Board will take, to whom it will report and how much oversight and accountability it will be positioned to offer; however, it is undoubtedly good practice to have a multi-disciplinary committee, including members of the public, overseeing the system. It would be prudent to have a member of the ONS and of the existing governmental public health agency (either the soon to be abolished HPA, or the soon to be created Public Health England) assured permanent membership on the Ministerial Board. The Ministerial Board could, if retained, complement the oversight and accountability provided by the Chief Coroner.

Eliminate unjustified investigation of cases and submission of fees

One of the reasons provided by coroners for not participating in public health research or for not providing data upon request is that they are simply too busy. This may well be the case as many coroners simply do not have the capacity to take on extra work. However, it has been suggested by several research subjects (including two coroners) that, on occasion, coroners will assume jurisdiction not based on any justifiable need (many deaths are manifestly the result of natural causes) but because they are remunerated on a fee-for-service basis (this is often the case for part-time coroners) and that assuming jurisdiction over natural deaths - which are likely to require little in the way of investigation and time investment in the inquest - is financially motivated.++++ When I asked a coroner if Local Councils can forbid coroners from billing for thousands of cases that were uncovered during an archaeological excavation of a 700 year old battlefield his response was an emphatic 'no'.++++

It is to the benefit of the service to address some of these matters in order to normalise good practice, and to strengthen trust between coroners and the public they serve.

Addressing this type of issue may also address the problem of inconsistent assumption of jurisdiction among regions and, ultimately, of inconsistent reporting.

++++ "But you see, the thing is some coroners will say, [...] as a part time jurisdiction I get paid on the bodies that I deal with, so if I suddenly decide I want every lung cancer related death (if the person has been hospitalised in the last two years) reported to me, I'd triple my salary. And you'll find some coroners do that". [C04]

++++ "No, they can't. This is why the councils...most local authorities haven't got a clue what the coroner does. Not a clue. And the coroners bamboozle them, they boxed them into submission. Some local authorities now are wising up to this, you know this is where coroners are - they're not getting away with it like they used to". [C04]

Enforce Section 36(2) of the Coroners Rules 1984

Section 36(1) of the Coroners Rules 1984 lists the matters to be ascertained at inquest, namely the identity of the deceased, how, when and where the deceased came to be dead, as well as the particulars as required by the Registration Acts.^{§§§§§§} Section 36(2) states that, “neither the coroner nor the jury shall express any opinion on any other matters”.¹⁸ In spite of this rule it is not uncommon for coroners to make statements regarding public policy, political matters or their personal ideological position with regard to, for example: emergency response protocols¹⁹, drug and alcohol policy^{22, 24, 27, 476}, and social norms^{25, 28}. Coroners’ public comments reflect their opinion, often based on a single death or, at most, on a few deaths which may have occurred over a lengthy time interval. Spurious claims as to the relatedness of such deaths and the inclination to identify ‘trends’ is problematic when the perspective is limited, there is no denominator data, and/or any means to test for statistical association. Further, interventions suggested by coroners are often not evidence-based; on occasion coroners’ suggestions have been known to be ineffective. In addition, coroners lack the training and expertise to make informed public health recommendations. As facilitators of public health it is vital that coroners have an avenue for expressing their opinions and concerns to a public health official in a position to weigh or act on them. It is equally important that coroners not make public statements relating to a matter about which they lack evidence and expertise. As indicated above, the reports of the National Audit Office are subject to academic reviews which, “...draw on a breadth of knowledge and experience in work across the whole of government, and [...] provide authoritative comment on study methods and the technical rigour of our analysis”.⁴⁷⁴ Further, recommendations should be made on behalf of the coroner’s system and not by individual coroners.

Clarify the coronial status

There is currently disagreement as to whether or not coroners are part of the judiciary and/or if they should properly be considered judges. The widespread and longstanding practice of referring to coroners as ‘independent judicial officers’, suggests that they are distinct enough from judges to require this designation. The Judiciary of England and Wales states that, “...coroners are not considered to be members of the courts judiciary”⁴⁷⁷. Neither the Coroners Act 1988, the Constitutional Reform Act 2005, the Tribunals, Courts

^{§§§§§§} This is likely meant to refer to the Births and Deaths Registration 1953 as well as The Registration of Births and Deaths Regulations 1987.

and Enforcement Act 2007, or the Coroners and Justice Act 2009 define coroners as part of the judiciary. Recent case law, however, seems to suggest that coroners are, in fact, judges:

Certain things are beyond contention. The Coroner is a judge; and neither BCC nor anyone else, save a properly constituted court of appeal or review, has the least business interfering with his judgments or how he arrives at them. His independence as a judge is a matter of constitutional guarantee. Nothing could be more elementary.^{478, section 27}

That this statement appears *obiter dictum* and demonstrates no legal reasoning, justification or precedent suggests that it needs critical examination and need not be acknowledged as binding.^{*****} However, earlier common law seems to establish the coroner as a judge as is the case in *Garnett v Ferrand and another* (1827) which considered whether it was lawful for a coroner to have ordered his “servants” to “gently la[y] their hands on plaintiff and turn him out” of coroner’s court.^{480, p. 441} It was the decision of Lord Tenterden that, “[t]he Court of the coroner is a Court of record, of which the coroner is the judge...”.⁴⁸⁰

If coroners are judges then it is concerning that they have: no shared purpose, no effective system of oversight and accountability, no code of ethics, no consensus on the interpretation of the law and, as a consequence, they are afforded sufficient latitude to undermine the public good. It seems remiss to create (by virtue of case law) a judicial office that operates in the absence of many of the accountability mechanisms⁺⁺⁺⁺⁺ to which all other members of the judiciary are subject.⁺⁺⁺⁺⁺ Coroners differ in several respects from judges: they are not defined as part of the judiciary in the Constitutional Reform Act 2005, the Tribunals, Courts and Enforcement Act 2007, or the Coroners and Justice Act 2009; they are not subject to a transparent appointment process as would be carried out by the Judicial Appointments Commission; they do not have an arbitration function; they are paid for by Local Authorities; they are not permitted to retire (with

^{*****} “Within the common law system the judiciary is responsible for the interpretation of statutes and the development of the non-statutory principles embodied in case-law. This is done by the system of precedent and incremental development of the principles of law, in particular by appellate courts”⁴⁷⁹.

⁺⁺⁺⁺⁺ Judges are accountable to: the executive (in the form of the Lord Chief Justice and the Lord Chancellor), the legislature (in the form of the power of the House of Commons and the House of Lords to petition the Queen to remove a judge, and the ability of Parliament to legislate to reverse a judge’s decision), the judiciary (in that the decisions of judges can be overruled by senior judges, and in that judges are expected to observe the 2011 Guide to Judicial Conduct⁴⁸¹), and to the public (through the appeals process as well as the Office for Judicial Complaints and the Judicial Appointments and Conduct Ombudsman). There is very little in the way of internal or external accountability of the coroner.

⁺⁺⁺⁺⁺ With the exception of tribunal judges who are subject to different means of accountability.

pension) after 20 years of service (as is the case with members of the judiciary); and the standards of evidence in coroner's courts are not as strict as in other courts. It is thus unclear whether or not coroners are judges and it would benefit government, coroners and the public to clarify this status. If coroners are deemed to be judges their purpose needs to be clarified, they require a more rigorous system of appointment, a shared understanding of the law, equitable access to resources^{§§§§§§§§}, better training standards, and an appropriate system of oversight and accountability.

Clarify the nature of coronial independence

The importance of the independence of the coroner is frequently alluded to by government, NGOs, and by coroners themselves. Coroners' investigations into Article 2 deaths, for example, must not only be independent from improper influence but, perhaps more importantly, must be perceived to be independent as it is the action/inaction on behalf of the state which is implicated in a death. The coroner's independence was a recurrent theme in both the Luce Review, the Shipman Inquiry, as well as in the subsequent reform process. Though Tom Luce concluded that coroners should have "full independence"^{4, p. 25}, he accepted as problematic the fact that it was the opinion of many giving evidence to the Luce Review that "the coroner is a law unto himself"^{4, p. 71}

Coroners are described variously as: 'independent judicial officers'^{5, 31}, 'judicial officers'⁴ or 'judges'.⁴⁷⁸ These titles (regardless of whether they are appropriate or not) are interpreted as conferring upon the coroner some of the privileges of being a member of the judicial branch, including judicial independence. Judicial independence is, according to the Judiciary of England and Wales, meant to imply that "when carrying out their judicial function [judges] must be free of any *improper influence*" [emphasis mine].⁴⁸² That judicial independence presupposes the freedom from improper influence suggests that there is, in fact, influence which can be rightfully deemed *proper*.^{*****} Indeed, it is widely acknowledged and accepted that members of the judicial branch of government are subject to constraints and guidance with respect to the fulfilment of their role. This influence is not only considered proper, it has been argued that these constraints and guidance play a significant role in securing the legitimacy and accountability of the judiciary.

§§§§§§§§ It is one thing to constrain a coroner financially from carrying out his/her statutory duty, it is quite another to make it impossible (owing to financial constraints) for a judge to effectively rule on matters of law. ***** For example, a study carried out by academics at University College London suggested that not enough is being done to help juries understand the law.⁴⁸³ In response, the Lord Justice Thomas indicated that judges were being urged to give written directions to jurors⁴⁸⁴ - clearly this 'urging' of judges to change their practice for the purpose of ensuring justice constitutes *proper* influence.

If the coroner's purpose were acknowledged to be that of facilitating public health and safety, and they were somehow remiss in pursuing that mandate effectively then influence exerted on behalf of government with the intention of ensuring that mandate was realised may well be deemed *proper*. Given that the coroner currently has no clear mandate, determining at which point proper influence becomes improper interference becomes entirely subjective and arbitrary. With no clear concept of what constitutes interference, any attempt by government officials to constrain or guide the practice of coroners risks being labelled 'improper' since there are no criteria by which to judge such interference. It is clear that in executing their judicial function coroners must be free from improper influence as their independence is critical to their legitimacy (in a practicable sense) and the rule of law (in theory). Moreover, the stipulation that being free of improper influence is afforded only to those who are in the process of executing their judicial function suggests that influence may, again, be deemed proper if it is imposed on those while they are executing their administrative function.

In the recent Court of Appeal case *Forrest v The Lord Chancellor and the Lord Chief Justice*, Lord Justice Laws upheld the decision of a Review Body to disallow a judicial review of the decision by the Lord Chancellor and the Lord Chief Justice to remove the Avon coroner from his office owing, in part, to the coroner harbouring, "an *idée fixe* about the scope of his empire".⁴⁷⁸ In considering the former Avon coroner's conduct with respect to his relationship with Bristol City Council, Judge Risius (presiding over the judicial investigation) contrasted the Avon coroner's view, "that coroners are in a unique position, in that unlike other judicial office-holders, coroners are responsible solely to the Crown, and cannot be bound by any other authority or subjected to any budget..." with that of Bristol City Council (BCC) which contested that⁴⁷⁸:

[There is] a clear distinction between on the one hand a coroner's judicial decisions, for example concerning post-mortems and inquests, which are for the coroner alone to make and are not properly subject to either budgetary or any other form of control, direct or indirect, by the local authority, and, on the other hand, the local authority's legitimate interest in ensuring that public money is spent in supporting the coroner in the discharge of his duties is properly accounted for...⁴⁷⁸

Judge Risius made it clear in his report that he preferred the approach of BCC, suggesting a clear distinction between the coroner's judicial and administrative functions, and that independence (defined as being free from improper influence) was only afforded to the

coroner in the conduct of his/her judicial function. Further, the Review Body concluded that the coroner's belief in the extent of his independence was "erroneous" and "unreasonable".⁴⁷⁸

Thus, it would seem that there are outstanding matters to be decided including what precisely constitutes the coroner's judicial function? Much public health research relies on retrospectively collected inquest data. Does the coroner's responsibility for maintaining a database of past inquest data constitute a judicial function? Or would this more properly be considered an administrative function? Were it considered an administrative function could the Department of Health or the Health Protection Agency, for example, require that it be allowed access to the data without such a requirement being deemed improper influence and, thus, a threat to coronial independence? The CSEW's decision not to participate in the HPA's vCJD survey was based, in part, on claims that simply passing contact information on to researchers, "would be to adversely affect the independence of the coronial service".⁴⁸⁵

Additionally, and in the interests of transparency, it would benefit the public to understand what is meant by 'independent judicial officer' such that they do not impose unreasonable expectations on coroners with respect to independence. Therefore, it should be made clear that independence is not an absolute concept and that it is limited to the coroner's judicial function. It should also be made explicit that the coroner is manifestly not independent with respect to the fact that they spend public money, and that much of the investigation of deaths is carried out on their behalf initially by the police and/or prison services and, subsequently, by a coroners' officer who may be employed by the local police service. Further, it is often said that coroners are responsible only to the Crown^{5, 31, 478} and it is not uncommon for coroners to suggest that, by virtue of this putative relationship with the Crown, they are entirely independent from government; this is, however, a spurious claim to independence. The Queen acts on the advice of her ministers (*viz.* The Bill of Rights) and is, thus, accountable to Parliament. She does not exercise Royal Prerogative, in any manner, with respect to coroners. Alternately, coroners describe their relationship with Local Authorities as evidence of their independence from central government; however, Local Governments themselves have no legal autonomy from central government. In addition, it has recently been suggested that some coroners allow PCT's to choose their own witnesses, and that coroners may be too involved in their local communities and that, as a consequence, they do not wish to criticise their local institutions.⁴⁸⁶

Also, the fact that coroners have refused - and publically so - to participate in legitimate public health research, coupled with the lack of clarification as to the coroner's independence, may dissuade public health practitioners and researchers from approaching them to participate in the future - regardless of how critical their participation might be to the project.

Ultimately, this evidently confused notion of coronial independence is problematic for public health as, for some coroners, it justifies their not participating in public health initiatives and not making their data available for use in legitimate public health research.

Empower the bereaved

That the absence of an effective system of oversight and accountability compromises the well-being of the bereaved has been widely acknowledged.^{4, 5, 272, 275, 348, 387, 469, 473} In response to the government's intention to abolish the position of Chief Coroner, Baroness Finlay (a physician, professor of medicine, former president of the Royal Society of Medicine, and life peer), countered the government's estimated cost-saving estimates by arguing that:

...no estimate has been taken into account of the cost to the NHS of the morbidity [among] bereaved people. They often end up with complicated grief needing NHS support, and the majority have periods when they are unable to work. Consider, too, the cost of bereaved children who live feeling that justice was never done. They have a high risk of suicide, drug addiction, teenage pregnancy and acquiring a criminal record.^{274, c. 530}

It is commonly acknowledged that the coroner system operates to variable standards across the country and that families are subject to what has been described as a "postcode lottery"^{245, 363} in terms of variable service delivery, delayed inquests, and a complex appeal process. It is yet to be seen how well the Chief Coroner (or the proposed Bereaved Organisations Committee and Ministerial Board²⁷⁵) will function to reduce trauma like that described by Baroness Finlay and by many of the bereaved who have come into contact with the system.³⁴⁸ However, the draft Charter for the current coroner service explicitly states that it is intended to "address inconsistencies and inefficiencies in the delivery of service to bereaved people, witnesses and others who come into contact with the system"^{277, p. 3}

In addition, coroners do not routinely inform the bereaved they are legally able to consent to tissue donation for research purposes. The "therapeutic value of choice"^{487, p. 764} may

address some of the feelings of disempowerment that have come to characterise many of the negative experiences of the bereaved in dealing with coroners and their officers.³⁴⁸ As was indicated earlier in this thesis (*viz.* *The Bristol Royal Infirmary Inquiry and the Royal Liverpool Children's Inquiry*, p. 77-79), it is often the case that families wish to consent to tissue donation out of a genuine concern for the health and wellbeing of others who may benefit from such donation. Studies have shown that, when offered the option to donate tissue, nearly all bereaved people (whether they chose to participate or not) reported that they felt that, “all bereaved families should be offered, as their right, the opportunity of donating for research”.^{360, p. 372} It was also shown that very few bereaved persons will actively pursue the possibility of participating in research studies, suggesting that the initiative needs to be taken by someone in contact with the bereaved soon after the death.³⁶⁰ It seems appropriate, then, that coroner’s officers act as points of referral for donation and research programmes. It would likely constitute a minimal imposition on the coroner’s officer to require that they ask the bereaved if they would like their contact information to be passed on such that they might be contacted by a member of the tissue donation team (*e.g.* the NHS Blood and Transplant Authority) or by research personnel. One coroner with whom I spoke stated that she did not believe it was appropriate for her to ask families about tissue donation as she felt they might feel pressure to please her, but she did suggest that were the Chief Coroner to create a policy whereby coroners are required to ask, she would be willing to do so.+++++ It should be noted that the coroner for Preston, Dr. James Adeley, has instituted a Tissue Donation Protocol for his region.+++++

+++++ “It’s because the pressure is removed if you can say to a family, ‘this is the norm, this is the policy, this is what the law requires me to do...or the Chief Coroner requires me to do’. It’s not that I disagree with the idea of doing it; it’s that I would not willingly myself use my power in a way that might make a family feel under pressure. I won’t do that...”. [C20]

+++++ The protocol includes a Referral for Tissue Donation form which is to be filled in by the Coroner’s Officer upon being notified of a death (the Officer need only enter their name, the date, the name of the next-of-kin, and the name of the deceased) - the protocol requires that the Officer inquire as to the deceased’s wishes with respect to tissue donation. Should the next-of-kin indicate that they would be willing to have their contact details passed on to the Tissue Services, the Officer will notify Tissue Services by fax or pager of the contact details and the name of the deceased.

REFERENCES

1. Umfreville E. *Lex Coronatoria: Or, the Office and Duty of Coroners. In three parts. Wherein the theory of the office is distinctly laid down; and the practice illustrated: Volume I.* London: R. Griffiths and T. Becket; 1761.
2. Wright RA. *Report of the Departmental Committee on Coroners.* Home Office. Report No: Cd. 5070, 1935-36.
3. Brodrick N. *Report of the Committee on Death Certification and Coroners.* Home Office Report No: Cm 4810, 1971-1972.
4. Luce T. *Death Certification and Investigation in England, Wales and Northern Ireland.* Secretary of State for the Home Department. Report No: Cm 5831, 2003.
5. Smith J. *The Shipman Inquiry: Third Report (Death Certification and the Investigation of Deaths by Coroners).* The Shipman Inquiry Report No: Cm 5854, 2003.
6. Hansard HC, *Harold Shipman.* 01 February 2000, col. 907-919.
7. Ghosh P. Coroners 'reject plea over vCJD'. *BBC News.* [Online] 19 August 2009. Available from: <http://news.bbc.co.uk/1/hi/health/8207034.stm> [Accessed 17 January 2012].
8. Hughes D, Halfpenny M. Coroners 'should order tests for vCJD'. *The Independent.* [Online] 19 August 2009. Available from: <http://www.independent.co.uk/life-style/health-and-families/health-news/coroners-should-order-tests-for-vcjd-1774188.html> [Accessed 17 January 2012].
9. Meikle J. Coroners urged to back vCJD tests to track spread of disease. *The Guardian.* [Online] 08 January 2007. Available from: <http://www.guardian.co.uk/science/2007/jan/08/infectiousdiseases.bse> [Accessed 17 January 2012].
10. Meikle J. Coroners resist plans to investigate long-term health threat from vCJD at postmortems. *The Guardian.* [Online] 11 February 2008. Available from: <http://www.guardian.co.uk/society/2008/feb/11/health.bse> [Accessed 17 January 2012].
11. McGowan CR, Viens AM. Death investigation systems and disease surveillance. *Epidemiology and Infection.* 2010; 139(7): pp. 986-990.
12. McGowan CR, Viens AM. Coroners and the obligation to protect public health: The case of the failed UK vCJD study. *Public Health.* 2011; 125(4): pp. 234-237.
13. Staines R. Suicide data analysis marred by flaws in inquest outcomes. *Mental Health Practice.* 2010; 13(9): 6.
14. Parish C. Honesty must prevail. *Mental Health Practice.* 2010; 13(9): 5.

15. Hansard HC, *Coroners (Recording of Suicides)*. 27 April 2011, col. 134WH.
16. Gunnell D, Hawton K, Kapur N. Coroners' verdicts and suicide statistics in England and Wales: Increasing use of narrative verdicts raises serious concerns. *BMJ*. 2011; 343(d6030).
17. Bazalgette L, Bradley W, Ousbey J. *The Truth About Suicide*. DEMOS. 2011.
18. London. *Coroners Rules 1984*, SI 552. The Stationery Office; 1984.
19. Thomas E. Derrick Bird inquest coroner criticises paramedic delays. *BBC News*. [Online] 25 March 2011. Available from: <http://www.bbc.co.uk/news/uk-12866467> [Accessed 17 January 2012].
20. BBC. Derrick Bird gun rampage coroner criticises medic delay. *BBC News*. [Online] 25 March 2011. Available from: <http://www.bbc.co.uk/news/uk-england-12861441> [Accessed 17 January 2012].
21. Booker C. The coroner grabs the headlines, while the true dangers pass in silence. *The Telegraph*. [Online] 23 March 2008. Available from: <http://www.telegraph.co.uk/comment/columnists/christopherbooker/3556465/The-coroner-grabs-the-headlines-while-the-true-dangers-pass-in-silence.html> [Accessed 17 January 2012].
22. Jamieson A. Coroner criticises supermarket cheap alcohol after fatal '£10' binge. *The Telegraph*. [Online] 21 January 2010. Available from: <http://www.telegraph.co.uk/finance/newsbysector/retailandconsumer/7042815/Coroner-criticises-supermarket-cheap-alcohol-after-fatal-10-binge.html> [Accessed 17 January 2012].
23. The Telegraph. All pregnant women should take vitamin D, coroner says *The Telegraph*. [Online] 12 December 2011. Available from: <http://www.telegraph.co.uk/health/healthnews/8951232/All-pregnant-women-should-take-vitamin-D-coroner-says.html> [Accessed 17 January 2012].
24. Henry J. Cannabis use causes 'hundreds of deaths a year', coroner warns. *The Telegraph*. [Online] 2 November 2003. Available from: <http://www.telegraph.co.uk/news/uknews/1445718/Cannabis-use-causes-hundreds-of-deaths-a-year-coroner-warns.html> [Accessed 17 January 2012].
25. The Yorkshire Post. Coroner's sex advice for young after birth tragedy *The Yorkshire Post*. [Online] 16 July 2004. Available from: http://www.yorkshirepost.co.uk/news/around-yorkshire/local-stories/coroner_s_sex_advice_for_young_after_birth_tragedy_1_2546697 [Accessed 17 January 2012].
26. Fiona Geraghty inquest: Coroner attacks fashion industry and media. *BBC News*. [Online] 20 June 2012. Available from: <http://www.bbc.co.uk/news/uk-england-somerset-18521916> [Accessed 20 June 2012].

27. Mail Online. Cannabis 'is not harmless' warns coroner after drug use triggers teenager's fatal fit. *Mail Online*. [Online] 1 July 2009. Available from: <http://www.dailymail.co.uk/news/article-1196770/Cannabis-harmless-warns-coroner-drug-use-triggers-teenagers-fatal-fit.html> [Accessed 17 January 2012].
28. Cameron A. Coroner laments impact of casual sex on society. *Somerset County Gazette*. [Online] 15 April 2009. Available from: http://www.somersetcountygazette.co.uk/news/4288481.Coroner_laments_impact_of_casual_sex_on_society/ [Accessed 17 January 2012].
29. Brahams D. Unnatural death, AIDS, and coroners. *The Lancet*. 1996; 347(9004): 777-777.
30. McGowan CR, Viens AM. Reform of the coroner system: a potential public health failure. *Journal of Public Health (Oxf)*. 2010; 32(3): pp. 427-430.
31. Dorries C. *Coroners' Courts: A Guide to Law and Practice (Second Edition)*. Oxford: Oxford University Press; 2004.
32. The Coroners' Society of England and Wales. *The Ministry of Justice*. [Online]. Available from: <http://www.coronersociety.org.uk/wfDepConAffairs.aspx>.
33. United Kingdom. *Constitutional Reform Act*, Eliz II, Chapter 4. London: The Stationery Office; 2005.
34. United Kingdom. *Coroners Act*, Eliz II, Chapter 13. London: Her Majesty's Stationery Office; 1988.
35. *Coroners Statistics - England and Wales 2010*. Ministry of Justice. 2011.
36. Brend WA. The Futility of the Coroner's Inquest. *The Lancet*. 1913; 181(4681): 1404-1408.
37. United Kingdom. *Coroners and Justice Act (Explanatory Notes)*, Eliz II, Chapter 25. London: The Stationery Office; 2009.
38. *R v Bristol Coroner ex p Kerr*, [1974] QB 652
39. Clarke LJ. *Public inquiry into the identification of victims following major transport accidents : report of Lord Justice Clarke (Volume 1)*. The Stationery Office. Report No: Cm 5012, 2001.
40. McCarthy A. *Peer Pressure*. U.K.: BBC; 2011.
41. Parliamentary Information Office. *Key Dates on Parliament 1215-1900*. [Online]. Available from: <http://www.parliamentarydiary.co.uk/keydates1215.html>.

42. United Kingdom. *Births and Deaths Registration Act*, 1 & 2 Eliz. II, Chapter 20. London: Her Majesty's Stationery Office; 1953.
43. United Kingdom. *Coroners and Justice Act*, Eliz II, Chapter 25. London: The Stationery Office; 2009.
44. *Coroners and Justice Act 2009 – Implementation Schedule*. Ministry of Justice. 2009.
45. United Kingdom. *Public Bodies Bill*, HL Bill 25. London: The Stationery Office; 2010.
46. UK. *Cremation Act*, 2 Edw 7, Chapter 8. London: His Majesty's Stationery Office; 1902.
47. United Kingdom. *Treasure Act*, Eliz II, Chapter 24. London: Her Majesty's Stationery Office; 1996.
48. London. *The Registration of Births and Deaths Regulations*, 1987.
49. London. *Cremation Regulations 1930*, SI 1016. 1930.
50. Thomas L, Straw A, Friedman D. *Inquests: A Practitioner's Guide (Second Edition)*. London: Legal Action Group; 2008.
51. *Reform of the Coroners' System and Death Certification (Volume II - Oral and Written Evidence)*. The Constitutional Affairs Committee. Report No: HC 902-II, 2006.
52. Kennedy I. *The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995: Learning from Bristol*. The Bristol Royal Infirmary Inquiry. 2001.
53. Republic of Ireland. *Coroners Act (Ire)*, Number 9 of 1962. Dublin: Government of Ireland; 1962.
54. *Review of the Coroner Service: Report of the working group* Department of Justice, Equality and Law Reform. 2000.
55. Republic of Ireland. *Coroners Bill (Ire)*, Number 33. Dublin: Government of Ireland; 2007.
56. Gartland F. Dublin city coroner calls on Minister for Justice to reintroduce 2007 Bill. *The Irish Times*. [Online] 28 May 2011. Available from: <http://www.irishtimes.com/newspaper/ireland/2011/0528/1224297951340.html> [Accessed 17 January 2012].
57. Johnston E. *Royal Commission into Aboriginal Deaths in Custody: Volume 1*. Royal Commission into Aboriginal Deaths in Custody. 1991.

58. Johnston E. *Royal Commission into Aboriginal Deaths in Custody: Recommendations*. Royal Commission into Aboriginal Deaths in Custody. 1991.
59. National Coroners Information System. *Historical Background*. [Online]. Available from: http://www.ncis.org.au/web_pages/historical_background.htm.
60. Coroners Court of Victoria. *Coroners Prevention Unit*. [Online]. Available from: http://www.coronerscourt.vic.gov.au/home/investigations/who_s_involved/coroners_prevention_unit/.
61. Bugeja L, Ibrahim JE, Ozanne-Smith J, Brodie LR, McClure RJ. Application of a public health framework to examine the characteristics of coroners' recommendations for injury prevention. *Injury Prevention*. 2011.
62. New Zealand. *Coroners Act (NZ)*, 1988 Number 111. Wellington: Parliamentary Council Office; 1988.
63. *Coroners: A Review*. The Law Commission (New Zealand). Report No: Preliminary Paper 36, 1999.
64. *Coroners*. The Law Commission (New Zealand). Report No: 62, 2000.
65. New Zealand. *Coroners Act (NZ)*, 2006 Number 38. Wellington: Parliamentary Council Office; 2006.
66. Taurima S. *Coronial recommendations 'die in the ditch'*. TVNZ. Wellington (NZ)2012. Available from: <http://www.voxy.co.nz/national/shane-taurima-interviews-judge-neil-maclean/5/123230>.
67. *Uptake of coroners' recommendations investigated*. TVNZ. Wellington (NZ)2012. Available from: <http://tvnz.co.nz/national-news/study-review-coroners-recommendations-4889880>.
68. Jentzen JM. *Death Investigation in America: Coroners, Medical Examiners, and the Pursuit of Medical Certainty* London: Harvard University Press; 2009.
69. Hanzlick R. The conversion of coroner systems to medical examiner systems in the United States: A lull in the action. *American Journal of Forensic Medicine and Pathology*. 2007; 28(4): 279-283.
70. Committee on Identifying the Needs of the Forensic Sciences Community, National Research Council, Committee on Science Technology and Law, Committee on Applied and Theoretical Statistics, Policy and Global Affairs, Engineering and Physical Sciences. *Strengthening Forensic Science in the United States: A Path Forward*. Washington, D.C.: National Academies Press; 2009.

71. *The coroner and the medical examiner : issued under the auspices of the Committee on Medicolegal Problems.* Schultz OJT, Morgan EM, editors. Washington, D.C: National Research Council of the National Academy of Sciences; 1928.
72. United States. *Model Post-Mortem Examinations Act*, National Conference of Commissioners on Uniform State Laws. 1954.
73. Mangini T. *Post mortem: Death Investigation in America.* Frontline. United States: PBS; 2011. Available from: <http://www.pbs.org/wgbh/pages/frontline/post-mortem/>.
74. Hanzlick R. The Centers for Disease Control and Prevention's Medical Examiner/Coroner Information Sharing Program (MecISP).[Erratum appears in J Forensic Sci 1997 Jul;42(4):761]. *Journal of Forensic Sciences.* 1997; 42(3): 531-532.
75. Pablo C. B.C.'s coroner system questioned by forensic pathologist *The Georgia Straight.* [Online] 06 May 2010. Available from: <http://www.straight.com/article-321586/vancouver/coroner-system-questioned> [Accessed 17 January 2012].
76. Goudge ST. *Inquiry into Paediatric Forensic Pathology in Ontario (Volume 1: Executive Summary).* Ministry of the Attorney General of Ontario. Report No: 1, 2008.
77. Goudge ST. *Inquiry into Paediatric Forensic Pathology in Ontario (Volume 2: Systemic Review).* Ministry of the Attorney General of Ontario. Report No: 2, 2008.
78. Goudge ST. *Inquiry into Paediatric Forensic Pathology in Ontario (Volume 4: Inquiry Process).* Ministry of the Attorney General of Ontario. Report No: 4, 2008.
79. Goudge ST. *Inquiry into Paediatric Forensic Pathology in Ontario (Volume 3: Policy and Recommendations).* Ministry of the Attorney General of Ontario. Report No: 3, 2008.
80. Office of the Chief Coroner for Ontario. *Code of Ethics for Coroners.* [Online]. Available from: http://www.mcscs.jus.gov.on.ca/english/DeathInvestigations/office_coroner/CodeofEthicsforCoroners/OCC_code_of_ethics.html.
81. Bureau du Coroner Québec. *Code de déontologie des coroners.* [Online]. Available from: http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=3&file=/R_0_2/R0_2R1.htm.
82. *British Columbia Coroners Service.* Office of the Auditor General of British Columbia. Report No: 5, 2011.
83. Statistics Canada. *Canadian Coroner/Medical Examiner Database (CCMED).* [Online]. Available from: <http://www.statcan.gc.ca/cgi-bin/imdb/p2SV.pl?Function=getSurvey&SDDS=5125&lang=en&db=imdb&adm=8&dis=2>.

84. Statistics Canada. *Canadian Coroner and Medical Examiner Database: Annual Report*. 2012.
85. Ritchie J, Spencer L. Qualitative Data Analysis for Applied Policy Research. In: Bryman A, Burgess R, editors. *Analyzing Qualitative Data*. London: Routledge; 1994. p. 173-194.
86. Lucas S. Correspondence. *Epidemiology and Infection*. 2011: 1-3.
87. *Select Charters*. 9th Edition ed. Stubbs W, editor. Oxford: Clarendon Press; 1913.
88. Gross C. The Early History and Influence of the Office of Coroner. *Political Science Quarterly*. 1892; 7(4): 18.
89. Hunnisett RF. The Origins of the Office of Coroner: The Alexander Prize Essay. *Transactions of the Royal Historical Society*. 1958; 8: 85-104.
90. Knight B. *Crowner: Origins of the Office of the Coroner*. . Available from: <http://www.britannia.com/history/coroner1.html>. [Accessed 02 April 2009].
91. Moher D, Liberati A, Tetzlaff J, Altman DG. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *BMJ*. 2009; 339.
92. Stubbs W. *The Constitutional History of England*. London: Clarendon Press; 1874.
93. Bingham C. *The crowned lions: the early Plantagenet Kings*. North Pomfret: David & Charles PLC; 1978.
94. Havard JDJ. *The Detection of Secret Homicide: A Study of the Medico-legal System of Investigation of Sudden and Unexplained Deaths*. New York: St. Martin's Press; 1960.
95. Hunnisett RF. *The Medieval Coroner*. Cambridge: Cambridge University Press; 1961.
96. The National Archives. *General eyres 1194-1348*. [Online]. Available from: <http://www.nationalarchives.gov.uk/documents/research-guides/general-eyres.pdf>.
97. United Kingdom. *Deodands Act, 9 & 10 Vict., Chapter 62*. London: Her Majesty's Stationery Office; 1846.
98. Riley HT. *Chronicles of the Mayors and Sheriffs: 1257-8, Chronicles of the Mayors and Sheriffs of London: 1188-1274*. 1863. Available from: <http://www.british-history.ac.uk/report.aspx?compid=64825>. [Accessed 15 December 2010].
99. England. *Provisions of Westminster, 43 Hen. III, Chapter 21*. 1258.

100. Brand P. *Kings, barons and justices : the making and enforcement of legislation in thirteenth-century England*. Cambridge: Cambridge University Press; 2003.
101. England. *Justices of the Peace Act*, 34 Edw 3, Chapter 1. 1361.
102. England. *Coroners Act*, 1 Hen. VIII, Chapter 7. 1509.
103. *The Statutes at Large of England and of Great-Britain: from Magna Carta to the Union of the Kingdoms of Great Britain and Ireland*. Raithby J, editor. London: G. Eyre and A. Strahan; 1811.
104. A Bill for the Better Ordering of the Office of the Coroner, (1747-1749).
105. United Kingdom. *Coroners Act*, 25 Geo. II, Chapter 29. 1751.
106. Wecht CH. The history of legal medicine. *Journal of the American Academy of Psychiatry and the Law*. 2005; 33(2): 245-251.
107. Garland AN. Forensic medicine in Great Britain. I. The beginning. *American Journal of Forensic Medicine and Pathology*. 1987; 8(3): 269-272.
108. *Parocial Registration*. Select Committee Report. Report No: 669, 1833.
109. McMenemey WH. Life and death in Shakespeare's London. *BMJ*. 1972; 1(5803): 795-796.
110. United Kingdom. *Births and Deaths Registration Act*, 6 & 7 Will. IV, Chapter 86. London: Her Majesty's Stationery Office; 1836.
111. Office for National Statistics. *Births: 1837-1937*. [Online]. Available from: <http://www.statistics.gov.uk/statbase/Product.asp?vlnk=7205&More=Y>.
112. Porter D. *Health, civilisation and the state : a history of public health from ancient to modern times* London: Routledge; 1999.
113. Rumsey HW. Public health: the right use of records founded on local facts ; being two papers read before the National Association for the Promotion of Social Science, at Bradford, in October 1859, with an account of subsequent proceedings, further remarks and evidence on the main subject, and replies to certain objections. *Knowsley Pamphlet Collection*. 1860.
114. United Kingdom. *Coroners Act*, 6 & 7 Will. IV, Chapter 89. London: Her Majesty's Stationery Office; 1836.

115. Glasgow GHH. The campaign for medical coroners in nineteenth-century England and its aftermath: a Lancashire focus on failure (Part I) (published in two parts). *Mortality*. 2004; 9(2): 150-167.
116. Farr W. Mortality of Children in the Principal States of Europe. *Journal of the Statistical Society of London*. 1866; 29(1): 1-12.
117. Clay J. Burial clubs and infanticide in England: a letter to William Brown, Esq., M.P. for South Lancashire. *Knowsley Pamphlet Collection*. 1853.
118. United Kingdom. *Friendly Societies Act*, 13 & 14 Vict., Chapter 115. London: Her Majesty's Stationery Office; 1850.
119. Collins A. *Burial clubs - the unfriendly societies*. London: The National Archives; 2009.
120. United Kingdom. *Coroners' Inquests Expenses Act*, 1 Vict., Chapter 68. London: Her Majesty's Stationery Office; 1837.
121. United Kingdom. *Evidence Act*, 6 & 7 Vict., Chapter 85. London: Her Majesty's Stationery Office; 1843.
122. United Kingdom. *Sale of Arsenic Regulation Act*, 14 & 15 Vict., Chapter 13. London: His Majesty's Stationery Office; 1851.
123. Anonymous. Court in Ireland for the protection of murderers. *The Lancet*. 1840; 2: p. 932-935.
124. Smith JT. *The Laws of England Relating to Public Health*. London: S. Sweet; 1848.
125. James W. *The Varieties of Religious Experience: A Study in Human Nature* New York: Random House; 1929.
126. Dempsey JJ. The coroner's court, its uses and abuses, with suggestions for reform: addressed to the legislature and the people of the United Kingdom, and dedicated to ... Lord Brougham, and the members of the Law Amendment Society. *Knowsley Pamphlet Collection*. 1859.
127. Richardson R. Coroner Wakley : two remarkable eyewitness accounts. *The Lancet*. 2001; 358(9299): 2150-2154.
128. Cawthon E. Thomas Wakley and the medical coronership--occupational death and the judicial process. *Medical History*. 1986; 30(2): 191-202.
129. Sharp D. Thomas Wakley (1795-1862): a biographical sketch. *Lancet*. 2012.
130. Wakley T. The Lancet. *The Lancet*. 1841; 1(1): 400-413.

131. McEgan WB. Questions relating to the evidence of medical witnesses at coroners' inquests. *The Lancet*. 1841; 1: 437-438.
132. United Kingdom. *Fatal Accidents Act*, 9 & 10 Vict., Chapter 93. London: Her Majesty's Stationery Office; 1846.
133. Glasgow GHH. The campaign for medical coroners in nineteenth-century England and its aftermath: a Lancashire focus on failure. Part II. *Mortality*. 2004; 9(3): 223-234.
134. Lankester E. What shall we teach? or, Physiology in schools: being an attempt to advocate instruction in the laws of life as a branch of general education. *Cowen Tracts*. 1870.
135. *Report from the Select Committee on Coroners*. House of Commons Papers (Reports of Committees). Report No: 584, 1851.
136. *Report from the Select Committee on the Office of Coroner*. House of Commons Papers (Reports of Committees). Report No: 193, 1860.
137. Ridley M. *Special report from the Select Committee on Coroners Bill*. House of Commons Papers (Reports of Committee). Report No: 279, 1878-79.
138. United Kingdom. *Coroners Act*, 50 & 51 Vict., Chapter 71. London: Her Majesty's Stationery Office; 1887.
139. England. *Engleschrie Act*, 14 Edw. III, Chapter 4. 1340.
140. United Kingdom. *Local Government Act*, 51 & 52 Vict., Chapter 41. London: Her Majesty's Stationery Office; 1888.
141. United Kingdom. *Coroners (Amendment) Act*, 16 & 17 Geo. V, Chapter 59. London: His Majesty's Stationery Office; 1926.
142. Chalmers MD. *Coroners' Committee. Report of inquiry into the question of the danger arising from the use of flannelette for articles of clothing*. Report No: Cm 5376, 1910.
143. Chalmers MD. *Coroners' Committee. Report of inquiry into the question of deaths resulting from the administration of anaesthetics*. Report No: Cm 5111, 1910.
144. Chalmers MD. *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. Part II. Evidence*. Report No: Cm 5139, 1910.
145. Chalmers MD. *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. Part I. Report*. Report No: Cm 5004, 1910.

146. United Kingdom. *Births and Deaths Registration Act*, 16 & 17 Geo. V, Chapter 48. London: His Majesty's Stationery Office; 1926.
147. Shiel J. The Departmental Committee on Coroners (Correspondence). *BMJ*. 1936; 1(3920): p. 389.
148. Hansard HL, *Coroners*. 15 April 1937, col. 948-956
149. London. *Coroners Rules 1953*, SI 205. The Stationery Office; 1953.
150. Editorial: Coroners and the public interest. *BMJ*. 1974; 3(5927): 374.
151. Robinson JS, Wise CC. Letter: Coroners and the public interest. *BMJ*. 1974; 4(5936): 103.
152. United Kingdom. *Coroners Act*, 2 & 3 Eliz. II, Chapter 31. London: Her Majesty's Stationery Office; 1954.
153. Republic of Ireland. *Coroners Act (Ire)*, 9 & 10 Vict., Chapter 37. 1846.
154. UK. *Coroners Act (Northern Ireland)*, Chapter 15 (NI). London: Her Majesty's Stationery Office; 1959.
155. Pascoe N. Obituary: Judge Norman Brodrick. *The Independent*. [Online] 15 July 1992. Available from: <http://www.independent.co.uk/news/people/obituary-judge-norman-brodrick-1533421.html> [Accessed 17 January 2012].
156. Editorial: Whatever happened to Brodrick? *BMJ*. 1974; 1(5908): 589-590.
157. Havard JDJ. Letter: Whatever happened to Brodrick? *BMJ*. 1974; 2(5910): 117-118.
158. Kerr D. Letter: Whatever happened to Brodrick? *BMJ*. 1974; 2(5910): 117.
159. United Kingdom. *Criminal Law Act*, Eliz II, Chapter 58. London: Her Majesty's Stationery Office; 1977.
160. Cordner SM, Loff B. 800 years of coroners: have they a future? *The Lancet*. 1994; 344(8925): 799-801.
161. *R v Poplar Coroner ex p Thomas sum nom R v Inner North London Coroner ex p Thomas*, [1993] QB 610.
162. London. *Coroners Rules 1956*, SI 1691. The Stationery Office; 1956.
163. London. *Coroners (Amendment) Rules 1974*, SI 2128. The Stationery Office; 1974.

164. London. *Coroners (Amendment) Rules 1977*, SI 1881. The Stationery Office; 1977.
165. London. *Coroners (Amendment) Rules 1980*, SI 557. The Stationery Office; 1980.
166. United Kingdom. *Coroners (Amendment) Act*, SI 1539. London: Her Majesty's Stationery Office; 1983.
167. Cooper H, Leigh MA, Lucas S, Martin I. The coroner's autopsy. The final say in establishing cause of death? *The Medico-legal Journal*. 2007; 75(Pt 3): 114-119.
168. London. *Coroners (Amendment) Rules 2004*, SI 921. The Stationery Office; 2004.
169. London. *Coroners (Amendment) Rules 2005*, SI 420. The Stationery Office; 2005.
170. London. *Coroners (Amendment) Rules 2008*, SI 1652. The Stationery Office; 2008.
171. London. *Coroners (Amendment) Rules 2010*, SI 564. The Stationery Office; 2010.
172. United Kingdom. *Human Tissue Act*, Eliz II, Chapter 30. London: The Stationery Office; 2004.
173. Hansard HC, *Coroners (Amendment) Act 2008*. 26 June 2008, Col. 37WS.
174. *Guidance for coroners on changes to Rule 43: Coroner reports to prevent future deaths*. Ministry of Justice. 2009.
175. *Summary of Reports Under Rule 43 of the Coroners Rules, and Responses (July 2009)*. Ministry of Justice. 2009.
176. *Summary of Reports and Responses Under Rule 43 of the Coroners Rules (March 2010)*. Ministry of Justice. 2010.
177. *Summary of Reports and Responses Under Rule 43 of the Coroners Rules (Sept 2010)*. Ministry of Justice. 2010.
178. *Summary of Reports and Responses Under Rule 43 of the Coroners Rules (March 2011)*. Ministry of Justice. 2011.
179. *Summary of Reports Under Rule 43 of the Coroners Rules, and Responses (Sept 2011)*. Ministry of Justice. 2011.
180. *Summary of Reports and Responses under Rule 43 of the Coroners Rules (May 2012)*. Ministry of Justice. 2012.
181. Bugeja L, Ranson D. Coroners' recommendations: do they lead to positive public health outcomes? *Journal of Law and Medicine*. 2003; 10(4): 399-400.

182. Bugeja L, Ranson D. Coroners' recommendations: a lost opportunity. *Journal of Law and Medicine*. 2005; 13(2): 173-175.
183. Brodie L, Bugeja L, Ibrahim J. Coroners' recommendations following fatal heavy vehicle crash investigations. *Australian and New Zealand Journal of Public Health*. 2010; 34(2): 136-141.
184. *Reform of the Coroner System: Next Stage - Preparing for Implementation (Response to Consultation)*. Ministry of Justice. Report No: CP(R) CP/06/10, 2010.
185. Hansard HC, *Coroners*. 11 Mar 2010, col. WS29.
186. Bernstein J. Secondary Legislation
187. Bracton H, Woodbine GE. *De legibus et consuetudinibus Angliae*. New Haven: Yale University Press; 1915.
188. De Officio Coronatoris. *The Lancet*. 1927; 210(5428): 559-559.
189. England. *De Officio Coronatoris (Office of the Coroner Act)*, 4 Edw. I. 1276.
190. Broadbent G. *Public Law*. Oxford: Oxford University Press; 2009.
191. Roberts IS, Gorodkin LM, Benbow EW. What is a natural cause of death? A survey of how coroners in England and Wales approach borderline cases. *Journal of Clinical Pathology*. 2000; 53(5): 367-373.
192. *R v HM Coroner for Inner North London ex parte Touche*, [2001] EWCA Civ 383.
193. The Times. Government resists demands for judges to conduct inquests. *The Times*. [Online] 19 October 1981. Available from: [Accessed 17 January 2012].
194. *R v South London Coroner ex p Thompson*, [1982] 126 SJ 625.
195. *R v North Humberside & Scunthorpe Coroner ex parte Jamieson* [1995] QB 1.
196. *R (Takoushis) v HM Coroner for Inner North London*, [2005] EWCA Civ 1440.
197. European Court of Human Rights. *Convention for the Protection of Human Rights and Fundamental Freedoms*. 1950. [Online]. Available from: <http://www.echr.coe.int/nr/rdonlyres/d5cc24a7-dc13-4318-b457-5c9014916d7a/0/englishanglais.pdf>. [Accessed 18 January 2012].
198. *McCann v UK*, [1996] 21 EHRR 97.
199. *Osman v. United Kingdom*, [1998] 29 EHRR 245.

200. *Jordan v UK*, [2003] 37 EHRR 52.
201. BBC. Provisional date set for IRA man's inquest. *BBC News Northern Ireland*. [Online] 24 February 2011. Available from: <http://www.bbc.co.uk/news/uk-northern-ireland-12567776> [Accessed 17 January 2012].
202. Telegraph TB. New evidence delays Jordan inquest. *The Belfast Telegraph*. [Online] 23 September 2011. Available from: <http://www.belfasttelegraph.co.uk/news/local-national/northern-ireland/new-evidence-delays-jordan-inquest-16054305.html> [Accessed 17 January 2012].
203. *R (on the application of Middleton) v West Somerset Coroner* [2004] 2All ER 465
204. *R v HM Coroner for the Western District of Somerset (Respondent) and another (Appellant) ex p Middleton (FC) (Respondent)*, [2004] UKHL 10.
205. *R v Secretary of State for the Home Department (Respondent) ex parte Amin (FC) (Appellant)* [2003] UKHL 51.
206. *Report of the Zahid Mubarek Inquiry*. House of Commons. Report No: HC 1082-II, 2006.
207. *R v HM Coroner for the County of West Yorkshire ex parte Sacker*, [2004] UKHL 11
208. Clothier C. *The Allitt Inquiry: Independent inquiry relating to deaths and injuries on the children's ward at Grantham and Kesteven General Hospital during the period February to April 1991*. Department of Health. 1994.
209. Redfern M. *The Royal Liverpool Children's Inquiry: Report*. The Royal Liverpool Children's Inquiry. 2001.
210. United Kingdom. *Human Tissue Act*, 9 & 10 Eliz II, Chapter 54. London: Her Majesty's Stationery Office; 1961.
211. Redfern M. *The Royal Liverpool Children's Inquiry: Summary & Recommendations*. The Royal Liverpool Children's Inquiry. 2001.
212. Hansard HC, *Royal Liverpool Children's Inquiry*. 30 January 2001, col. 175-178.
213. Metters JS. *Isaacs report: The investigation of events that followed the death of Cyril Mark Isaacs*. HM Inspector of Anatomy, Department of Health. 2003.
214. *Isaacs Report Response*. Department of Health, Home Office, and the Department for Education and Skills. 2003.

215. Clarke LJ. *Public inquiry into the identification of victims following major transport accidents : report of Lord Justice Clarke (Volume 2)*. The Stationery Office. Report No: Cm 5012, 2001.
216. Clarke A, Gladwin J. *Improving the health of the living? An Investigation into death certification and coronial services and some suggestions for change (Report from the London School of Hygiene & Tropical Medicine to The Fundamental Review of Death Certification and the Coroner Services in England, Wales and Northern Ireland)*. London School of Hygiene & Tropical Medicine. 2003.
217. Hamilton C. GP charged with patient's murder *The Independent*. [Online] 26 August 2009. Available from: <http://www.independent.co.uk/news/gp-charged-with-patients-murder-1196704.html> [Accessed 17 January 2012].
218. The Shipman Inquiry. *Terms of Reference*. [Online]. Available from: http://www.the-shipman-inquiry.org.uk/bg_termsoref.asp.
219. United Kingdom. *Tribunals of Inquiry (Evidence) Act* c.7. 1921.
220. Swift C. The Shipman inquiry: a progress report. *Medicine, Science and the Law*. 2003; 43(3): 188-192.
221. Smith J. *The Shipman Inquiry: Second Report (The Police Investigation of March 1998)*. The Shipman Inquiry. Report No: Cm 5853, 2003.
222. *Society Response to the Publication of Home Office Review Team Report under the chairmanship of Tom Luce* The Coroners' Society of England and Wales. 2003.
223. *Response to the Third Shipman Inquiry Report*. The Coroners' Society of England and Wales, 2003.
224. Milroy CM, Whitwell HL. Reforming the coroner's service. *BMJ*. 2003; 327(7408): 175-176.
225. Coles D, Shaw H. *INQUEST Annual Report 2003*. INQUEST. 2004.
226. Young JG. Speaking for the dead to protect the living: the role of the coroner and the Shipman Inquiry. *British Journal of General Practice*. 2004; 54(500): 162-163.
227. Baker R. Making haste slowly: the response to the Shipman Inquiry? *British Journal of General Practice*. 2008; 58(550): 307-308.
228. Reisner C. What are coroners and pathologists for? *BMJ*. 2009; 338(7698): 835-835.
229. *A national human post-mortem tissue archive to study the prevalence of abnormal prion protein*. Health Protection Agency. 2007.

230. Phillips MJ, Bridgeman J, Ferguson-Smith M. *The BSE Inquiry: Findings and Conclusions*. 2000.
231. Dato V, Shephard R, Wagner M. Outbreaks and Investigations. In: Wagner M, Moore AW, Aryel R, editors. *Handbook of Biosurveillance*. London: Elsevier Academic Press; 2006. p. 13-26.
232. Smith PG, Bradley R. Bovine spongiform encephalopathy (BSE) and its epidemiology. *British Medical Bulletin*. 2003; 66: 185-198.
233. Llewelyn CA, Hewitt PE, Knight RS, Amar K, Cousens S, Mackenzie J, et al. Possible transmission of variant Creutzfeldt-Jakob disease by blood transfusion. *The Lancet*. 2004; 363(9407): 417-421.
234. Peden AH, Head MW, Ritchie DL, Bell JE, Ironside JW. Preclinical vCJD after blood transfusion in a PRNP codon 129 heterozygous patient. *The Lancet*. 2004; 364(9433): 527-529.
235. University of Edinburgh. *The National Creutzfeldt-Jakob Disease Surveillance Unit (NCJDSU)*. [Online]. Available from: <http://www.cjd.ed.ac.uk/>.
236. Bishop MT, Hart P, Aitchison L, Baybutt HN, Plinston C, Thomson V, et al. Predicting susceptibility and incubation time of human-to-human transmission of vCJD. *The Lancet Neurology*. 2006; 5(5): 393-398.
237. Clarke P, Ghani AC. Projections of the future course of the primary vCJD epidemic in the UK: inclusion of subclinical infection and the possibility of wider genetic susceptibility. *Journal of the Royal Society Interface*. 2005; 2(2): 19-31.
238. *Position Statement - Prevalence of Subclinical Variant Creutzfeldt-Jakob Disease Infections*. Spongiform Encephalopathy Advisory Committee. 2008.
239. BBC. Call for tests after sudden death *BBC News*. [Online] 7 November 2009. Available from: <http://news.bbc.co.uk/1/hi/health/8346901.stm> [Accessed 17 January 2012].
240. Womack C, Jack AL. Family attitudes to research using samples taken at coroner's postmortem examinations: review of records *BMJ*. 2003; 327: 781-782.
241. Thayyil S, Robertson NJ, Scales A, Weber MA, Jacques TS, Sebire NJ, et al. Prospective parental consent for autopsy research following sudden unexpected childhood deaths: a successful model. *Archives of Disease in Childhood*. 2009; 94(5): 354-358.
242. *Advisory Committee on Dangerous Pathogens TSE Risk Assessment Subgroup (The 1st meeting of the ACDP TSE Risk Assessment Subgroup was held on 14th July 2011 in Wellington House, Department of Health, London)*. [Online]. Available from:

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@ab/documents/digitalasset/dh_129920.pdf.

243. *Reforming the Coroner and Death Certification Service: A Position Paper*. Home Office. Report No: Cm 6159, 2004.
244. Harman H. *Reform of the coroners' system (Oral ministerial statement)*. Department for Constitutional Affairs. 2006.
245. *Coroner Reform: The Government's Draft Bill*. Department for Constitutional Affairs. Report No: Cm 6849, 2006.
246. *Draft Coroners Bill: Regulatory Impact Assessment*. Department for Constitutional Affairs. 2006.
247. *Consultation on Improving the Process of Death Certification*. Department of Health. 2007.
248. Baker R, Cordner S. Reform of investigation of deaths. *BMJ*. 2006; 333(7559): 107-108.
249. *Reform of the Coroners' System and Death Certification*. The Constitutional Affairs Committee. Report No: HC 902-I, 2006.
250. *Coroner Reform: The Government's Draft Bill (Response from the BMA)*. British Medical Association. 2006.
251. CSEW. *Coroner Reform: The Government's Draft Bill (Response from CSEW)*. Coroners' Society of England and Wales. 2006.
252. *Coroner Reform: The Government's Draft Bill (Response from the COA)*. The Coroner's Officers Association. 2006.
253. *Coroner Reform: The Government's Draft Bill (Response from INQUEST)*. INQUEST. 2006.
254. Crossman G, Johnson G. *Coroner Reform: The Government's Draft Bill* The National Council for Civil Liberties. 2006.
255. Essential reforms still elude the UK coroner system. *The Lancet*. 2006; 368(9546): 1468.
256. *Reform of the Coroners' System and Death Certification: Government Response to the Constitutional Affairs Select Committee's Report*. Secretary of State for Constitutional Affairs and Lord Chancellor. Report No: Cm 6943, 2006.

257. Opinion Leader Research. *Draft Coroners Bill: Analysis of Scrutiny by Bereaved People's Panel* Department for Constitutional Affairs. 2007.
258. *Coroner Reform: The Government's Draft Bill (Response to Consultation)*. Department for Constitutional Affairs. Report No: Cm 6849, 2007.
259. *Coroners Bill: Changes Made Resulting from Consultation* Ministry of Justice. 2008.
260. The Prime Minister's Office. *Queen's Speech, Coroners and Justice Bill*. Number10govuk. London. 2008.
261. United Kingdom. *Coroners and Justice Bill (Bill as Introduced)*, Bill 9. London: The Stationery Office; 2009.
262. United Kingdom. *Coroners and Justice Bill*, HC 185. London: The Stationery Office; 2009.
263. United Kingdom. *Coroners and Justice Bill (Bill as brought from the Commons)*, HL Bill 33. London: The Stationery Office; 2009.
264. Dyer C. Reform of death certificate system doesn't go far enough, says Shipman inquiry judge. *BMJ*. 2009; 338: b660.
265. *Reform of the Coroner System: Next Stage - Preparing for implementation (Consultation Paper)*. Ministry of Justice. Report No: CP06/10, 2010.
266. Lucas SB, Cooper H, Emmett S, Hargreaves C, Mason MJ. *The Coroner's Autopsy: Do we deserve better?* National Confidential Enquiry into Patient Outcome and Death. 2006.
267. BBC. Quango list shows 192 to be axed. *BBC News*. [Online] 14 October 2010. Available from: <http://www.bbc.co.uk/news/uk-politics-11538534> [Accessed 17 January 2012].
268. The Independent. Bonfire of the quangos: bodies to be abolished. *The Independent*. [Online] 15 October 2010. Available from: <http://www.independent.co.uk/news/uk/politics/bonfire-of-the-quangos-bodies-to-be-abolished-2107709.html> [Accessed 17 January 2012].
269. Directgov. *Public Bodies Reform – Proposals for Change*. [Online]. Available from: http://www.direct.gov.uk/prod_consum_dg/groups/dg_digitalassets/@dg/@en/documents/digitalasset/dg_191543.pdf.
270. Gibby E. Deputy Director responsible for Coroners, Burials and Legal Services Regulation and Redress, Ministry Of Justice. Personal Communication. 16 October 2010.
271. Rebello A. *Written Ministerial Statement laid before Parliament this morning* The Coroners' Society of England and Wales. 2010.

272. *Bereaved People Failed by Government Plans to Jettison Chief Coroner in Bonfire of the Quangos*. INQUEST. 2010.
273. Luce T. Coroners and death certification law reform: the Coroners and Justice Act 2009 and its aftermath. *Medicine, Science and the Law*. 2010; 50(4): 171-178.
274. Hansard HL, *Public Bodies Bill*. 14 December 2010.
275. Hansard HC, *Public Bodies Bill*. 25 October 2011.
276. Kirkup J. Lords reject Coalition 'betrayal' of Forces families. *The Telegraph*. [Online] 16 December 2010. Available from: <http://www.telegraph.co.uk/news/newstoppers/politics/8202228/Lords-reject-Coalition-betrayal-of-Forces-families.html> [Accessed 17 January 2012].
277. *The draft Charter for the current coroner service: Consultation Paper*. Ministry of Justice. Report No: CP 5/2011, 2011.
278. *Charter for current coroner services: Response to consultation*. Ministry of Justice. Report No: CP(R) 5/2011, 2011.
279. *Guide to Coroners and Inquests and Charter for coroner services [Canllaw ar gyfer Crwneriaid a Chwestau a Siarter ar gyfer Gwasanaethau Crwneriaid]*. Ministry of Justice. 2012.
280. BBC. Clarke U-turn over scrapping of chief coroner *BBC News*. [Online] 22 November 2011. Available from: <http://www.bbc.co.uk/news/uk-politics-15847352> [Accessed 17 January 2012].
281. Smales D. Chief Coroner Announcement
282. Walker R, editor. *Applied Qualitative Research*. London: Gower; 1985.
283. Green J, Thorogood N. *Qualitative Methods for Health Research*. Silverman D, editor. London: SAGE Publications; 2004.
284. Seigler V, Langford A, Johnson B. Regional differences in male mortality inequalities using the National Statistics Socio-economic Classification, England and Wales, 2001-03. *Health Statistics Quarterly*. 2008.
285. Office for National Statistics. *Regional Household Income*. [Online]. Available from: <http://www.statistics.gov.uk/cci/nugget.asp?id=1552>.
286. Department for Education. *Children, Education and Skills: In Your Area*. [Online]. Available from: <http://www.dcsf.gov.uk/rsgateway/DB/STA/t000280/index.shtml>.
287. *Labour Force Survey*. Office for National Statistics. 2004.

288. Office for National Statistics. *National and Regional Rankings: Population*. [Online]. Available from: http://www.statistics.gov.uk/census2001/profiles/rank/rank_population.asp.
289. *Indications of Public Health in the English Regions: Older people*. The Association of Public Health Observatories. Report No: 9, 2008.
290. Office for National Statistics. *National and Regional Rankings: Work*. [Online]. Available from: http://www.statistics.gov.uk/census2001/profiles/rank/rank_work.asp.
291. *Indications of Public Health in the English Regions*. The Association of Public Health Observatories. Report No: 1(1), 2003.
292. *Indications of Public Health in the English Regions: Lifestyle and its impact on health*. The Association of Public Health Observatories. Report No: 3, 2005.
293. *Indications of Public Health in the English Regions: Ethnicity and health*. The Association of Public Health Observatories. Report No: 4, 2005.
294. *Indications of Public Health in the English Regions: Child health*. The Association of Public Health Observatories. Report No: 5, 2006.
295. *Indications of Public Health in the English Regions: Sexual health*. The Association of Public Health Observatories. Report No: 6, 2006.
296. *Indications of Public Health in the English Regions: Mental health*. The Association of Public Health Observatories. Report No: 7, 2007.
297. *Indications of Public Health in the English Regions: Alcohol*. The Association of Public Health Observatories. Report No: 8, 2007.
298. *Indications of Public Health in the English Regions: Drug use*. The Association of Public Health Observatories. Report No: 10, 2009.
299. Flatley J, Kershaw C, Smith K, Chaplin R, Moon De. *Crime in England and Wales 2009/10*. Home Office. Report No: Home Office Statistical Bulletin 12/10, 2010.
300. *Experimental Statistics: Integrated Household Survey*. Office for National Statistics. 2010.
301. Marmot M. *Fair Society, Healthy Lives: The Marmot Review*. 2010.
302. *Tackling Health Inequalities: A Programme for Action*. Department of Health. 2003.
303. Ministry of Justice. *HM Prison Service: Prisons map*. London: MH Prison Service; 2010. Available from:

http://www.hmprisonservice.gov.uk/assets/documents/10004ADFprisonsonlymap_A3.pdf.

304. Kazmer M, Xie B. Qualitative Interviewing in Internet Studies: Playing with the media, playing with the method. *Information, Communication & Society*. 2008; 11(2): pp. 257-278.
305. Green J. Multi-method and multi-disciplinary approaches. In: Green J, Browne J, editors. *Principles of Social Research*. Maidenhead: Open University Press; 2008. p. 156-164.
306. NatCen Social Research. *NatCen: Social Research that Works for Society*. [Online]. Available from: <http://www.natcen.ac.uk/>.
307. Canada. *Fatality Inquiries Act*, Revised Statutes of Alberta, Chapter F-9. Edmonton: Alberta Queen's Printer; 2000.
308. Ministry of Justice and Attorney General. *Medical Investigator - Job Description*. Edmonton, Canada. 17 March 2011.
309. Csete J, Cohen J. Abusing the User: Police Misconduct, Harm Reduction and HIV/AIDS in Vancouver. *Human Rights Watch*. 2003; Vol. 15(No. 2(B)).
310. Eby D. The political power of police and crackdowns: Vancouver's example. *International Journal of Drug Policy*. 2006; 17(2): 96-100.
311. Marshall BDL, Milloy MJ, Wood E, Montaner JSG, Kerr T. Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: a retrospective population-based study. *The Lancet*. 2011; In Press, Corrected Proof.
312. Cain V. *Report of the Task Force Into Illicit Narcotic Overdose Deaths in British Columbia*. Office of the Chief Coroner of British Columbia. 1994.
313. Wood E, Werb D, Marshall BDL, Montaner JSG, Kerr T. The war on drugs: a devastating public-policy disaster. *The Lancet*. 2009; 373(9668): 989-990.
314. deBeck K, Wood E, Montaner J, Kerr T. Canada's 2003 renewed drug strategy--an evidence-based review. *HIV/AIDS Policy and Law Review*. 2006; 11(2-3): 1, 5-12.
315. Kobayashi A, Ray B. Civil risk and landscapes of marginality in Canada: a pluralist approach to social justice. *Canadian Geographer / Le Géographe canadien*. 2000; 44(4): 401-417.
316. Schatz D. *Unsettling the Politics of Exclusion: Aboriginal Activism and the Vancouver Downtown East Side*. Annual Meeting of the Canadian Political Science Association; Montreal. 2010.

317. CBC News. Crown lays out grisly case against Pickton. *CBC News*. [Online] 23 January 2007. Available from: <http://www.cbc.ca/news/canada/british-columbia/story/2007/01/22/pickton-trial.html> [Accessed 17 January 2012].
318. Missing Women Commission of Inquiry, Vancouver. 08 November 2011. Available from: <http://www.missingwomeninquiry.ca/wp-content/uploads/2010/10/November-8-20111.pdf>. [Accessed 18 January 2012].
319. *BC Coroners Service warns of rise in heroin-related deaths (Information Bulletin)*. Ministry of Public Safety and Solicitor General. Report No: 2011PSSG0059-000493, 2011.
320. McGowan C. *The Psychodynamics of Death Investigation: A case study of the Office of the Chief Coroner for Ontario, Canada*. Cape Town: University of Cape Town; 2005.
321. Canada. *Coroners Act*, Revised Statute of Ontario, Chapter 37. Toronto: Queen's Printer for Ontario; 1990.
322. *First Report of the Select Committee on Death Certification*. Report No: (373) XI. 195, 1893-4.
323. *Safeguarding Patients: The Government's response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries*. Department of Health. Report No: Cm 7015, 2007.
324. *Summary of Responses to the Consultation on Improving the Process of Death Certification*. Department of Health. 2008.
325. Alderson MR, Bayliss RI, Clarke CA, Whitfield AG. Death certification. *BMJ*. 1983; 287(6390): 444-445.
326. Maudsley G, Williams EM. Death certification by house officers and general practitioners--practice and performance. *Journal of Public Health Medicine*. 1993; 15(2): 192-201.
327. Weeramanthri TS. Reporting deaths to the coroner. Death certification needs urgent overhaul. *BMJ*. 1993; 306(6891): 1539-1540.
328. Maudsley G, Williams L. Death certification--a sad state of affairs. *Journal of Public Health Medicine*. 1994; 16(3): 370-371.
329. Maudsley G, Williams EM. 'Inaccuracy' in death certification--where are we now? *Journal of Public Health Medicine*. 1996; 18(1): 59-66.
330. Parker M. Certification of cause of death in patients dying soon after proximal femoral fracture: Mortality inferred from death certificates reflects coroners' practice, not the true mortality. *BMJ*. 1996; 313(7061): 879; author reply 879-880.

331. Ruddy GN, Duerden RM, Carter N, Clark JC. Are coroners' necropsies necessary? A prospective study examining whether a "view and grant" system of death certification could be introduced into England and Wales. *Journal of Clinical Pathology*. 2001; 54(4): 279-284.
332. Dyer C. Shipman inquiry calls for major changes in death certification. *BMJ*. 2002; 325(7370): 919.
333. Leadbeatter S, James D, Davison A. Are coroners' necropsies necessary? A prospective study examining whether a "view and grant" system of death certification could be introduced into England and Wales. *Journal of Clinical Pathology*. 2002; 55(11): 878-879.
334. Ranson D. Review of death investigation and certification in the United Kingdom. *Journal of Law and Medicine*. 2002; 10(2): 155-157.
335. Swift B, West K. Death certification: an audit of practice entering the 21st century. *Journal of Clinical Pathology*. 2002; 55(4): 275-279.
336. Berry C. Death Certification and Dr Shipman. *Medicine, Science and the Law*. 2003; 43(3): 193-194.
337. Gladwin J, Clarke A. Information Management Strategies and Death Certification in the UK. *Health Informatics Journal*. 2003; 9(4): 283-300.
338. Hasleton P. Reforming the coroner and death certification service. *Current Diagnostic Pathology*. 2004; 10(6): 453-462.
339. Luce T. Certifying and investigating deaths: the need for reform. 2. Death certification and the coroner service. *Medicine, Science and the Law*. 2004; 44(4): 287-294.
340. Smith DJ. Certifying and investigating deaths: the need for reform. 1. The shipman inquiry-death certification. *Medicine, Science and the Law*. 2004; 44(4): 280-287.
341. Godwin TA. End of life: natural or unnatural death investigation and certification. *Disease-a-Month*. 2005; 51(4): 218-277.
342. Sinfield P, Wilson A. Death certification: issues from a pilot of the Shipman Inquiry's interim proposals. *Health Statistics Quarterly*. 2005; (26): 23-32.
343. British Medical Association. *Death certification reforms impossible within current resources, says BMA*. 16 May 2006. Available from: <http://www.bma.org/pressrel.nsf/wlu/STRE-6PTE7N?OpenDocument&vw=wfmms>. [Accessed 12 April 2008].
344. Luce T. Reform of the coroner system and death certification. *BMJ*. 2007; 335(7622): 680-681.
345. Ellis P. Inquest and death certification update. *Clinical Risk*. 2009; 15(2): 76-82.

346. *Improving the process of death certification in England and Wales: overview of programme.* Department of Health. Report No: 10797, 2008.
347. Fletcher AK, Dorries CP, Clayson I, da Costa DF. *Improving the Death Certification Process: The Sheffield medical examiner pathfinder pilot.* [Online]. Available from: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_087826.pdf.
348. *How the inquest system fails bereaved people: INQUEST's Response to the Fundamental Review of Coroner Services.* INQUEST. 2002.
349. Evening Post. Avon coroner suspended while complaint is investigated. *Evening Post.* [Online] 21 March 2009. Available from: <http://www.thisisbristol.co.uk/news/Avon-coroner-suspended-complaint-investigated/article-787228-detail/article.html> [Accessed 17 January 2012].
350. Matthews P. *Jervis on the Office and Duties of Coroners (Twelfth Edition).* London: Sweet & Maxwell Limited; 2002.
351. Hill C, Cook L. Narrative verdicts and their impact on mortality statistics in England and Wales. *Health Statistics Quarterly.* 2011; (49): 81-100.
352. *International Statistical Classification of Diseases and Related Health Problems (ICD-10).* World Health Organization. 2010.
353. Bingham T. *The Rule of Law.* London: Penguin Books; 2011.
354. The Commonwealth Secretariat. *Commonwealth (Latimer House) Principles on the Three Branches of Government.* 2004. [Online]. Available from: http://www.thecommonwealth.org/shared_asp_files/uploadedfiles/%7BACC9270A-E929-4AE0-AEF9-4AAFEC68479C%7D_Latimer%20House%20Booklet%20130504.pdf. [Accessed 18 January 2012].
355. Judicial Group on Strengthening Judicial Integrity. *The Bangalore Principles of Judicial Conduct.* 2002. [Online]. Available from: http://www.ajs.org/ethics/pdfs/Bangalore_principles.pdf. [Accessed 18 January 2012].
356. Office of the United Nations Commissioner for Human Rights. *Basic Principles on the Independence of the Judiciary.* 1985. [Online]. Available from: <http://www2.ohchr.org/english/law/indjudiciary.htm>. [Accessed 18 January 2012].
357. *R v Inner West London Coroner Ex parte Dallaglio and another,* [1994] 4 All E.R. 139.
358. Biddle L. Public hazards or private tragedies? An exploratory study of the effect of coroners' procedures on those bereaved by suicide. *Social Science and Medicine.* 2003; 56(5): 1033-1045.

359. Autopsies—why families count too. *BMJ*. 2010; 340.
360. Millar T, Walker R, Arango JC, Ironside JW, Harrison DJ, MacIntyre DJ, et al. Tissue and organ donation for research in forensic pathology: the MRC Sudden Death Brain and Tissue Bank. *Journal of Pathology*. 2007; 213(4): 369-375.
361. Wexler DB, Winick BJ. *Law in Therapeutic Key: Developments in Therapeutic Jurisprudence*. Durham, NC: Carolina Academic Press; 1996.
362. *R v Birmingham Coroner ex parte Benton* [1998] 162 JP 807.
363. Hansard HL, *Public Bodies Bill*. 11 October 2011.
364. *INQUEST Briefing on coronial reform October 2011*. INQUEST. 2011.
365. Carroll R, Hawton K, Kapur N, Bennewith O, Gunnell D. Impact of the growing use of narrative verdicts by coroners on geographic variations in suicide: analysis of coroners' inquest data. *Journal of Public Health (Oxf)*. 2011.
366. Stanistreet D, Gabbay M, Jeffrey V, Taylor S. Are Deaths Due to Drug Use Among Young Men Underestimated in Official Statistics? *Drugs: Education, Prevention & Policy*. 2004; 11(3): 229-242.
367. *Reducing Drug Related Deaths: A report by the advisory council on the misuse of drugs*. The Advisory Council on the Misuse of Drugs. 2000.
368. Moss R. Call for coroner to resign over Teesside inquest delays. *BBC News*. [Online] 22 July 2011. Available from: <http://www.bbc.co.uk/news/uk-england-14252396> [Accessed 17 January 2012].
369. *A Dictionary of Epidemiology*. Fourth Edition ed. Last JM, editor. Oxford: Oxford University Press; 2001.
370. Tarling R. *Coroner Service Survey: A Research and Statistics Directorate Report*. Home Office Report No: Home Office Research Study 181, 1998.
371. Ruttly JE. Her Majesty's coroners and home office forensic pathologists perception of the nurses' role in the coroner's enquiry. *International Journal of Nursing Studies*. 2000; 37(4): 351-359.
372. United Kingdom. *Freedom of Information Act*, Eliz II, Chapter 36. London: The Stationery Office; 2000.
373. Bugeja L, Ibrahim J, Brodie L. Occupational death investigation and prevention model for coroners and medical examiners. *Injury Prevention*. 2010; 16(1): 2-6.

374. Stack S. Suicide in the media: a quantitative review of studies based on non-fictional stories. *Suicide and Life-Threatening Behavior*. 2005; 35(2): 121-133.
375. Diekstra RF, Gulbinat W. The epidemiology of suicidal behaviour: a review of three continents. *World Health Statistics Quarterly/Rapport Trimestriel de Statistiques Sanitaires Mondiales*. 1993; 46(1): 52-68.
376. Hassan R. Effects of newspaper stories on the incidence of suicide in Australia: a research note. *Australian and New Zealand Journal of Psychiatry*. 1995; 29(3): 480-483.
377. *Review of Forensic Pathology Services in England and Wales*. Home Office. 2003.
378. Ministry of Justice. *Statistics on deaths reported to coroners in England and Wales, 2008* Ministry of Justice. 2009.
379. Ministry of Justice. *Statistics on deaths reported to coroners in England and Wales, 2009*. 2010.
380. Ministry of Justice. *Coroners Statistics 2010 England and Wales*. 2011.
381. Ministry of Justice. *Coroners Statistics 2011 England and Wales*. 2012.
382. *Death Certification Reforms: New Duty on Local Authorities*. Department of Health. 2011.
383. *R on the application of Amin v Secretary of State for the Home Department*, [2004] 1 AC 653.
384. *L.C.B. v. The United Kingdom*, [1998] 27 EHRR 212.
385. *Öneriyildiz v Turkey*, [2004] 41 EHRR 20.
386. Bailey L, Vardulaki K, Langham J, Chandramohan D. *Introduction to Epidemiology*. Black N, Raine R, editors. Oxford: Open University Press; 2006.
387. *INQUEST Briefing on coronial reform June 2011*. INQUEST. 2011.
388. Cardiac Risk in the Young (CRY). *CRY's Coroners and Justice Act Campaign - History*. [Online]. Available from: http://www.c-r-y.org.uk/coronersbillcampaign_history.htm.
389. The Royal British Legion. *Parliamentary Briefing for the Consideration of Commons amendments to the Public Bodies Bill on 23rd November 2011*. The Royal British Legion. 2011.
390. BBC. Open Verdict at Menezes Inquest. *BBC News*. [Online] 12 December 2008. Available from: <http://news.bbc.co.uk/1/hi/uk/7764882.stm> [Accessed 17 January 2012].
391. Tran M. Court overturns inquest ruling on balcony fall death of Liam Hogan. *The Guardian*. [Online] 07 May 2009. Available from:

- <http://www.guardian.co.uk/world/2009/may/07/john-hogan-balcony-inquest> [Accessed 17 January 2012].
392. Dixon L. Inquest verdict on Liam Hogan's death was flawed. *The Sunday Times*. [Online] 02 April 2009. Available from: <http://www.timesonline.co.uk/tol/news/uk/article6018299.ece> [Accessed 17 January 2012].
393. BBC. Avon coroner sacked over mortuary dispute with council. *BBC News Bristol*. [Online] 29 June 2010. Available from: <http://www.bbc.co.uk/news/10455753> [Accessed 17 January 2012].
394. Evening Post. Police investigate complaint from suspended Bristol coroner. *Evening Post*. [Online] 02 April 2009. Available from: <http://www.thisisbristol.co.uk/homepage/Police-investigate-complaint-suspended-Bristol-coroner/article-866991-detail/article.html> [Accessed 17 January 2012].
395. UK Parliament. *Coroners and Justice Bill 2008-09 - Progress of the Bill*. [Online]. Available from: <http://services.parliament.uk/bills/2008-09/coronersandjustice.html>.
396. Umfreville E. *Lex Coronatoria: Or, the Office and Duty of Coroners. In three parts. Wherein the theory of the office is distinctly laid down; and the practice illustrated: Volume II*. London: R. Griffiths and T. Becket; 1761.
397. Jervis J. *A practical treatise on the office and duties of coroners: with an appendix of forms and precedents*. London: S. Sweet; 1829.
398. Hansard HC, *Coroners and Justice Bill (Written evidence)*. 3 February 2009.
399. Ministry of Justice. *A Guide to Coroners and Inquests*. London: Ministry of Justice; 2010. Available from: http://www.direct.gov.uk/prod_consum_dg/groups/dg_digitalassets/@dg/@en/documents/digitalasset/dg_185904.pdf.
400. *Response to the Queen's Speech 2007*. Coroners Society of England and Wales, The. 2007.
401. Simmons J, Legg C, Hosking R. *National Crime Recording Standard (NCRS): an analysis of the impact on recorded crime*. Home Office. 2003.
402. Buse K, Mays N, Walt G. *Making Health Policy*. Black N, Raine R, editors. Maidenhead: Open University Press; 2005.
403. Ministry of Justice. *Ministry of Justice*. [Online]. Available from: <http://www.justice.gov.uk/about/moj/index.htm>.

404. United Kingdom. *Tribunals, Courts and Enforcement Act*, Eliz. II, Chapter 15. London: The Stationery Office; 2007.
405. National Health Service Litigation Authority. *Family Health Services Appeal Unit*. [Online]. Available from: <http://www.nhsla.com/FHSAU/>.
406. *History of Tribunals Reform*. HM Courts and Tribunals Service. 2011.
407. *Departmental Budgets*. HM Treasury. 2011.
408. *Spending Review documents* HM Treasury. 2010.
409. *Healthy Lives, Healthy People: Our strategy for public health in England*. Department of Health. Report No: Cm 7985, 2010.
410. United Kingdom. *Health and Social Care Bill*, HL Bill 92. London: The Stationery Office; 2010-2011.
411. United Kingdom. *National Health Service Act* Eliz II, Chapter 41. London: The Stationery Office; 2006.
412. United Kingdom. *Health and Social Care Bill (Explanatory Notes)*, HL Bill 92. London: The Stationery Office; 2011.
413. Marsland A. Transition Managing Director, Public Health England, Department of Health. Personal communication. 17 March 2011.
414. *Public Health (Volume I)*. House of Commons - Health Committee. Report No: 12 (of Session 2010-2012), 2011.
415. *Public Health (Volume II)*. House of Commons - Health Committee. Report No: 12 (of Session 2010-2012), 2011.
416. Hanzlick R, Parrish RG. The role of medical examiners and coroners in public health surveillance and epidemiologic research. *Annual Review of Public Health*. 1996; 17: 383-409.
417. Minnesota Department of Health. *Medical Examiner Infectious Deaths Surveillance Program (MED-X)*. [Online]. Available from: <http://www.health.state.mn.us/divs/idepc/dtopics/unexplained/me/index.html>.
418. Groenewold MR. Comparison of Two Signal Detection Methods in a Coroner-Based System for near Real-Time Mortality Surveillance. *Public Health Reports*. 2007; 122(4): 521-530.

419. Gaffney BP. Use of Coroner's reports for surveillance of accidental death. *Journal of Public Health Medicine*. 1993; 15(3): 272-276.
420. Aryel R, Wagner M. Coroners and Medical Examiners. In: Wagner M, A. M, Aryel R, editors. *Handbook of Biosurveillance*. Burlington: Academic Press; 2006. p. 179-181.
421. Graitcer PL, Williams WW, Finton RJ, Goodman RA, Thacker SB, Hanzlick R. An evaluation of the use of medical examiner data for epidemiologic surveillance. *American Journal of Public Health*. 1987; 77(9): 1212-1214.
422. Dijkhuis H, Zwerling C, Parrish G, Bennett T, Kemper HC. Medical examiner data in injury surveillance: a comparison with death certificates. *American Journal of Epidemiology*. 1994; 139(6): 637-643.
423. Comstock R, Mallonee S, Jordan F. A comparison of two surveillance systems for deaths related to violent injury. *Injury Prevention*. 2005; 11(1): 58-63.
424. Gardner JW, Cozzini CB, Kelley PW, Kark JA, Peterson MR, Gackstetter GD, et al. The department of defense medical mortality registry. *Military Medicine*. 2000; 165(7 SUPPL.): 57-61.
425. Jason DR. A national survey of postmortem human immunodeficiency virus testing by medical examiners and coroners. *American Journal of Forensic Medicine and Pathology*. 1995; 16(4): 325-332.
426. Lathrop S, Paul I, Schwartz M, Nolte K. Utility of infectious disease coding sheets for surveillance in a state medical examiner's office. *Journal of Forensic Sciences*. 2008; 53(4): 949-951.
427. Logan JE, Karch DL, Crosby AE. Reducing "Unknown" Data in Violent Death Surveillance: A Study of Death Certificates, Coroner/Medical Examiner and Police Reports From the National Violent Death Reporting System, 2003-2004. *Homicide Studies*. 2009; 13(4): 385-397.
428. Nolte K, Lathrop S, Nashelsky M, Nine J, Gallaher M, Umland E, et al. "Med-X": a medical examiner surveillance model for bioterrorism and infectious disease mortality. *Human Pathology*. 2007; 38(5): 718-725.
429. Paulozzi L, Mercy J, Frazier L, Annest J. CDC's National Violent Death Reporting System: background and methodology. *Injury Prevention*. 2004; 10(1): 47-52.
430. Poulin C, Stein J, Butt J. Surveillance of drug overdose deaths using medical examiner data. *Chronic Diseases in Canada*. 1998; 19(4): 177-182.
431. Scheer S, McQuitty M, Denning P, Hormel L, Stephens B, Katz M, et al. Undiagnosed and unreported AIDS deaths: Results from the San Francisco medical examiner. *Journal of Acquired Immune Deficiency Syndromes*. 2001; 27(5): 467-471.

432. Simon P, Hu Y. Use of coroner's data to monitor HIV seroprevalence among injection drug users. *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology*. 1996; 13(1): 98-99.
433. Smith GS, Veazie MA, Benjamin KL. The Use of Sentinel Injury Deaths to Evaluate the Quality of Multiple Source Reporting for Occupational Injuries. *Annals of Epidemiology*. 2005; 15(3): 219-227.
434. Sternfeld I, Perras N, Culross P. Development of a Coroner-Based Surveillance System for Drug-Related Deaths in Los Angeles County. *Journal of Urban Health*. 2010; 87(4): 656-669.
435. Thompson SC, Manjikian A, Ambrose A, Ireland LA, Stevenson EM. HIV positive tests at Coronial Services in Victoria 1989-1996: lessons for HIV surveillance. *Australian and New Zealand Journal of Public Health*. 1998; 22(5): 532-535.
436. Walsh S, Dignan M, Caldwell G. The PAPM, Diffusion Theory, and Violent Death Surveillance. *American Journal of Health Behavior*. 2007; 31(5): 451-461.
437. Wolfe MI, Nolte KB, Yoon SS. Fatal Infectious Disease Surveillance in a Medical Examiner Database. *Emerging Infectious Diseases*. 2004; 10(1): 6.
438. Wolfe MI, Yoon SS, Nolte K. Utility of a computerized text search tool for infectious disease mortality surveillance: Development and implementation in a medical examiner database. *Clinical Infectious Diseases*. 2001; 33(7): 840.
439. Archer PJ, Mallonee S, Schmidt AC, Ikeda RM. Oklahoma firearm-related injury surveillance. *American Journal of Preventive Medicine*. 1998; 15(3 SUPPL.): 83-91.
440. Biroscak B, Smith P, Post L. A practical approach to public health surveillance of violent deaths related to intimate partner relationships. (Special issue: Intimate partner violence.). *Public Health Reports*. 2006; 121(4): 393-399.
441. Lunetta P, Lounamaa A, Sihvonen S. Surveillance of injury-related deaths: medicolegal autopsy rates and trends in Finland. *Injury Prevention*. 2007; 13(4): 282-284.
442. Bugeja L, Clapperton AJ, Killian JJ, Stephan KL, Ozanne-Smith J. Reliability of ICD-10 external cause of death codes in the National Coroners Information System. *Health Information Management Journal*. 2010; 39(3): 16-26.
443. Driscoll T, Henley G, Harrison J. *The National Coroners Information System as an information tool for injury surveillance*. Australian Institute of Health and Welfare. Report No: Injury Research and Statistics Series 21, 2003.
444. Edwards N, Alaghehbandan R, MacDonald D, Sikdar K, Collins K, Avis S. Suicide in Newfoundland and Labrador: a linkage study using medical examiner and vital statistics data. *Canadian Journal of Psychiatry/Revue Canadienne de Psychiatrie*. 2008; 53(4): 252-259.

445. Hajjeh RA, Sofair AN. Can Surveillance of Unexplained Deaths Be Used as a Public Health Approach for Early Recognition of New Pathogens? In: Scheld MW, Murray BE, Hughes JM, editors. *Emerging Infections*. Washington D.C.: ASM Press; 2004. p. 177-190.
446. Nolte KB, Wolfe MI. Medical Examiner and Coroner Surveillance for Emerging Infections. In: Scheld MW, Craig WA, Hughes JM, editors. *Emerging Infections*. Washington D.C.: ASM Press; 1999. p. 201-218.
447. Nolte KB, Fischer M, Reagan S, Lynfield R. Guidelines to Implement Medical Examiner/Coroner-Based Surveillance for Fatal Infectious Diseases and Bioterrorism ("Med-X"). *American Journal of Forensic Medicine and Pathology*. 2010; 31(4): 308-312.
448. Rigau-Perez JG, Torres JV, Mosely Hayes J, Vorndam V, Clark GG. Medical examiner samples: a source for dengue surveillance. *Puerto Rico Health Sciences Journal*. 2006; 25(1): 67-69.
449. Nolte KD, Hanzlick RL, Payne DC, Kroger AT, Oliver WR, Baker AM, et al. Medical examiners, coroners, and biologic terrorism: a guidebook for surveillance and case management. *MMWR Recommendations and Reports*. 2004; 53(RR-8): 1-27.
450. Nolte KB. Medical examiners and bioterrorism. *American Journal of Forensic Medicine and Pathology*. 2000; 21(4): 419-420.
451. Williams AA, Parashar UD, Stoica A, Ridzon R, Kirschke DL, Meyer RF, et al. Bioterrorism-related anthrax surveillance, Connecticut, September - December, 2001. *Emerging Infectious Diseases*. 2002; 8(10): 1078-1082.
452. Koehler SA. Using medical examiner/coroner-generated Death Certificates in research: advantages and limitations. *Journal of Forensic Nursing*. 2005; 1(3): 133-135.
453. Tawney RH. *The Acquisitive Society*. New York: Harcourt, Brace and Company; 1920. Available from: <http://www.gutenberg.org/files/33741/33741-h/33741-h.htm>.
454. Freidson E. *Profession of Medicine: A Study of the Sociology of Applied Knowledge*. London: University of Chicago Press; 1988.
455. Larson MS. *The Rise of Professionalism: A Sociological Analysis*. London: University of California Press; 1977.
456. Freidson E. Theory and Professions. *Indiana Law Journal*. 1989; 64(3).
457. Ministry of Community Safety and Correctional Services. *Office of the Chief Coroner*. [Online]. Available from: http://www.mcscs.jus.gov.on.ca/english/DeathInvestigations/office_coroner/coroner.html.

458. *Patient Safety Review Committee 2010 Annual Report*. Office of the Chief Coroner for Ontario. 2011.
459. *Annual Report 2004*. Office of the Chief Coroner for Ontario. 2004.
460. *Annual Report 2007*. Office of the Chief Coroner for Ontario. 2008.
461. *Annual Report 2005 & 2006*. Office of the Chief Coroner for Ontario. 2007.
462. Bureau du Coroner Québec. *Le Bureau du coroner*. [Online]. Available from: http://www.coroner.gouv.qc.ca/index.php?id=bureau_coroner.
463. *Bureau du Coroner Plan Stratégique: 2009-2012*. Québec Bureau du Coroner. 2009.
464. Gostin LO. *Public Health Law: Power, duty, restraint (Second Edition)*. London: University of California Press, Ltd.; 2008.
465. Chichevalieva S. *Developing a Framework for Public Health Law in Europe*. World Health Organization. 2011.
466. *Suicide rates in the United Kingdom, 2000-2009*. Office for National Statistics. 2011.
467. O'Donnell I, Farmer R. The limitations of official suicide statistics. *British Journal of Psychiatry*. 1995; 166: 458-461.
468. Victorian Institute of Forensic Medicine, Australasian Coroners Society. *The National Coroners Information System (NCIS)*. [Online]. Available from: <http://www.ncis.org.au/>.
469. Pounder D. The coroner service. A relic in need of reform. *BMJ*. 1999; 318(7197): 1502-1503.
470. *R v Minister of Agriculture and Fisheries ex p. Padfield*, [1968] APP.L.R. 02/14.
471. Canada. *Canada Consumer Product Safety Act*, Chapter 21. Ottawa: Minister of Justice; 2010.
472. Canada. *Youth Criminal Justice Act*, Chapter 1. Ottawa: Minister of Justice; 2002.
473. *Public Bodies Bill Briefing, Commons Report Stage and Third Reading*. British Medical Association. 2011.
474. *Quality Assurance of NAO Value for Money Studies*. The National Audit Office.

475. Public Appointments Secretariat for Ontario. *Death Investigation Oversight Council*. [Online]. Available from: <http://www.pas.gov.on.ca/scripts/en/boardDetails.asp?boardID=142400>.
476. BBC. Coroner questions drugs policy. *BBC News*. [Online] 26 June 2001. Available from: <http://news.bbc.co.uk/1/hi/uk/1409036.stm> [Accessed 17 January 2012].
477. The Judiciary of England and Wales. *Coroners*. [Online]. Available from: <http://www.judiciary.gov.uk/about-the-judiciary/introduction-to-justice-system/coroners>.
478. *Forrest v Lord Chancellor and Lord Chief Justice*, [2011] EWHC 142 (Admin) (2011).
479. *The Accountability of the Judiciary*. The Judiciary of England and Wales. 2007.
480. Garnett v Ferrand and Another. In: Dowling J, Ryland A, editors. *Reports of Cases Relating to the Duty and Office of Magistrates Determined in the Court of King's Bench from Easter Term, 1826 to Trinity Term, 1827 (1831)*. London: S. Sweet; 1827.
481. *Guide to Judicial Conduct*. Judges' Council of England and Wales. 2011.
482. The Judiciary of England and Wales. *Independence*. [Online]. Available from: <http://www.judiciary.gov.uk/about-the-judiciary/the-judiciary-in-detail/jud-acc-ind/independence>.
483. Thomas C. *Are juries fair?* Ministry of Justice. Report No: Ministry of Justice Research Series 1/10, 2010.
484. Gibb F. Courts overhaul planned to help juries baffled by judges. *The Times*. [Online] 17 February 2010. Available from: <http://business.timesonline.co.uk/tol/business/law/article7029809.ece> [Accessed 17 January 2012].
485. Rebello A. Honorary Secretary of the Coroners' Society of England and Wales. Personal communication. 3 July 2007-14 October 2008.
486. Alexander A. Concerns over inquest 'failures' after hospital deaths. *BBC News*. [Online] 15 November 2011. Available from: <http://www.bbc.co.uk/news/health-15635021> [Accessed 17 January 2012].
487. Slobogin C. Therapeutic Jurisprudence: Five Dilemmas to Ponder. In: Wexler DB, Winick BJ, editors. *Law in a Therapeutic Key: Developments in Therapeutic Jurisprudence*. Durham, North Carolina: Carolina Academic Press; 1996. p. 763-793.

APPENDIX A

STATUTORY INSTRUMENTS

1984 No. 552

CORONERS

The Coroners Rules 1984

Made - - - - *9th April 1984*
Coming into Operation *1st July 1984*

The Lord Chancellor, in exercise of the powers conferred on him by sections 26 and 27 of the Coroners (Amendment) Act 1926 and with the concurrence of the Secretary of State, hereby makes the following Rules:—

PART I
GENERAL

Citation and commencement

1. These Rules may be cited as the Coroners Rules 1984 and shall come into operation on 1st July 1984.

Interpretation

2.—(1) In these Rules, unless the context otherwise requires—

“the Act of 1887” means the Coroners Act 1887;

“the Act of 1926” means the Coroners (Amendment) Act 1926;

“appropriate officer” has the same meaning as it has in section 3A of the Act of 1887 (1);

“chief officer of police” means the chief officer of police for the area in which the coroner's jurisdiction is comprised;

“coroner” includes a deputy and assistant deputy coroner;

“deceased” means the person upon whose body a post-mortem examination is made or touching whose death an inquest is held or the person whose death is reported to the coroner, as the case may be;

“enforcing authority” has the same meaning as it has in section 18(7) of the Health and Safety at Work etc. Act 1974;

(1) Section 3A was inserted by the Coroners' Juries Act 1983, section 1.

“hospital” means any institution for the reception and treatment of persons suffering from illness or mental disorder, any maternity home, and any institution for the reception and treatment of persons during convalescence;

“industrial disease” means a disease prescribed under section 76 of the Social Security Act 1975(2);

“inquest” means an inquest for the purpose of inquiring into the death of a person;

“legal proceedings” includes proceedings for the purpose of obtaining any benefit or other payments under the provisions of the Social Security Act 1975 relating to industrial injuries or under section 5 of the Industrial Injuries and Diseases (Old Cases) Act 1975;

“pneumoconiosis medical board” and “pneumoconiosis medical panel” have the same meanings as they have in the Social Security (Industrial Injuries) (Prescribed Diseases) Regulations 1980;

“post-mortem examination” means a post-mortem examination which a legally qualified medical practitioner is directed or requested by a coroner to make under section 21 of the Act of 1887 (3) or under section 21(1) or 22(1) of the Act of 1926 (4);

“registrar” means a registrar of births and deaths;

“the Registration Acts” has the same meaning as it has in the Act of 1887;

“special examination” has the same meaning as it has in section 22(1) of the Act of 1926.

(2) In these Rules any reference to a Rule or Schedule shall be construed as a reference to a Rule contained in these Rules, or, as the case may be, to a Schedule thereto; and any reference in a Rule to a paragraph shall be construed as a reference to a paragraph of that Rule.

Revocations and application

3.—(1) Subject to paragraph (2), the Rules specified in Schedule 1 are hereby revoked.

(2) These Rules shall not have effect in relation to any inquest begun before 1st July 1984 or to any post-mortem examination which, before that day, a coroner has directed or requested a medical practitioner to make; and, accordingly, the Rules revoked by paragraph (1) shall continue to have effect in relation to any such inquest or post-mortem examination.

PART II

AVAILABILITY OF CORONER

Coroner to be available at all times

4. A coroner shall at all times hold himself ready to undertake, either by himself or by his deputy or assistant deputy, any duties in connection with inquests and post-mortem examinations.

(2) the relevant instrument is S.I. 1980/377, as amended by S.I. 1980/1493, 1982/249 and 566.

(3) Section 21 was amended by the Coroners (Amendment) Act 1926, sections 30 and 31 and Schedules 2 and 3.

(4) Section 21(1) was amended by the Coroners Act 1980 (c. 38), section 1 and Schedule 1.

PART III

POST-MORTEM EXAMINATIONS

Delay in making post-mortem to be avoided

5. Where a coroner directs or requests that a post-mortem examination shall be made, it shall be made as soon after the death of the deceased as is reasonably practicable.

Medical practitioner making post-mortem

6.—(1) In considering what legally qualified medical practitioner shall be directed or requested by the coroner to make a post-mortem examination the coroner shall have regard to the following considerations:—

- (a) the post-mortem examination should be made, whenever practicable, by a pathologist with suitable qualifications and experience and having access to laboratory facilities;
- (b) if the coroner is informed by the chief officer of police that a person may be charged with the murder, manslaughter or infanticide of the deceased, the coroner should consult the chief officer of police regarding the legally qualified medical practitioner who is to make the post-mortem examination;
- (c) if the deceased died in a hospital, the coroner should not direct or request a pathologist on the staff of, or associated with, that hospital to make a post-mortem examination if—
 - (i) that pathologist does not desire to make the examination, or
 - (ii) the conduct of any member of the hospital staff is likely to be called in question, or
 - (iii) any relative of the deceased asks the coroner that the examination be not made by such a pathologist,unless the obtaining of another pathologist with suitable qualifications and experience would cause the examination to be unduly delayed;
- (d) if the death of the deceased may have been caused by any of the diseases or injuries within paragraph (2), the coroner should not direct or request a legally qualified medical practitioner who is a member of a pneumoconiosis medical panel to make the post-mortem examination.

(2) The diseases and injuries within this paragraph are those in connection with which duties are from time to time imposed upon pneumoconiosis medical boards by Part III of the Social Security Act 1975 and any regulations made under that Act (5).

Coroner to notify persons of post-mortem to be made

7.—(1) Where a coroner directs or requests a legally qualified medical practitioner to make a post-mortem examination, the coroner shall notify the persons and bodies set out in paragraph (2) of the date, hour and place at which the examination will be made, unless it is impracticable to notify any such persons or bodies or to do so would cause the examination to be unduly delayed.

(2) The persons and bodies to be notified by the coroner are as follows:—

- (a) any relative of the deceased who has notified the coroner of his desire to attend, or be represented at, the post-mortem examination;
- (b) the deceased's regular medical attendant;

(5) The relevant instrument and the instruments amending it are set out in the footnote to the definition of "industrial disease" in Rule 2(1).

- (c) if the deceased died in a hospital, the hospital;
- (d) if the death of the deceased may have been caused by any of the diseases or injuries within Rule 6(2) (other than occupational asthma), the pneumoconiosis medical panel for the area;
- (e) if the death of the deceased may have been caused by any accident or disease notice of which is required by or under any enactment to be given—
 - (i) to an enforcing authority, the appropriate inspector appointed by, or representative of, that authority; or
 - (ii) to an inspector appointed by an enforcing authority, that inspector;
- (f) any government department which has notified the coroner of its desire to be represented at the examination;
- (g) if the chief officer of police has notified the coroner of his desire to be represented at the examination, the chief officer of police.

(3) Any person or body mentioned in paragraph (2) shall be entitled to be represented at a post-mortem examination by a legally qualified medical practitioner, or if any such person is a legally qualified medical practitioner he shall be entitled to attend the examination in person; but the chief officer of police may be represented by a member of the police force of which he is chief officer.

(4) Nothing in the foregoing provisions of this Rule shall be deemed to limit the discretion of the coroner to notify any person of the date, hour and place at which a post-mortem examination will be made and to permit him to attend the examination.

Persons attending post-mortem not to interfere

8. A person attending a post-mortem examination by virtue of paragraph (3) or (4) of Rule 7 shall not interfere with the performance of the examination.

Preservation of material

9. A person making a post-mortem examination shall make provision, so far as possible, for the preservation of material which in his opinion bears upon the cause of death for such period as the coroner thinks fit.

Report on post-mortem

10.—(1) The person making a post-mortem examination shall report to the coroner in the form set out in Schedule 2 or in a form to the like effect.

(2) Unless authorised by the coroner, the person making a post-mortem examination shall not supply a copy of his report to any person other than the coroner.

Premises for post-mortems

11.—(1) No post-mortem examination shall be made in a dwelling house or in licensed premises.

(2) Every post-mortem examination shall be made in premises which are adequately equipped for the purpose of the examination.

(3) Where a person dies in a hospital possessing premises so equipped, any post-mortem examination of the body of that person shall, with the consent of the hospital authority, be made in those premises unless the coroner otherwise decides.

(4) For the purpose of this Rule no premises shall be deemed to be adequately equipped for the purpose of post-mortem examinations unless they are supplied with running water, proper heating and lighting facilities, and containers for the storing and preservation of material.

PART IV

SPECIAL EXAMINATIONS

Preservation of material

12. A person making a special examination shall make provision, so far as possible, for the preservation of the material submitted to him for examination for such period as the coroner thinks fit.

Report on special examination

13. Unless authorised by the coroner, the person making a special examination shall not supply a copy of his report to any person other than the coroner.

PART V

BURIAL ORDERS

Issue of burial order

14. An order of a coroner authorising the burial of a body shall not be issued unless the coroner has held, or has decided to hold, an inquest touching the death.

Burial order where certificate for disposal of body issued

15. Where a coroner is satisfied that a certificate for the disposal of a body has been issued by a registrar, the coroner shall not issue an order authorising the burial of that body unless the certificate has been surrendered to him; and in such a case he shall on issuing the order transmit the certificate to the registrar and inform him of the issue of the order.

PART VI

INQUESTS

Formality

16. Every inquest shall be opened, adjourned and closed in a formal manner.

Inquest in public

17. 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.

Days on which inquest not to be held

18. An inquest shall not be held on Christmas Day, Good Friday, or a bank holiday unless the coroner thinks it requisite on grounds of urgency that an inquest should be held on such a day, and no inquest shall be held on a Sunday.

Coroner to notify persons of inquest arrangements

19. The coroner shall notify the date, hour and place of an inquest to—

- (a) the spouse or a near relative or personal representative of the deceased whose name and address are known to the coroner; and
- (b) any other person who—
 - (i) in the opinion of the coroner is within Rule 20(2); and
 - (ii) has asked the coroner to notify him of the aforesaid particulars of the inquest; and
 - (iii) has supplied the coroner with a telephone number or address for the purpose of notifying him.

Entitlement to examine witnesses

20.—(1) Without prejudice to any enactment with regard to the examination of witnesses at an inquest, any person who satisfies the coroner that he is within paragraph (2) shall be entitled to examine any witness at an inquest either in person or by counsel or solicitor:

Provided that—

- (a) the chief officer of police, unless interested otherwise than in that capacity, shall only be entitled to examine a witness by counsel or solicitor;
 - (b) the coroner shall disallow any question which in his opinion is not relevant or is otherwise not a proper question.
- (2) Each of the following persons shall have the rights conferred by paragraph (1):—
- (a) a parent, child, spouse and any personal representative of the deceased;
 - (b) any beneficiary under a policy of insurance issued on the life of the deceased;
 - (c) the insurer who issued such a policy of insurance;
 - (d) any person whose act or omission or that of his agent or servant may in the opinion of the coroner have caused, or contributed to, the death of the deceased;
 - (e) any person appointed by a trade union to which the deceased at the time of his death belonged, if the death of the deceased may have been caused by an injury received in the course of his employment or by an industrial disease;
 - (f) an inspector appointed by, or a representative of, an enforcing authority, or any person appointed by a government department to attend the inquest;
 - (g) the chief officer of police;
 - (h) any other person who, in the opinion of the coroner, is a properly interested person.

Examination of witnesses

21. Unless the coroner otherwise determines, a witness at an inquest shall be examined first by the coroner and, if the witness is represented at the inquest, lastly by his representative.

Self-incrimination

22.—(1) No witness at an inquest shall be obliged to answer any question tending to incriminate himself.

(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.

Adjournment where inspector or representative of enforcing authority etc. is not present

23.—(1) Where a coroner holds an inquest touching the death of a person which may have been caused by an accident or disease notice of which is required to be given to an enforcing authority, the coroner shall adjourn the request unless an inspector appointed by, or a representative of, the enforcing authority is present to watch the proceedings and shall, at least four days before holding the adjourned inquest, give to such inspector or representative notice of the date, hour and place of holding the adjourned inquest.

(2) Where a coroner holds an inquest touching the death of a person which may have been caused by an accident or disease notice of which is required to be given to an inspector appointed by an enforcing authority, the coroner shall adjourn the inquest unless the inspector or a representative of the inspector is present to watch the proceedings and shall, at least four days before holding the adjourned inquest, give to the inspector or representative notice of the date, hour and place of holding the adjourned inquest.

Notice to person whose conduct is likely to be called in question

24. Any person whose conduct is likely in the opinion of the coroner to be called in question at an inquest shall, if not duly summoned to give evidence at the inquest, be given reasonable notice of the date, hour and place at which the inquest will be held.

Adjournment where person whose conduct is called in question is not present

25. If the conduct of any person is called in question at an inquest on grounds which the coroner thinks substantial and which relate to any matter referred to in Rule 36 and if that person is not present at the inquest and has not been duly summoned to attend or otherwise given notice of the holding of the inquest, the inquest shall be adjourned to enable him to be present, if he so desires.

Request by chief officer of police for adjournment

26.—(1) If the chief officer of police requests a coroner to adjourn an inquest on the ground that a person may be charged with an offence within paragraph (3), the coroner shall adjourn the inquest for twenty-eight days or for such longer period as he may think fit.

(2) At any time before the date fixed for the holding of the adjourned inquest, the chief officer of police may ask the coroner for a further adjournment and the coroner may comply with his request.

(3) The offences within this paragraph are murder, manslaughter or infanticide of the deceased, an offence under section 1 of the Road Traffic Act 1972 (6) committed by causing the death of the deceased and an offence under section 2(1) of the Suicide Act 1961 consisting of aiding, abetting, counselling or procuring the suicide of the deceased.

Request by Director of Public Prosecutions for adjournment

27.—(1) If the Director of Public Prosecutions requests a coroner to adjourn an inquest on the ground that a person may be charged with an offence (whether or not involving the death of a person other than the deceased) committed in circumstances connected with the death of the deceased, not being an offence within Rule 26(3), the coroner shall adjourn the inquest for twenty-eight days or for such longer period as he may think fit.

(2) At any time before the date fixed for the holding of the adjourned inquest, the Director of Public Prosecutions may ask the coroner for a further adjournment and the coroner may comply with his request.

(6) section 1 was substituted by the Criminal Law Act 1977 (c. 45), section 50.

Coroner to adjourn in certain other cases

28.—(1) If during the course of an inquest evidence is given from which it appears to the coroner that the death of the deceased is likely to be due to an offence within Rule 26(3) and that a person might be charged with such an offence, then the coroner, unless he has previously been notified by the Director of Public Prosecutions that adjournment is unnecessary, shall adjourn the inquest for fourteen days or for such longer period as he may think fit and send to the Director particulars of that evidence.

(2) At any time before the date fixed for the holding of the adjourned inquest, the Director of Public Prosecutions may ask the coroner for a further adjournment and the coroner may comply with his request.

Coroner to furnish certificate after adjournment

29. A certificate under the hand of a coroner stating the particulars which under the Registration Acts are required to be registered concerning a death which he furnishes to a registrar of deaths under section 20(4)(7) of the Act of 1926 shall be furnished within five days from the date on which the inquest is adjourned.

Coroner's interim certificate of the fact of death

30. When an inquest has been adjourned for any reason and section 20(4) of the Act of 1926 does not apply, the coroner shall on application supply to any person who, in the opinion of the coroner, is a properly interested person an interim certificate of the fact of death.

Coroner to furnish certificate stating result of criminal proceedings

31. A certificate under the hand of a coroner stating the result of the relevant criminal proceedings which he furnishes to a registrar of deaths under section 20(5) or section 20(7) of the Act of 1926 shall be furnished within twenty-eight days from the date on which he is notified of the result of the proceedings under section 20(9) or section 20(10) of that Act or, if the person charged with an offence before a magistrates' court as mentioned in section 20(8) of that Act is not committed for trial to the Crown Court, within twenty-eight days from the date on which he is notified under the said section 20(8) of the result of the proceedings in the magistrates' court.

Effect of institution of criminal proceedings

32. Subject to section 20 of the Act of 1926, an inquest shall not be adjourned solely by reason of the institution of criminal proceedings arising out of the death of the deceased.

Coroner to notify persons as to resumption of, and alteration of arrangements for, adjourned inquest

33.—(1) If an inquest which has been adjourned in pursuance of section 20 of the Act of 1926 is not to be resumed, the coroner shall notify the persons within paragraph (4).

(2) If an inquest which has been adjourned as aforesaid is to be resumed, the coroner shall give reasonable notice of the date, hour and place at which the inquest will be resumed to the persons within paragraph (4).

(3) Where a coroner has fixed a date, hour and place for the holding of an inquest adjourned for any reason, he may, at any time before the date so fixed, alter the date, hour or place fixed and shall then give reasonable notice to the persons within paragraph (4).

(7) Section 20 was substituted by the Criminal Law Act 1977, section 56 and Schedule 10, and was amended by the Coroners Act 1980, section 1 and Schedules 1 and 2.

(4) The persons within this paragraph are the members of the jury (if any), the witnesses, the chief officer of police, any person notified under Rule 19 or 24 and any other person appearing in person or represented at the inquest.

Recognizance of witness or juror becoming void

34. Where any witness or juror who has been bound over to attend at an adjourned inquest, whether without further notice or conditionally on receiving further notice, is notified by the coroner that his attendance at the adjourned inquest is not required or that the inquest will not be resumed, the recognizance entered into by him shall be void.

Coroner to notify Crown Court officer of adjournment in certain cases

35. Where a person charged with an offence within Rule 26(3) is committed for trial to the Crown Court, the coroner who has adjourned an inquest in pursuance of section 20 of the Act of 1926 shall inform the appropriate officer of the Crown Court at the place where the person charged is to be tried of such adjournment.

Matters to be ascertained at inquest

36.—(1) The proceedings and evidence at an inquest shall be directed solely to ascertaining the following matters, namely—

- (a) who the deceased was;
- (b) how, when and where the deceased came by his death;
- (c) the particulars for the time being required by the Registration Acts to be registered concerning the death.

(2) Neither the coroner nor the jury shall express any opinion on any other matters.

Documentary evidence

37.—(1) Subject to the provisions of paragraphs (2) to (4), the coroner may admit at an inquest documentary evidence relevant to the purposes of the inquest from any living person which in his opinion is unlikely to be disputed, unless a person who in the opinion of the coroner is within Rule 20(2) objects to the documentary evidence being admitted.

(2) Documentary evidence so objected to may be admitted if in the opinion of the coroner the maker of the document is unable to give oral evidence within a reasonable period.

(3) Subject to paragraph (4), before admitting such documentary evidence the coroner shall at the beginning of the inquest announce publicly—

- (a) that the documentary evidence may be admitted, and
- (b) (i) the full name of the maker of the document to be admitted in evidence, and
(ii) a brief account of such document, and
- (c) that any person who in the opinion of the coroner is within Rule 20(2) may object to the admission of any such documentary evidence, and
- (d) that any person who in the opinion of the coroner is within Rule 20(2) is entitled to see a copy of any such documentary evidence if he so wishes.

(4) If during the course of an inquest it appears that there is available at the inquest documentary evidence which in the opinion of the coroner is relevant to the purposes of the inquest but the maker of the document is not present and in the opinion of the coroner the content of the

documentary evidence is unlikely to be disputed, the coroner shall at the earliest opportunity during the course of the inquest comply with the provisions of paragraph (3).

(5) A coroner may admit as evidence at an inquest any document made by a deceased person if he is of the opinion that the contents of the document are relevant to the purposes of the inquest.

(6) Any documentary evidence admitted under this Rule shall, unless the coroner otherwise directs, be read aloud at the inquest.

Exhibits

38. All exhibits produced in evidence at an inquest shall be marked with consecutive numbers and each number shall be preceded by the letter "C".

Notes of evidence

39. The coroner shall take notes of the evidence at every inquest.

No addresses as to facts

40. No person shall be allowed to address the coroner or the jury as to the facts.

Summing-up and direction to jury

41. Where the coroner sits with a jury, he shall sum up the evidence to the jury and direct them as to the law before they consider their verdict and shall draw their attention to Rules 36(2) and 42.

Verdict

42. 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.

Prevention of similar fatalities

43. 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.

PART VII

SUMMONING OF JURORS AND EXCUSAL FROM JURY SERVICE

Summoning of jurors

44. Subject to the provisions of these Rules, the person to whom the coroner's warrant is issued under section 3 of the Act of 1887 for the summoning of persons to attend as jurors at inquests shall have regard to the convenience of the persons summoned and to their respective places of residence, and in particular to the desirability of selecting jurors within reasonable daily travelling distance of the place where they are to attend.

Method of summoning

45. Subject to the provisions of these Rules, jurors shall be summoned by notice in writing sent by post or delivered by hand and a notice shall be sent or delivered to a juror at his address as shown in the electoral register.

Notice to accompany summons

46. A written summons sent or delivered to any person under Rule 45 shall be accompanied by a notice informing him—

- (a) of the effect of section 3A of the Act of 1887 and Rules 51(1) and 52; and
- (b) that he may make representations to the appropriate officer with a view to obtaining the withdrawal of the summons, if for any reason he is not qualified for jury service, or wishes or is entitled to be excused.

Withdrawal or alteration of summons

47. If it appears to the appropriate officer, at any time before the day on which any person summoned under section 3 of the Act of 1887 is to attend, that his attendance is unnecessary, or can be dispensed with, the appropriate officer may withdraw or alter the summons by notice served in the same way as a notice of summons.

Summoning in exceptional circumstances

48. If it appears to the coroner that a jury will be, or probably will be, incomplete, the coroner may, if he thinks fit, require any persons who are in, or in the vicinity of, the place of the inquest to be summoned (without any written notice) for jury service up to the number needed (after allowing for any who may not be qualified under section 3A of the Act of 1887 and for excusals) to make up such number.

Excusal for previous jury service

49.—(1) If a person summoned under section 3 of the Act of 1887 shows to the satisfaction of the appropriate officer or of the coroner—

- (a) that he has served on a jury, or duly attended to serve on a jury, at inquests held in that coroner's jurisdiction on three or more days in the period of one year ending with the service of the summons on him; or
- (b) that he has served on a jury, or duly attended to serve on a jury, in the Crown Court, the High Court or any county court in the period of two years ending with the service of the summons on him; or
- (c) that any such court or a coroner has excused him from jury service for a period which has not terminated,

the appropriate officer or the coroner shall excuse him from attending, or further attending, in pursuance of the summons.

(2) In reckoning the days for the purpose of paragraph (1)(a) no account shall be taken of any day or days to which an inquest is adjourned.

Certificate of attendance

50. A person duly attending to serve on a jury in compliance with a summons under section 3 of the Act of 1887 shall be entitled on application to the appropriate officer to a certificate recording that he has so attended.

Excusal for certain persons and discretionary excusal

51.—(1) A person summoned under section 3 of the Act of 1887 shall be entitled, if he so wishes, to be excused from jury service if he is among the persons for the time being listed in Part III of Schedule 1 to the Juries Act 1974 but, except as provided by that Part of that Schedule in the case of members of the forces, a person shall not by this Rule be exempt from his obligation to attend if summoned unless he is excused from attending under paragraph (2).

(2) If any person so summoned shows to the satisfaction of the appropriate officer or of the coroner that there is good reason why he should be excused from attending in pursuance of the summons, the appropriate officer or the coroner may excuse him from so attending and shall do so if the reason shown is that the person is entitled under paragraph (1) to excusal.

Discharge of summons in case of doubt as to capacity to act effectively as a juror

52. Where it appears to the appropriate officer, in the case of a person attending in pursuance of a summons under section 3 of the Act of 1887, that on account of physical disability or insufficient understanding of English there is doubt as to his capacity to act effectively as a juror, the person may be brought before the coroner, who shall determine whether or not he should act as a juror and, if not, shall discharge the summons.

Saving for inquests held by the coroner of the Queen's household

53. Nothing in this Part of these Rules shall have effect in relation to any inquest held by the coroner of the Queen's household.

PART VIII

RECORDS, DOCUMENTS, EXHIBITS AND FORMS

Register of deaths

54. A coroner shall keep an indexed register of all deaths reported to him, or to his deputy or assistant deputy, which shall contain the particulars specified in Schedule 3.

Retention and delivery or disposal of exhibits

55. Every exhibit at an inquest shall, unless a court otherwise directs, be retained by the coroner until he is satisfied that the exhibit is not likely to be, or will no longer be, required for the purposes of any other legal proceedings, and shall then, if a request for its delivery has been made by a person appearing to the coroner to be entitled to the possession thereof, be delivered to that person, or, if no such request has been made, be destroyed or otherwise disposed of as the coroner thinks fit.

Retention and delivery of documents

56. Any document (other than an exhibit at an inquest) in the possession of a coroner in connection with an inquest or post-mortem examination shall, unless a court otherwise directs, be retained by the coroner for at least fifteen years:

Provided that the coroner may deliver any such document to any person who in the opinion of the coroner is a proper person to have possession of it.

Inspection of, or supply of copies of, documents etc

57.—(1) A coroner shall, on application and on payment of the prescribed fee (if any), supply to any person who, in the opinion of the coroner, is a properly interested person a copy of any report of a post-mortem examination (including one made under section 21 of the Act of 1926) or special examination, or of any notes of evidence, or of any document put in evidence at an inquest.

(2) A coroner may, on application and without charge, permit any person who, in the opinion of the coroner, is a properly interested person to inspect such report, notes of evidence, or document.

Deputy or assistant deputy to sign documents in own name

58. Where a deputy or assistant deputy coroner acting for, or as, the coroner signs a document, he shall sign it in his own name as deputy or assistant deputy coroner, as the case may be.

Transfer of documents etc. to next-appointed coroner

59. Where a coroner vacates his office by death or otherwise, all documents, exhibits, registers and other things in the custody of the coroner in connection with inquests or post-mortem examinations shall be transferred to the coroner next appointed to that office.

Forms

60. The forms set out in Schedule 4, with such modifications as circumstances may require, may be used for the purposes for which they are expressed to be applicable.

5th April 1984

Hailsham of St. Marylebone, C

I concur,

9th April 1984

Leon Brittan
One of Her Majesty's Principal Secretaries of
State
Home Office

Status: This is the original version (as it was originally made). UK
 Statutory Instruments are not carried in their revised form on this site.

SCHEDULES

SCHEDULE 1

Rule 3

REVOCATIONS

<i>Rules revoked</i>	<i>References</i>
The Coroners Rules 1953	S.I. 1953/205
The Coroners Rules 1956	S.I. 1956/1691
The Coroners (Amendment) Rules 1974	S.I. 1974/2128
The Coroners (Amendment) Rules 1977	S.I. 1977/1881
The Coroners (Amendment) Rules 1980	S.I. 1980/557
The Coroners (Amendment) (Savings) Rules 1980	S.I. 1980/668
The Coroners (Amendment) Rules 1983	S.I. 1983/1539

SCHEDULE 2

Rule 10

POST-MORTEM EXAMINATION REPORT

SCHEDULE 3

Rule 54

REGISTER OF DEATHS REPORTED TO THE CORONER

<i>Date on which death is reported to coroner</i>	<i>Particulars of deceased</i>				<i>State whether case disposed of by using Pink Form A or B or whether inquest was held</i>	<i>Verdict at inquest (if any)</i>
	<i>Full name and address</i>	<i>Age</i>	<i>Sex</i>	<i>Cause of death</i>		

SCHEDULE 4

Rule 60

FORMS

- 1 Form of declaration of office of coroner
- 2 Warrant to exhume
- 3 Warrant to summon jury
- 4 Summons to juror
- 5 Notice to accompany summons and reply thereto
- 6 Certificate of attendance
- 7 Form of oath of juror
- 8 Summons to witness
- 9 Oath of witness
- 10 Direction to medical practitioner to make a post-mortem examination
- 11 Certificate of fine
- 12 Form of recognizance—witnesses or jurors
- 13 Notice of inquest arrangements
- 14 Coroner's interim certificate of the fact of death
- 15 Notice that an inquest which is adjourned in pursuance of section 20 of the Coroners (Amendment) Act 1926 will not be resumed
- 16 Notice that an inquest which is adjourned in pursuance of section 20 of the Coroners (Amendment) Act 1926 will be resumed
- 17 Notice that the attendance of a witness will not be required at the holding of an adjourned inquest
- 18 Notice that the date, hour or place fixed for the holding of an adjourned inquest has been altered
- 19 Certificate of forfeiture of recognizance
- 20 Order to remove body for inquest or post-mortem examination
- 21 Coroner's order for burial
- 22 Inquisition

Status: *This is the original version (as it was originally made). UK
Statutory Instruments are not carried in their revised form on this site.*

EXPLANATORY NOTE

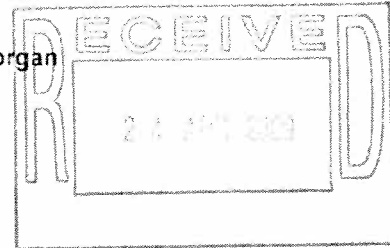
These Rules consolidate with minor amendments the Coroners Rules 1953 as from time to time amended. They govern the powers and duties of coroners in England and Wales, and associated procedural matters, in relation to the holding of inquests and post-mortem examinations. The principal amendment of substance is the introduction of Rule 30, with its associated form in Schedule 4, Form 14. The Rule obliges a coroner, when he has adjourned an inquest and is unable to furnish the registrar of deaths with a certificate stating the particulars which are required to be registered concerning the death, to issue to any properly interested person who applies to him a certificate (Form 14) recording the date of the deceased's death and the precise medical cause (if established).

Another amendment of substance is the removal of "chronic alcoholism" from the list of suggested verdicts in the notes to the Form of Inquisition (Schedule 4, Form 22); and, also in the notes to that form, the suggested verdict "C.D. died from addiction to drugs" has been altered to "C.D. died from dependence on drugs/non-dependent abuse of drugs".

APPENDIX B



Ms M E Hassell
H M Coroner
for Cardiff and the Vale of Glamorgan



Chief Executive
Welsh Health Estates
PO Box 182
Bevan House
24-30 Lambourne Crescent
Llanishen
Cardiff CF14 5GS

23 April 2009

Dear Sir/Madam

**Re: Rule 43 Coroners Rules report
John William Joseph MANLEY (died 11.10.09)**

I concluded the inquest touching the death of Jack Manley yesterday. Mr Manley died when he left a third floor window in Cardiff Royal Infirmery, whilst a patient of the regional stroke unit. The window from which Mr Manley exited the building, was fitted with a window restrictor that allowed it to open up to a width of 185mm, and 230mm under pressure. The jury returned a narrative verdict, a copy of which I enclose for your consideration.

If a coroner believes that action should be taken to prevent or reduce the risk of recurrence of fatalities, under Rule 43 of The Coroners Rules 1984 it is open to him or her to make a report to a person who may have power to take this action. I make such a report to you now.

I heard evidence during the course of the inquest that technical memorandum number 55, recommends that 100mm window restrictors be placed on hospital windows to be used on wards for the elderly and the mentally ill. However, this is only an essential requirement if the ward is to be used for children.

If the windows on the stroke unit, where patients are often confused, had been fitted with 100mm restrictors, then it seems unlikely that Mr Manley could have exited from one of them. Given this, I wonder whether consideration could be given to the 100mm window restriction being mandatory, rather than simply a recommendation?

Under Rule 43 of The Coroners (Amendment) Rules 2008, you are obliged to give me a written response to my report within 56 days of the date at the top of this letter. Your response must detail the action that you have taken or the reasons why no action has been taken.

I shall copy your response to the Lord Chancellor and to a representative of the interested persons to this inquest. The Lord Chancellor may, if he chooses, publish a copy of your response.

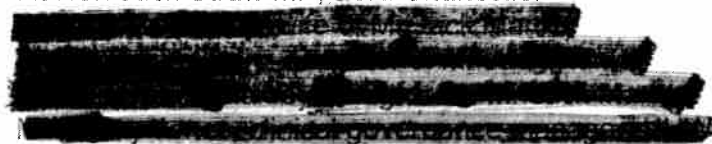
You are entitled to make written representations to me about copying your response to interested persons and/or the publication of it by the Lord Chancellor. These written representations must be made at least by the time of your substantive response.

I look forward to hearing from you with your decided course of action.

Yours faithfully

Mary Hassell
HM Coroner

cc Rt Hon Jack Straw MP, Lord Chancellor

A large black rectangular redaction box covering several lines of text in the distribution list.



WELSH HEALTH ESTATES
YSTADAU IECHYD CYMRU

PO Box 182, Bevan House,
24-30 Lambourne Crescent, Llanishen, Cardiff CF14 5GS
Bwlch SP 182, Tŷ Bevan,
24-30 Cilgant Lambourne, Llanisien, Caerdydd CF14 5GS
Telephone/Ffôn: 029 2031 5500
Fax/Ffacs: 029 2031 5501
Internet/Rhyngwyd: www.wales.nhs.uk/whe
Intranet/Mewnwyd: hows.wales.nhs.uk/whe

Our ref: NHD/EO
Your ref:
Enquiries to: Mr Neil Davies

Director/Cyfarwyddwr:
N.H. Davies BSc, Dip Proj Man (RICS), MBA, MCIOB, FIHEEM

12 June 2009

Ms M E Hassell
HM Coroner
For Cardiff and the Vale of Glamorgan
The Coroner's Court
Central Police Station
Cathays Park
CARDIFF
CF10 3NN

Dear Ms Hassell

**Re: Rule 43 Coroners Rules report
John William Joseph MANLEY (died 11.10.08)**

I refer to your letter dated 23rd April 2009.

Your letter requested *whether consideration could be given to the 100mm window restriction being mandatory, rather than simply a recommendation* and before responding directly to your request I think it might be helpful if I first explained the process by which technical guidance for the NHS is produced as it does have an influence on our response to this issue.

NHS buildings are subject to the same legislative requirements that apply to all buildings but in recognition of the specialist functionality of healthcare buildings the NHS has a long tradition of producing bespoke technical guidance. The vast majority of this guidance is contained within the Health Building Note (HBN) and Health Technical Memorandum (HTM) series, which includes HTM 55 – Building Components: Windows.

- 1 -

Direct Line 029 20315538
e-mail address
neil.davies@whe.wales.nhs.uk



Technical guidance is developed in partnership with the different health administrations across the United Kingdom; a process that pre-dated the establishment of the National Assembly for Wales and has not changed significantly with the devolution of health and social policy to Scotland, Wales and Northern Ireland. Unlike health service policy, technical estates issues tend not to differ greatly between administrative boundaries but where they do, amendments can be made unilaterally to reflect the needs of the devolved Government.

Welsh Health Estates represents the Welsh Assembly Government and the NHS in Wales in this process.

HTM 55 - Building Components: Windows was first issued in 1989 and revised in 1998 and this HTM together with others dealing with Building Components is currently being reviewed by CODA Architects as part of a national (UK) commission. The intention is that this group of HTMs is rationalised and integrated into one core Building Component HTM. CODA Architects have been informed of the circumstances of Mr Manley's death and with your concerns with the current guidance.

The first formal meeting of the Steering Group for this work is likely to take place in early July 2009 at which a more detailed works programme will be agreed.

Welsh Health Estates has reviewed the current guidance and contacted all NHS Trusts in Wales and our private sector colleagues responsible for designing windows for all our new major hospital developments, to invite comment and feedback, specifically in respect to HTM 55 - Building Components: Windows, paragraph 2.11- Safety, which states the following in respect of window restrictors:

Project teams must decide on the needs for safety in health buildings, the restriction of opening lights will be required in many rooms, or even throughout a building. A restricted opening of not more than 100mm is recommended for use within reach of patients, particularly in areas for the elderly, those with learning difficulties or mental illness, and is essential where windows are accessible to children.

We are also mindful that as a result of a number of incidents where patients fell from windows of upper floors, a Department of Health Estates and Facilities Alert was issued in November 2007 in respect of window restrictors. The Alert, which was distributed to all NHS Trusts in Wales, highlighted the need to review all installed window restrictors in light of the HTM guidance and to assess the need for restrictors in patient locations where none currently exist.

Whilst all NHS Trusts in Wales and our private sector architect partners acknowledge that the vast majority of windows should be (and are) fitted with 100mm window opening restrictors, there are certain circumstances where alternative solutions are more appropriate. These include, for example:

- Mental Health Unit sliding sash windows which have openings greater than 100mm but have an integral mesh cover to both top and bottom openings, effectively 'closing' the window opening, and making it secure.
- Windows acting as smoke vents, e.g. in restaurants/cafés, and at the top of stairs. These need to open wider than 100mm but can only operate in the event of a fire (activated either by the Fire and Rescue Service or by the activation of the Fire Detection systems/alarm). These are not located in ward areas, and the opening lights are located at approximately 2700mm above floor level.

It is important to note that all technical guidance is considered to reflect best practice at the time of publication but it is recognised that it is not always possible for published documents, which are refreshed once every 5-10 years, to reflect the most innovative standards and practices. Consequently derogations from HTM standards are currently allowable but should only be agreed in the context of well documented risk assessments supporting the alternative approach.

In light of the above Welsh Health Estates does not intend amending HTM 55 at this time, particularly as the document is currently being incorporated in to a revised Building Components HTM and the architect responsible for this commission has been informed of your views and the document will be subject to the usual pre-publication scrutiny process.

Welsh Health Estates also believes that it is appropriate to continue to allow derogations to best practice guidance to encourage innovation but only if supported by thorough and well documented risk assessments.

As an interim action, prior to the publication of the new HTM, Welsh Health Estates will distribute a Welsh Health Estates Notification letter highlighting the importance of 100mm window restrictors, reminding NHS Trusts of their obligations detailed in the DH Estates and Facilities Alert issued in November 2007 and emphasising that derogations to HBN 55 should only be allowable if supported by risk assessments and 'signed off' by a senior responsible officer.

Finally may I take this opportunity on behalf of Welsh Health Estates to pass on my condolences to the family and friends of Mr Manley. This has clearly been a very difficult time for all involved in this incident.

Yours sincerely,



NEIL H DAVIES

Director

- 3 -

Direct Line 029 20315538
e-mail address
neil.davies@whe.wales.nhs.uk



Dr Robert W Hunter
Her Majesty's Coroner
For the Derby & South
Derbyshire Coroner's
District

Miss Louise Pinder
H M Deputy Coroner

Mr Michael Bird
Mr Paul McCandless
Mrs Catherine Mason
H M Assistant
Deputy Coroners

Coroner's Office
St Katherine's House
St Mary's Wharf
Mansfield Road
Derby
DE1 3TQ

Tel : 01332 513014
Fax : 01332 294942

derby.coroner@
btopenworld.com

1st June 2009

Rt Hon Jacqui Smith MP
Home Secretary
House of Commons
London
SW1A 0AA

Dear Secretary

Re : Rule 43 letter following the inquest touching the death of
Adrian Thomas Pollard

On the 21st May 2009 I concluded the inquest into Mr Pollard's death.
The medical cause of death was

- 1(a) Left Ventricular Failure
- (b) Severe Left Ventricular Hypertrophy
- (c) Ingestion of (D)-Amphetamine and Benzylpiperazine
(Piperazine)

The circumstances were that Mr Pollard was known to use anabolic steroids, amfetamines and Ecstasy. On the evening prior to his death he had taken amfetamine and what was believed to be Ecstasy, but was in fact Piperazine. He had complained of chest pains in the early hours of the morning of the 30th August 2008 and he developed a headache, became clammy and sweaty. He went outside for fresh air and he then collapsed and died.

Evidence was heard during the course of the inquest from the Pathologist and Toxicologist that Piperazine, like Ecstasy and amfetamines, is known to cause fatal cardiac disturbance leading to sudden cardiac arrest.

Mr [REDACTED], a drugs adviser to Derbyshire Constabulary had informed the court that Piperazine is a relatively new drug on the party scene. It is commercially available as a de-worming agent, primarily for veterinary practice, but can also be used in humans. It is marketed as legal Ecstasy or a herbal Ecstasy.

Mr [REDACTED] informed the court that currently, certainly within Derbyshire, 60% of what people believe to be Ecstasy is in fact Piperazine, as Piperazine is commercially and freely available and unscrupulous drug pushers use this to pass over as Ecstasy.

Please address all correspondence to H.M. Coroner

Mr [REDACTED] informed the court that previously Piperazine and Benzylpiperazine had no formal legal status and could readily be purchased over the counter. However recently it has been changed to a prescription only medicine and therefore the selling of it is illegal and contrary to the Medicine's Act, however possession is not an offence.

The court also heard evidence that in the last year there has been one other case in North Derbyshire of someone dying of Piperazine and, more recently a death was reported and inquested by the Sheffield Coroner, again, Piperazine being a contributing factor or the cause of death.

I am writing to you under Rule 43 of the Coroner's Rules for you to consider whether, at the next review to reclassify Piperazine as a controlled drug.

Rule 43 states :

"Prevention of future deaths

43. – (1) *Where –*

- (a) a Coroner is holding an inquest into a person's death;*
- (b) the evidence gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future; and*
- (c) in the Coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances,*

the Coroner may report the circumstances to a person who the Coroner believes may have power to take such action"

Under Rule 43, subsection four, I'm obliged to send a copy of this letter to the Lord Chancellor and to any other person who has been served with a notice under Rule 19. In this case I shall be sending a copy of this letter to [REDACTED] Mr Pollard's [REDACTED]

Similarly, under Rule 43A, subsection one :

"Response to report under Rule 43

43A. – (1) *A person to whom a Coroner sends a report under Rule 43(1) must give the Coroner a written response to the report containing -*

(a) details of any action that has been taken or which it is proposed will be taken whether in response to the report or otherwise; or;

(b) an explanation as to why no action is proposed

within the period of 56 days beginning with the day on which the report is sent."

Similarly, I am obliged to forward a copy of the response to the Lord Chancellor and to any persons served with notice under Rule 19.

I thank you for the attention you've given this matter and I await your response.

Yours sincerely

A large black rectangular redaction covers the signature area of the letter.

Dr Robert Hunter
HM Coroner



Home Office

Direct Communications Unit
2 Marsham Street, London SW1P 4DF
Switchboard 020 7035 4848 Fax: 020 7035 4745 Textphone: 020 7035 4742
E-mail: public.enquiries@homeoffice.gsi.gov.uk Website: www.homeoffice.gov.uk

Dr Robert Hunter
HM Coroner
St Katherine's House
St Mary's Wharf
Mansfield Road, Derby
DE1 3TQ

Reference: T9348/9

3 July 2009

Dear Dr Hunter,

Rule 43A reply

Thank you for your Rule 43 letter of 1 June to the former Home Secretary, following the inquest into Mr Adrian Thomas Pollard's death and referring to the current and future legal status and control of 1-benzylpiperazine (BZP) and related piperazine compounds. Your letter has been passed to the Drug Strategy Unit and I have been asked to provide a Rule 43A reply.

In March 2008, the European Council decided to subject 1-benzylpiperazine (BZP) to 'control measures and criminal provisions' across the EU Member States in response to concerns over the misuse of the drug. The Home Office subsequently requested advice from the Advisory Council on the Misuse of Drugs, the independent statutory advisory body on drug misuse matters, on the appropriate level of control under the Misuse of Drugs Act 1971. The Government expects to bring BZP under control of that Act later this year, following the completion of some wider consultation and the necessary Parliamentary process.

A formal, 12 week public consultation began on 21 May, bringing forward options to control 1-benzylpiperazine (BZP) and a group of substituted piperazines, including full control as a Class C drug under the 1971 Act. The

- 8 JUL 2009

closing date is 13 August. The consultation paper is available at <http://www.homeoffice.gov.uk/about-us/haveyoursay/current-consultations/>.

Following the consultation, the Government will bring forward for Parliamentary consideration such legislation that it considers will respond best to the problem in the UK and help to ensure that others do not undergo the distressing experiences or otherwise suffer in the way that the families and friends of those deceased, to whom your correspondence draws attention, have done.

✓ I enclose three copies of the consultation paper, including one each for the Lord Chancellor and [REDACTED]

Yours sincerely,

[REDACTED]

[REDACTED]

MJL/TJL/J-Flitcroft-Rule 43

Ms Bev Humphrey
Chief Executive
Greater Manchester West Mental Health
NHS Foundation Trust
Trust Headquarters
Bury New Road
Prestwich
Manchester M25 3BL

1st June 2009

Dear Ms Humphrey

JOHN FLITCROFT Deceased

I recently conducted the Inquest into the death of Mr John Flitcroft who died on the 27th April 2008 whilst an inpatient at the Trust.

At the end of the Inquest Hearing I returned a conclusion that Mr Flitcroft had taken his own life whilst suffering from diagnosed anxiety and depression. The balance of his mind was disturbed to a degree that his ability to form an intention to end his life is unclear.

In the course of the Inquest Hearing I heard evidence that Mr Flitcroft was subject to general observations at the time of his death. General observations were described as being conducted at intervals of 2 hours. Both Nurse [REDACTED] and Dr [REDACTED] in evidence told me that the next level of observations formally available within the Trust was constant observations. Observations at an intermittent level between 2 hourly and constant were not formally within Trust Policy according to the evidence that I received.

Dr [REDACTED] explained that she thought that the difficulty which had been found with intermittent observations was that patients were still able to harm themselves within any intermittent period and if therefore there were concerns about a patient's risk of self-harm then the safest thing was to proceed to constant observations. This would of course mean that a member of staff would effectively be constantly detailed to observe an individual patient.

At the conclusion of the Inquest Hearing I expressed concern about the Policy that I had heard described of there being only two observation levels, either general or constant. I indicated that whilst I accepted Dr [REDACTED] evidence that a patient might harm him or herself even within short intervals of time, my understanding of the purpose of intermittent observations was that it would not only detect patients in the act of harming themselves but would also detect, or have the possibility of detecting, preliminary steps. Additionally it is my understanding that a further purpose of intermittent observations is to detect deteriorations in mood or behaviour over a shorter period of time than general observations would reveal.

In those circumstances I announced that I would be writing to you under the terms of Rule 43 of the Coroners Rules in order to ask you to review the Policy with regard to observations, bearing in mind the comments that I have made.

I must therefore formally advise you that I am reporting this matter to you in accordance with Rule 43 of the Coroners Rules 1984 (as amended by the Coroners (Amendment) Rules 2008). This Rule provides that where the evidence at an Inquest gives rise to a concern that circumstances creating a risk of other deaths will occur or will continue to exist in the future and in the Coroner's opinion action should be taken to prevent the occurrence or continuation of such circumstances or to eliminate or reduce the risk of death created by such circumstances the Coroner may report the circumstances to a person who may have power to take such action and in this case that is of course yourself.

I must further formally advise you that in accordance with Rule 43 a copy of this report is being sent to the Lord Chancellor and to all the other properly Interested Persons identified at the Inquest. In this case I am sending a copy of the report to [REDACTED] on behalf of the family and to their Solicitors, [REDACTED]. Your response to this report will be shared with those individuals.


The Lord Chancellor may send a copy of the report and your response to any person whom the Lord Chancellor believes may find it useful or of interest. In addition the Lord Chancellor may publish a full copy or a summary of the report and response (unless I have decided otherwise in response to a written representation about the release and publication of your response).

Rule 43a of the Coroners Rules requires that you give a written response within 56 days of the date that this report is sent. If you are unable to respond within that time you may apply to me for an extension. Your response is to contain details of any action that has been taken or which it is proposed will be taken whether in response to this report or otherwise, or an explanation as to why no action is proposed.

If there are circumstances where you do not want your full response to be shared with the aforementioned recipients or a copy of your response to be published you may make a written representation to me at the time of giving your response. Instead of releasing or publishing your full response it may be possible to share or publish a summary in accordance with Rule 43a.

I look forward to hearing from you.

Yours sincerely


M Jennifer Leeming
H M Coroner
Greater Manchester County (West)

Greater Manchester West
Mental Health NHS Foundation Trust



Our Ref: Bev Humphrey
Your Ref: MJL/TJL/J-Flitcroft3 2009

Trust Headquarters
Bury New Road
Prestwich
Manchester
M25 3BL
01617739121

14/08/09

Mrs M J Leeming
HM Coroner
Greater Manchester County (West District)
Coroner's Court
Paderborn House
Civic Centre
Howell Croft North
Bolton
BL1 1JW

Dear Mrs Leeming

John Flitcroft (Deceased)

I am writing with reference to your letter of 1 June, that letter being written under the provisions of Rule 43 of the Coroner's Rules (as amended). Further, I am grateful to you for providing the transcript of the proceedings.

I note from the Rule 43 letter that you require the Trust to undertake a review with regard to its Policy on observations, reflecting the matters that you have raised in your letter.

By way of background, the Trust routinely reviews its Observation Policy, this being led by Dr [REDACTED], Nurse Consultant who is viewed as one of the national leading experts around observation and suicide prevention. Reflecting upon the dates that Mr Flitcroft died, the Trust last reviewed its Observation Policy in 2006. I enclose for your information a copy of the Observation Policy that was in place at the time.

Further, the issue of the level of observations used upon patients within mental health settings has been the subject of a number of national reviews and studies. The National Confidential Inquiry into Suicide and Homicide by Mentally Ill People found that no less than 22% of mental health inpatient suicides take place while the patient is under increased observation, usually Level 2 or intermittent observation. Other studies have emphasised the importance of using the opportunity provided by observation duties to engage with the patient rather than merely check on them. Also, in 2005 the National Institute for Clinical Excellence (NICE) provided guidance on observation policies to all mental health services, specifying that a range of levels of observation, including intermittent observation, should be available to staff. The Trust's observation policy reflects all these findings.

You will note from the Trust's Observation Policy in place at the time of Mr Flitcroft's death that contrary to the impression that may have been given by the staff who gave evidence at the inquest.

The NHS has a responsibility for the nation's health.
Protect yourself, service users, visitors and staff by adhering to our no smoking policy.

Greater Manchester West Mental Health NHS Foundation Trust, Trust HQ, Bury New Road, Prestwich,
Manchester M25 3BL Tel 0161 773 9121

Acting Chair Alan Maden

Chief Executive: Bev Humphrey


Level 2, intermittent observations, were still part of the Trust's Observation Policy that staff could employ if concerns existed about a patient.

Again, this is in line with the NICE guidance of 2005 referred to above. Indeed, as the evidence from [REDACTED] and [REDACTED] indicated, they had on occasions continued to use Level 2, intermittent observations. Further, I note that the inquest concluded that Mr Flitcroft was nursed on the appropriate level of observations at the time of his death.

It is important to note that the use of Level 3 observations does not mean that a patient would necessarily only be observed every 2 hours. This is the minimum interval. In most cases staff will interact with patients in between formal observations. Finally, staff seek to ensure that a patient's risk is adequately monitored and also to support their privacy and dignity, avoiding unnecessary intrusion. Moreover, in the case of Mr Flitcroft, adequate sleep was a crucial issue for him and it was essential that staff disturbed him as little as possible while bearing in mind reasonable concerns about his safety.

What has become apparent however is that there is an impression amongst nursing staff that the Trust's Observation Policy has directed that Level 2 intermittent observations should no longer be used and as the Trust Observation Policy makes clear this was not in fact the case. Recognising that there is this discrepancy, the Trust has ensured that the Observation Policy forms part of the Trust's clinical risk training for all clinical staff. As part of this training, staff are made aware or reminded of the options that exist regarding the levels of observation and the sorts of occasions upon which each level of observation should be adopted without taking away the staff member's clinical judgment. The Trust will also be reinforcing that Level 2 observations remain part of the strategy for nursing a patient via an alert placed in the Trusts Lessons learned Newsletter which is distributed to all clinical staff on a bi monthly basis.

Yours sincerely


[REDACTED]
Bev Humphrey
Chief Executive

The NHS has a responsibility for the nation's health.
Protect yourself, service users, visitors and staff by adhering to our no smoking policy.

Greater Manchester West Mental Health NHS Foundation Trust, Trust HQ, Bury New Road, Prestwich,
Manchester M25 3BL Tel 0161 773 9121
Chair Alan Maden Chief Executive: Bev Humphrey

APPENDIX C

Excerpt from: Secretary of State for the Home Department. *Death Certification and Investigation in England, Wales and Northern Ireland*. London: The Stationery Office 2003 Cm 5831. (p. 95-96)

Coroners Recommendations

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.

APPENDIX D



Coroners Act 1988

1988 CHAPTER 13

An Act to consolidate the Coroners Acts 1887 to 1980 and certain related enactments, with amendments to give effect to recommendations of the Law Commission. [10th May 1988]

Be it enacted by the Queen's most Excellent Majesty, by and with the advice and consent of the Lords Spiritual and Temporal, and Commons, in this present Parliament assembled, and by the authority of the same, as follows:—

Annotations:

Modifications etc. (not altering text)

- C1 Act amended (24.9.1997) by 1996 c. 24, s. 7(3); S.I. 1997/1977, art. 2
- C2 Act restricted (*temp.* from 19.7.1996 to 31.3.1998) by S.I. 1996/1867, art. 4(2)(d)
- C3 By Criminal Justice Act 1991 (c.53, SIF 39:1), s. 101(1), Sch. 12 para. 23; S.I. 1991/2208, art. 2(1), Sch. 1 it is provided (14.10.1991) that in relation to any time before the commencement of s.70 of that 1991 Act (which came into force on 1.10.1992 by S.I. 1992/333, art. 2(2), Sch. 2) references in any enactment amended by that 1991 Act, to youth courts shall be construed as references to juvenile courts.

Commencement Information

- I1 Act wholly in force at 10.7.1988 see s. 37(2)

Coroners

1 Appointment of coroners.

[^{F1}(1) Coroners shall be appointed—

- (a) for each coroner's district in a metropolitan county, [^{F2}in a special non-metropolitan county or in] Greater London or Wales;

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

- (b) for each coroner's district constituted by an order under section 17 of the Local Government Act 1992 which lies partly in each of two or more non-metropolitan counties;
 - (c) for each non-metropolitan county in England ^[F3], other than a special non-metropolitan county,] none of which is included in such a coroner's district as is mentioned in paragraph (b) above;
 - (d) in the case of a non-metropolitan county in England part of which is included in such a coroner's district as is mentioned in paragraph (b) above, for so much of that county as is not so included; and
 - (e) for the City.
- (1A) Coroners shall be appointed by the relevant council, that is to say—
- (a) in the case of a coroner's district consisting of or included in a metropolitan district ^[F4], special non-metropolitan district] or London borough, the council of that district or borough;
 - (b) in the case of a coroner's district consisting of two or more metropolitan districts ^[F5], special non-metropolitan districts] or London boroughs, such one of the councils of those districts or boroughs as may be designated by an order made by the Secretary of State by statutory instrument;
 - (c) in the case of a coroner's district consisting of or included in a Welsh principal area, the council of that area;
 - (d) in the case of a coroner's district lying partly in each of two or more Welsh principal areas, such one of the councils of those areas as may be designated by an order made by the Secretary of State by statutory instrument;
 - (e) in a case falling within subsection (1)(b) above, such one of the councils of the non-metropolitan counties in question as may be designated by an order under section 17 of the Local Government Act 1992;
 - (f) in a case falling within subsection (1)(c) or (d) above, the council of the non-metropolitan county in question; and
 - (g) in the case of the City, the Common Council.]
- (2) A relevant council falling within paragraph (a) or (b) of ^[F6]subsection (1A)] above shall not appoint a coroner except with the approval of the Secretary of State; and a relevant council falling within paragraph (b) ^[F7](d) or (e)] of that subsection shall not appoint a coroner except after consultation with the other council or councils in question.
- (3) Subject to subsection (2) above, where a vacancy occurs in the office of coroner, the relevant council shall—
- (a) immediately give notice of the vacancy to the Secretary of State;
 - (b) within three months of the vacancy occurring or within such further period as the Secretary of State may allow, appoint a person to that office; and
 - (c) immediately after making the appointment, give notice of the appointment to the Secretary of State.

Annotations:

Amendments (Textual)

- F1** S.1(1)(1A) substituted (1.4.1996) for s. 1(1) by S.I. 1996/655, reg. 2(2)
- F2** Words in s. 1(1)(a) inserted (1.4.1998) by S.I. 1998/465, reg. 2(2)
- F3** Words in s. 1(1)(c) inserted (1.4.1998) by S.I. 1998/465, reg. 2(3)
- F4** Words in s. 1(1A)(a) inserted (1.4.1998) by S.I. 1998/465, reg. 2(4)

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

- F5** Words in s. 1(1A)(b) inserted (1.4.1998) by S.I. 1998/465, **reg. 2(5)**
F6 Words in s. 1(2) substituted (1.4.1996) by S.I. 1996/655, **reg. 2(3)**
F7 Words in s. 1(2) substituted (1.4.1996) by S.I. 1996/655, **reg. 2(3)**

2 Qualifications for appointment as coroner.

- (1) No person shall be qualified to be appointed as coroner [^{F8}unless—
- (a) he has a 5 year general qualification, within the meaning of section 71 of the Courts and Legal Services Act 1990; or
 - (b) he is a] legally qualified medical practitioner of not less than five years' standing . . . ^{F9}.

- (2) A person shall, so long as he is a councillor of a metropolitan district [^{F10}, special non-metropolitan district] or London borough, and for six months after he ceases to be one, be disqualified for being a coroner for a coroner's district which consists of, includes or is included in that metropolitan district [^{F10}, special non-metropolitan district] or London borough.

- [^{F11}(2A) A person shall, so long as he is a councillor of a Welsh principal area, and for six months after he ceases to be one, be disqualified for being a coroner for a coroner's district which, or any part of which, falls within that area.]

- (3) A person shall, so long as he is an alderman or a councillor of a non-metropolitan county [^{F12}in England], and for six months after he ceases to be one, be disqualified
- [^{F13}(a) in the case of a county none of which is included in such a coroner's district as is mentioned in section 1(1)(b) above, for being a coroner for that county;
 - (b) in the case of a county the whole or part of which is included in such a coroner's district as is mentioned in section 1(1)(b) above, for being a coroner for that coroner's district and for so much of that county (if any) as is not so included.]

- (4) A person shall, so long as he is an alderman of the City or a common councillor, and for six months after he ceases to be one, be disqualified for being a coroner for the City.

Annotations:

Amendments (Textual)

- F8** Words substituted by Courts and Legal Services Act 1990 (c. 41, SIF 37), s. 71(2), **Sch. 10 para. 70**
F9 Words repealed by Courts and Legal Services Act 1990 (c. 41, SIF 37), s. 125(7), **Sch. 20**
F10 Words in s. 2(2) inserted (1.4.1998) by S.I. 1998/465, **reg. 2(6)**
F11 S. 2(2A) inserted (from 3.4.1995 to 1.4.1996 for specified purposes only and thereafter wholly in force) by 1994 c. 19, s. 66(6), **Sch. 16 para. 82(3)** (with ss. 54(5)(7), 55(5), Sch. 17 paras. 22(1), 23(2)); S.I. 1995/852, art. 9(1)(4), **Sch. 5** (with art. 9(5))
F12 Words in s. 2(3) inserted (from 3.4.1995 to 1.4.1996 for specified purposes only and thereafter wholly in force) by 1994 c. 19, s. 66(6), **Sch. 16 para. 82(3)** (with ss. 54(5)(7), 55(5), Sch. 17 paras. 22(1), 23(2)); S.I. 1995/852, art. 9(1)(4), **Sch. 5** (with art. 9(5))
F13 Words in s. 2(3) substituted (1.4.1996) by S.I. 1996/655, **reg. 2(4)**

Modifications etc. (not altering text)

- C4** S. 2(2)(3) extended (E.) (6.5.2002) by S.I. 2002/975, **reg. 2(a)**

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

3 Terms on which coroners hold office.

- (1) The provisions of Schedule 1 to this Act shall have effect with respect to the payment of salaries and the grant of pensions to coroners.
- (2) Except as authorised by this or any other Act, a coroner shall not take any fee or remuneration in respect of anything done by him in the execution of his office.
- (3) A coroner may resign his office by giving notice in writing to the relevant council, but the resignation shall not take effect unless and until it is accepted by that council.
- (4) The Lord Chancellor may, if he thinks fit, remove any coroner from office for inability or misbehaviour in the discharge of his duty.
- (5) A coroner who is guilty of corruption, wilful neglect of his duty or misbehaviour in the discharge of his duty shall be guilty of an offence and liable on conviction on indictment to imprisonment for a term not exceeding two years or to a fine or to both.
- (6) Where a coroner is convicted of an offence under subsection (5) above, the court may, unless his office as coroner is annexed to any other office, order that he be removed from office and be disqualified for acting as coroner.

4 Coroners' districts.

- (1) The Secretary of State may by order divide, amalgamate or otherwise alter the coroners' districts for the time being existing in a metropolitan county [^{F14}, special non-metropolitan county] or Greater London; and before making any such order, the Secretary of State shall consult the councils and coroners appearing to him to be affected by the order and such other persons as he thinks appropriate.
- (2) The council of a non-metropolitan county [^{F15}in England] may, and shall if directed to do so by the Secretary of State, after complying with such requirements as to notice and consideration of objections as may be prescribed, submit to the Secretary of State a draft order providing—
 - (a) for such alteration of any existing division of the county into coroners' districts as appears to them suitable; or
 - (b) where there is no such division, for the division of the county into such coroners' districts as they think expedient;
 and the Secretary of State, after taking into consideration any objections to the draft made in the prescribed manner and within the prescribed time, may make the order, either in the terms of the draft submitted to him or with such modifications as he thinks fit.
- (3) If by reason of any order under subsection (2) above it is in the opinion of the Secretary of State necessary that the number of coroners for a non-metropolitan county should be increased,
 - (a) the council shall appoint such number of additional coroners for that county as the Secretary of State may direct; and
 - (b) section 1(3) above shall apply with respect to any such appointment as if a vacancy had occurred in the office of coroner for that county.
- (4) Where a non-metropolitan county [^{F15}in England] is divided into coroners' districts, each of the coroners for that county shall be assigned to one of those districts; and where a non-metropolitan county is not so divided, the following provisions of this Act shall have effect as if the whole of that county were a coroner's district.

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

- (5) Except as provided by this Act, a coroner appointed for or assigned to a coroner's district—
- (a) shall for all purposes be regarded as a coroner for the whole administrative area [^{F16}in England] which includes that district; and
 - (b) shall have the same jurisdiction, rights, powers and authorities throughout that area as if he had been appointed as coroner for that area or, as the case may be, had not been assigned to that district.
- [^{F17}(5A) Subsections (2) to (5) above shall not apply to a non-metropolitan county the whole of which is included in such a coroner's district as is mentioned in section 1(1)(b) above [^{F18}or a special non-metropolitan county].
- (5B) In the application of this section to a non-metropolitan county part of which is included in such a coroner's district as is mentioned in section 1(1)(b) above, any reference in subsections (2)(a) and (b), (3) and (4) to a county shall be construed as a reference to so much of that county as is not so included.]
- (6) The power to make orders under this section shall be exercisable by statutory instrument; and a statutory instrument containing an order under this section shall be laid before each House of Parliament after being made.
- (7) An order under subsection (2) above shall be published in the London Gazette and particulars of any order under that subsection shall be published by the council of the non-metropolitan county in such manner as may be prescribed.
- (8) In this section "prescribed" means prescribed by the Secretary of State either by general rules made by statutory instrument or by directions given as respects any particular occasion.

Annotations:

Amendments (Textual)

- F14** Words in s. 4(1) inserted (1.4.1998) by S.I. 1998/465, **reg. 2(7)**
- F15** Words in s. 4(2) and (4) inserted (3.4.1995) by 1994 c. 19, s. 66(6), **Sch. 16 para. 82(4)** (with ss. 54(5)(7), 55(5), Sch. 17 paras. 22(1), 23(2)); S.I. 1995/852, art. 9(1), **Sch. 5** (with art. 9(5))
- F16** Words in s. 4(5)(a) inserted (3.4.1995) by 1994 c. 19, s. 66(6), **Sch. 16 para. 82(4)** (with ss. 54(5)(7), 55(5), Sch. 17 paras. 22(1), 23(2)); S.I. 1995/852, art. 9(1), **Sch. 5** (with art. 9(5))
- F17** S. 4(5A)(5B) inserted (1.4.1996) by S.I. 1996/655, **reg. 2(5)**
- F18** Words in s. 4(5A) inserted (1.4.1998) by S.I. 1998/465, **reg. 2(8)**

[4A] ^{F19}Coroners' districts: Wales.

- (1) The Secretary of State may by order divide, amalgamate or otherwise alter—
- (a) any coroner's district for the time being existing in Wales; or
 - (b) any such coroners' districts.
- (2) Before making any order under subsection (1) above, the Secretary of State shall consult the councils and coroners appearing to him to be affected by the order and such other persons as he thinks appropriate.
- (3) The Secretary of State may, in relation to any area in Wales (the "review area"), direct the council or councils for each Welsh principal area which, or any part of which, falls within the review area to consider any of the following questions—

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

- (a) whether any alteration should be made in a boundary between coroners' districts which falls within the review area;
 - (b) whether a new coroner's district should be created for the whole or any part of the review area;
 - (c) whether a coroner's district which falls wholly within the review area should be abolished.
- (4) The council or councils to whom such a direction is given shall submit their conclusions to the Secretary of State, together with a statement of their reasons for reaching those conclusions.
- (5) In making an order under subsection (1) above in a case where he has given a direction under subsection (3) above, the Secretary of State shall have regard to any proposals made to him under subsection (4) above.
- (6) Where the Secretary of State intends to give effect to any such proposals without modification, subsection (2) above shall not require him to consult the council or councils who made those proposals.
- (7) An order made under subsection (1) above may make such incidental, consequential, transitional or supplemental provision as appears to the Secretary of State to be appropriate.
- (8) Except as provided by this Act, a coroner appointed for any coroner's district in Wales
- (a) shall for all purposes be regarded as a coroner for the whole of Wales; and
 - (b) shall have the same jurisdiction, rights, powers and authorities throughout Wales as if he had been appointed as coroner for the whole of Wales.
- (9) The power to make orders under this section shall be exercisable by statutory instrument.
- (10) Any such statutory instrument shall be laid before each House of Parliament after being made.]

Annotations:

Amendments (Textual)

F19 S.4A inserted (3.4.1995 in respect of the insertion of s. 4A(1)(2)(7)(9)(10) and 1.4.1996 otherwise) by 1994 c. 19, s. 66(6), **Sch. 16 para. 82(5)** (with ss. 54(5)(7), 55(5), Sch. 17 paras. 22(1), 23(2)); S.I. 1995/852, art. 9(1), **Sch. 5**; S.I. 1996/396, art. 4, **Sch. 2**

Modifications etc. (not altering text)

C5 S.4A restricted (3.4.1995) by 1994 c. 19, s. 66(7), **Sch. 17 Pt. II para. 23(5)** (with ss. 54(5)(7), 55(5), Sch. 17 paras. 22(1), 23(2)); S.I. 1995/852, art. 9(1), **Sch. 5**

5 Jurisdiction of coroners.

- (1) Subject to subsection (3) and sections 7 and 13 to 15 below, an inquest into a death shall be held only by the coroner within whose district the body lies.
- (2) Subject to subsection (3) and section 13 below, a coroner shall hold inquests only within his district.

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

- (3) A coroner may act as coroner for another district in the same administrative area—
- (a) during the illness, incapacity or unavoidable absence of the coroner for that district; or
 - (b) where there is a vacancy in the office of coroner for that district;
- and the inquisition returned in respect of an inquest held under this subsection shall certify the cause of the coroner's holding the inquest and shall be conclusive evidence of any matter stated in it which falls within paragraph (a) or (b) above.

Deputy coroners

6 Appointment of deputy coroners.

- (1) Every coroner—
- (a) shall appoint as his deputy a person approved by the chairman of the relevant council; and
 - (b) may appoint as his assistant deputy a person so approved.
- (2) A coroner may at any time revoke an appointment made under subsection (1) above; but a revocation of an appointment made under paragraph (a) of that subsection shall not take effect until the appointment of a successor to the deputy has been approved by the chairman of the relevant council.
- (3) The following, namely—
- (a) every appointment made under subsection (1) above; and
 - (b) every revocation of an appointment made under paragraph (b) of that subsection,
- shall be in writing under the hand of the coroner; and a copy of every such appointment or revocation shall be sent to the relevant council and be kept with the council's records.
- (4) Subsection (1) of section 2 above shall apply in relation to the office of deputy or assistant deputy coroner as it applies in relation to the office of coroner; and subsections (2) to (4) of that section shall apply in relation to, or to persons holding, the office of deputy coroner as they apply in relation to, or to persons holding, the office of coroner.
- (5) In this section "chairman", in relation to the Common Council, means the Lord Mayor.

7 Functions of deputy coroners.

- (1) A deputy coroner may act for his coroner in the following cases but no others, namely—
- (a) during the illness of the coroner;
 - (b) during the coroner's absence for any lawful or reasonable cause; or
 - (c) at an inquest for the holding of which the coroner is disqualified.
- (2) Where a coroner vacates office, his deputy—
- (a) shall continue in office until a new deputy is appointed;
 - (b) shall act as coroner while the office remains vacant; and

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

- (c) shall be entitled to receive in respect of the period of the vacancy the same remuneration as the vacating coroner.
- (3) An assistant deputy coroner—
- (a) may act as coroner where the deputy coroner would be entitled to act as coroner but is unable so to act owing to illness or absence for any reasonable cause; and
 - (b) where the coroner vacates office, may act for the deputy coroner in like manner while the office of coroner is vacant.
- (4) In relation to an inquest or act which he is authorised to hold or to do, a deputy or assistant deputy to a coroner shall—
- (a) have the same jurisdiction and powers;
 - (b) be subject to the same obligations, liabilities and disqualifications; and
 - (c) generally be subject to the provisions of this Act and the law relating to coroners in the same manner,
- as if he were the coroner.

Inquests: general

8 Duty to hold inquest.

- (1) Where a coroner is informed that the body of a person (“the deceased”) is lying within his district and there is reasonable cause to suspect that the deceased—
- (a) has died a violent or an unnatural death;
 - (b) has died a sudden death of which the cause is unknown; or
 - (c) has died in prison or in such a place or in such circumstances as to require an inquest under any other Act,
- then, whether the cause of death arose within his district or not, the coroner shall as soon as practicable hold an inquest into the death of the deceased either with or, subject to subsection (3) below, without a jury.
- (2) In the case of an inquest with a jury—
- (a) the coroner shall summon by warrant not less than seven nor more than eleven persons to appear before him at a specified time and place, there to inquire as jurors into the death of the deceased; and
 - (b) when not less than seven jurors are assembled, they shall be sworn by or before the coroner diligently to inquire into the death of the deceased and to give a true verdict according to the evidence.
- (3) If it appears to a coroner, either before he proceeds to hold an inquest or in the course of an inquest begun without a jury, that there is reason to suspect—
- (a) that the death occurred in prison or in such a place or in such circumstances as to require an inquest under any other Act;
 - (b) that the death occurred while the deceased was in police custody, or resulted from an injury caused by a police officer in the purported execution of his duty;
 - (c) that the death was caused by an accident, poisoning or disease notice of which is required to be given under any Act to a government department, to any inspector or other officer of a government department or to an inspector

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

appointed under section 19 of the ^{M1}Health and Safety at Work etc. Act 1974;
or

- (d) that the death occurred in circumstances the continuance or possible recurrence of which is prejudicial to the health or safety of the public or any section of the public,

he shall proceed to summon a jury in the manner required by subsection (2) above.

- (4) If it appears to a coroner, [^{F20}before he proceeds to hold an inquest, on resuming an inquest begun with a jury after the inquest has been adjourned and the jury discharged] or in the course of an inquest begun without a jury, that there is any reason for summoning a jury, he may proceed to summon a jury in the manner required by subsection (2) above.
- (5) In the case of an inquest or any part of an inquest held without a jury, anything done by or before the coroner alone shall be as validly done as if it had been done by or before the coroner and a jury.
- (6) Where an inquest is held into the death of a prisoner who dies within a prison, neither a prisoner in the prison nor any person engaged in any sort of trade or dealing with the prison shall serve as a juror at the inquest.

Annotations:

Amendments (Textual)

F20 Words in s. 8(4) substituted (1.1.2000) by 1999 c. 22, s. 71(2) (with s. 107, Sch. 14 para. 7(2)); S.I. 1999/3344, art. 2(b)

Marginal Citations

M1 1974 c.37.

9 Qualifications of jurors.

- (1) A person shall not be qualified to serve as a juror at an inquest held by a coroner unless he is for the time being qualified to serve as a juror in the Crown Court, the High Court and county courts in accordance with section 1 of the ^{M2}Juries Act 1974.
- (2) If a person serves on a jury knowing that he is ineligible for such service under Group A, B or C in Part I of Schedule 1 to that Act, he shall be guilty of an offence and liable on summary conviction to a fine not exceeding level 3 on the standard scale.
- (3) If a person serves on a jury knowing that he is disqualified for such service under Part II of that Schedule, he shall be guilty of an offence and liable on summary conviction to a fine not exceeding level 5 on the standard scale.
- (4) The appropriate officer may at any time put or cause to be put to any person who is summoned under section 8 above such questions as he thinks fit in order to establish whether or not the person is qualified to serve as a juror at an inquest.
- (5) Where a question is put to any person under subsection (4) above, if that person—
- refuses without reasonable excuse to answer;
 - gives an answer which he knows to be false in a material particular; or
 - recklessly gives an answer which is false in a material particular,

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

he shall be guilty of an offence and liable on summary conviction to a fine not exceeding level 3 on the standard scale.

(6) If any person—

- (a) duly summoned as a juror at an inquest makes, or causes or permits to be made on his behalf, any false representation to the coroner or the appropriate officer with the intention of evading service as such juror; or
- (b) makes or causes to be made on behalf of another person who has been so summoned any false representation to the coroner or the appropriate officer with the intention of enabling that other person to evade such service,

he shall be guilty of an offence and liable on summary conviction to a fine not exceeding level 3 on the standard scale.

(7) A coroner may authorise a person to perform the functions conferred on the appropriate officer by subsection (4) above and references in this section to the appropriate officer shall be construed as references to the person so authorised.

Annotations:

Marginal Citations

M2 1974 c.23.

10 Attendance of jurors and witnesses.

(1) Where a person duly summoned as a juror at an inquest—

- (a) does not, after being openly called three times, appear to the summons; or
- (b) appears to the summons but refuses without reasonable excuse to serve as a juror,

the coroner may impose on that person a fine not exceeding [^{F21}£1,000].

(2) Where a person duly summoned to give evidence at an inquest—

- (a) does not, after being openly called three times, appear to the summons; or
- (b) appears to the summons but refuses without lawful excuse to answer a question put to him,

the coroner may impose on that person a fine not exceeding [£1,000].

(3) The powers conferred upon a coroner by this section shall be in addition to and not in derogation of any other power which the coroner may possess—

- (a) for compelling any person to appear and give evidence before him in any inquest or other proceeding; or
- (b) for punishing any person for contempt of court in not so appearing and giving evidence;

but a person shall not be fined by the coroner under this section and also be punished under any such other power.

(4) Notwithstanding anything in the foregoing provisions of this section, a juror shall not be liable to any penalty for non-attendance on a coroner's jury unless the summons requiring him to attend was duly served on him no later than six days before the day on which he was required to attend.

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

Annotations:

Amendments (Textual)

F21 Words in s. 10(1)(2) substituted (1.10.1992) by [Criminal Justice Act 1991 \(c. 53, SIF 39:1\)](#), s. 17(3), [Sch. 4 Pt. I](#) (with s. 28); [S.I. 1992/333](#), art. 2(2), [Sch. 2](#).

Modifications etc. (not altering text)

C6 [S. 10\(1\)\(2\)](#): power to amend conferred (1.10.1992) by [Magistrates' Courts Act 1980 \(c. 43, SIF 82\)](#), s. 143, [Sch. 6A](#) (as substituted (1.10.1992) by [Criminal Justice Act 1991 \(c. 53, SIF 39:1\)](#), s. 17(3), [Sch. 4 Pt. IV](#) (with s. 28)); [S.I. 1992/333](#), art. 2(2), [Sch. 2](#).

11 Proceedings at inquest.

- (1) It shall not be obligatory for a coroner holding an inquest into a death to view the body; and the validity of such an inquest shall not be questioned in any court on the ground that the coroner did not view the body.
- (2) The coroner shall, at the first sitting of the inquest, examine on oath concerning the death all persons who tender evidence as to the facts of the death and all persons having knowledge of those facts whom he considers it expedient to examine.
- (3) In the case of an inquest held with a jury, the jury shall, after hearing the evidence—
 - (a) give their verdict and certify it by an inquisition; and
 - (b) inquire of and find the particulars for the time being required by the ^{M3}Births and Deaths Registration Act 1953 (in this Act referred to as “the 1953 Act”) to be registered concerning the death.
- (4) In the case of an inquest held without a jury, the coroner shall, after hearing the evidence—
 - (a) give his verdict and certify it by an inquisition; and
 - (b) inquire of and find the particulars for the time being required by the 1953 Act to be registered concerning the death.
- (5) An inquisition—
 - (a) shall be in writing under the hand of the coroner and, in the case of an inquest held with a jury, under the hands of the jurors who concur in the verdict;
 - (b) shall set out, so far as such particulars have been proved—
 - (i) who the deceased was; and
 - (ii) how, when and where the deceased came by his death; and
 - (c) shall be in such form as the Lord Chancellor may by rules made by statutory instrument from time to time prescribe.
- (6) At a coroner’s inquest into the death of a person who came by his death by murder, manslaughter or infanticide, the purpose of the proceedings shall not include the finding of any person guilty of the murder, manslaughter or infanticide; and accordingly a coroner’s inquisition shall in no case charge a person with any of those offences.
- (7) Where an inquest into a death is held, the coroner shall, within five days after the finding of the inquest is given, send to the registrar of deaths a certificate under his hand—
 - (a) giving information concerning the death;

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

- (b) specifying the finding with respect to the particulars which under the 1953 Act are required to be registered concerning the death and with respect to the cause of death; and
 - (c) specifying the time and place at which the inquest was held.
- (8) In the case of an inquest into the death of a person who is proved—
- (a) to have been killed on a railway; or
 - (b) to have died in consequence of injuries received on a railway,
- the coroner shall within seven days after holding the inquest, make a return of the death, including the cause of death, to the Secretary of State in such form as he may require; and in this subsection “railway” has the same meaning as in the ^{M4}Railway Regulation Act 1842.

Annotations:

Marginal Citations

M3 [1953 c.20.](#)

M4 [1842 c.55.](#)

12 Failure of jury to agree.

- (1) This section applies where, in the case of an inquest held with a jury, the jury fails to agree on a verdict.
- (2) If the minority consists of not more than two, the coroner may accept the verdict of the majority, and the majority shall, in that case, certify the verdict under section 11(3) above.
- (3) In any other case of disagreement the coroner may discharge the jury and issue a warrant for summoning another jury and, in that case, the inquest shall proceed in all respects as if the proceedings which terminated in the disagreement had not taken place.

Inquests: special cases

13 Order to hold inquest.

- (1) This section applies where, on an application by or under the authority of the Attorney-General, the High Court is satisfied as respects a coroner (“the coroner concerned”) either—
 - (a) that he refuses or neglects to hold an inquest which ought to be held; or
 - (b) where an inquest has been held by him, that (whether by reason of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, the discovery of new facts or evidence or otherwise) it is necessary or desirable in the interests of justice that another inquest should be held.
- (2) The High Court may—
 - (a) order an inquest or, as the case may be, another inquest to be held into the death either—
 - (i) by the coroner concerned; or
 - (ii) by the coroner for another district in the same administrative area;

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

- (b) order the coroner concerned to pay such costs of and incidental to the application as to the court may appear just; and
 - (c) where an inquest has been held, quash the inquisition on that inquest.
- (3) In relation to an inquest held under subsection (2)(a)(ii) above, the coroner by whom it is held shall be treated for the purposes of this Act as if he were the coroner for the district of the coroner concerned.

14 Inquest out of jurisdiction.

- (1) If it appears to a coroner that, in the case of a body lying within his district, an inquest ought to be held into the death but it is expedient that the inquest should be held by some other coroner, he may request that coroner to assume jurisdiction to hold the inquest; and if that coroner agrees he, and not the coroner within whose district the body is lying, shall have jurisdiction to hold the inquest.
- (2) If the coroner who has been requested to assume jurisdiction declines to assume it, the coroner who has made the request may apply to the Secretary of State for a direction designating the coroner who is to hold the inquest.
- (3) On the making of an application under subsection (2) above, the Secretary of State—
- (a) shall determine by which coroner (whether one of the two mentioned in that subsection or another) the inquest should in all the circumstances be held; and
 - (b) shall direct him to assume jurisdiction or, as the case may be, to exercise his jurisdiction to hold the inquest;
- and where a direction is given under this subsection directing a coroner to assume jurisdiction, he, and not the coroner within whose district the body is lying, shall have jurisdiction to hold the inquest and shall hold it accordingly.
- (4) Where jurisdiction to hold an inquest is assumed under this section, it shall not be necessary to remove the body into the district of the coroner who is to hold the inquest.
- (5) Any request made or agreement given, any application for a direction and any direction under any of the foregoing provisions of this section shall be made or given in writing.
- (6) Notice of the making of an application under subsection (2) above shall be given to the coroner who declined to assume jurisdiction and notice of the direction given pursuant to such an application shall be given—
- (a) in a case where the direction is given to the coroner who made the application or the coroner who had notice of it, to the other coroner; and
 - (b) in a case where the direction is given to some other coroner, to the coroner who made the application and to the coroner who had notice of it.
- (7) On the assumption by a coroner of jurisdiction to hold an inquest under this section, the coroner—
- (a) shall also assume, in relation to the body and the inquest, all the powers and duties which would belong to him if the body were lying within his district (including the power to order its exhumation under section 23 below); and
 - (b) may exercise those powers notwithstanding that the body remains outside his district or, having been removed into it, is removed out of it by virtue of any order of his for its examination or burial.
- (8) On the assumption of the powers and duties referred to in subsection (7) above by the coroner who assumes jurisdiction to hold the inquest, the coroner within whose

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

district the body is lying shall cease to have any powers or duties in relation to the body or the inquest, notwithstanding that the body remains within his district or comes to be buried there.

- (9) It shall be for the coroner who assumes, and not for the coroner who ceases to have, jurisdiction to hold an inquest under this section to pay any fees or other expenses incurred in the course of his duties by the latter coroner before he ceased to have jurisdiction; and any such fees or other expenses shall be accounted for and repaid accordingly.

15 Inquest where body destroyed or irrecoverable.

- (1) Where a coroner has reason to believe—
- (a) that a death has occurred in or near his district in such circumstances that an inquest ought to be held; and
 - (b) that owing to the destruction of the body by fire or otherwise, or to the fact that the body is lying in a place from which it cannot be recovered, an inquest cannot be held except in pursuance of this section,
- he may report the facts to the Secretary of State.
- (2) Where a report is made under subsection (1) above, the Secretary of State may, if he considers it desirable to do so, direct a coroner (whether the coroner making the report or another) to hold an inquest into the death.
- (3) Where a coroner is directed under this section to hold an inquest, the provisions of this Act and the law relating to coroners and coroners' inquests shall apply with such modifications as may be necessary in consequence of the inquest being one into the death of a person whose body does not lie within the coroner's district.

16 Adjournment of inquest in [^{F22}event of criminal proceedings].

- (1) If on an inquest into a death the coroner before the conclusion of the inquest—
- (a) is informed by the [^{F23}justices' chief executive for] a magistrates' court under section 17(1) below that some person has been charged before a magistrates' court with—
 - (i) the murder, manslaughter or infanticide of the deceased;
 - (ii) an offence under [^{F24}section 1 or 3A of the Road Traffic Act 1988 (dangerous driving or careless driving when under the influence of drink or drugs)] committed by causing the death of the deceased; or
 - (iii) an offence under section 2(1) of the ^{M5}Suicide Act 1961 consisting of aiding, abetting, counselling or procuring the suicide of the deceased;

or
 - (b) is informed by the Director of Public Prosecutions that some person has been charged before examining justices with an offence (whether or not involving the death of a person other than the deceased) alleged to have been committed in circumstances connected with the death of the deceased, not being an offence within paragraph (a) above, and is requested by the Director to adjourn the inquest,

then, subject to subsection (2) below, the coroner shall, in the absence of reason to the contrary, adjourn the inquest until after the conclusion of the relevant criminal proceedings and, if a jury has been summoned, may, if he thinks fit, discharge them.

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

- (2) The coroner—
- (a) need not adjourn the inquest in a case within subsection (1)(a) above if, before he has done so, the Director of Public Prosecutions notifies him that adjournment is unnecessary; and
 - (b) may in any case resume the adjourned inquest before the conclusion of the relevant criminal proceedings if notified by the Director that it is open to him to do so.
- (3) After the conclusion of the relevant criminal proceedings, or on being notified under paragraph (b) of subsection (2) above before their conclusion, the coroner may, subject to the following provisions of this section, resume the adjourned inquest if in his opinion there is sufficient cause to do so.
- (4) Where a coroner adjourns an inquest in compliance with subsection (1) above, he shall send to the registrar of deaths a certificate under his hand stating, so far as they have been ascertained at the date of the certificate, the particulars which under the 1953 Act are required to be registered concerning the death.
- (5) Where a coroner does not resume an inquest which he has adjourned in compliance with subsection (1) above, he shall (without prejudice to subsection (4) above) send to the registrar of deaths a certificate under his hand stating the result of the relevant criminal proceedings.
- (6) Where a coroner resumes an inquest which has been adjourned in compliance with subsection (1) above and for that purpose summons a jury (but not where he resumes without a jury, or with the same jury as before the adjournment)—
- (a) he shall proceed in all respects as if the inquest had not previously been begun; and
 - (b) subject to subsection (7) below, the provisions of this Act shall apply accordingly as if the resumed inquest were a fresh inquest.
- (7) Where a coroner resumes an inquest which has been adjourned in compliance with subsection (1) above—
- (a) the finding of the inquest as to the cause of death must not be inconsistent with the outcome of the relevant criminal proceedings;
 - (b) the coroner shall supply to the registrar of deaths after the termination of the inquest a certificate under his hand stating the result of the relevant criminal proceedings; and
 - (c) the provisions of section 11(7) above shall not apply in relation to that inquest.
- (8) In this section “the relevant criminal proceedings” means the proceedings before examining justices and before any court to which the person charged is committed for trial.

Annotations:

Amendments (Textual)

- F22** S. 16: words in side note substituted (1.1.2000) by 1999 c. 22, s. 71(3) (with s. 107, Sch. 14 para. 7(2)); S.I. 1999/3344, art. 2(b)
- F23** Words in s. 16(1)(a) substituted (1.4.2001) by 1999 c. 22, s. 90, Sch. 13 para. 135 (with s. 107, Sch. 14 para. 2); S.I. 2001/916, art. 2(a)(ii) (with transitional provisions and savings in Sch. 2 para. 2)
- F24** Words in s. 16(1)(a)(ii) substituted (1.7.1992) by Road Traffic Act 1991 (c. 40, SIF 107:1), s. 48, Sch. 4 para. 40; S.I. 1992/1286, art. 2, Sch.

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

Marginal Citations

M5 1961 c.60.

17 Provisions supplementary to section 16.

- (1) Where a person is charged before a magistrates' court with—
- (a) murder, manslaughter or infanticide;
 - (b) an offence under [^{F25}section 1 or 3A of the Road Traffic Act 1988 (dangerous driving or careless driving when under the influence of drink or drugs)]; or
 - (c) an offence under section 2(1) of the ^{M6}Suicide Act 1961 consisting of aiding, abetting, counselling or procuring the suicide of another,
- the [^{F26}justices' chief executive for] the court shall inform the coroner who is responsible for holding an inquest into the death of the making of the charge and of the result of the proceedings before that court.
- (2) Where a person charged with—
- (a) murder, manslaughter or infanticide;
 - (b) an offence under [^{F27}section 1 or 3A of the Road Traffic Act 1988 (dangerous driving or careless driving when under the influence of drink or drugs)]; or
 - (c) an offence under section 2(1) of the ^{M7}Suicide Act 1961 consisting of aiding, abetting, counselling or procuring the suicide of another,
- is committed for trial to the Crown Court, the appropriate officer of the Crown Court at the place where the person charged is tried shall inform the coroner of the result of the proceedings before that court.
- (3) Where the Director of Public Prosecutions has under section 16(1)(b) above requested a coroner to adjourn an inquest, then, whether or not the inquest is adjourned as a result, the Director shall—
- (a) inform the coroner of the result of the proceedings before the magistrates' court in the case of the person charged as mentioned in that paragraph; and
 - (b) if that person is committed for trial to the Crown Court, inform the coroner of the result of the proceedings before that court.

Annotations:

Amendments (Textual)

- F25** Words in s. 17(1)(b) substituted (1.7.1992) by Road Traffic Act 1991 (c. 40, SIF 107:1), s. 48, **Sch. 4 para. 41**; S.I. 1992/1286, art. 2, **Sch.**
- F26** Words in s. 17(1) substituted (1.4.2001) by 1999 c. 22, s. 90, **Sch. 13 para. 135** (with s. 107, Sch. 14 para. 2); S.I. 2001/916, **art. 2(a)(ii)** (with transitional provisions and savings in Sch. 2 para. 2)
- F27** Words in s. 17(2)(b) substituted (1.7.1992) by Road Traffic Act 1991 (c. 40, SIF 107:1), s. 48, **Sch. 4 para. 41**; S.I. 1992/1286, art. 2, **Sch.**

Marginal Citations

M6 1961 c.60.
M7 1961 c.60.

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

[^{F28}17A **Adjournment of inquest in event of judicial inquiry.**

- (1) If on an inquest into a death the coroner is informed by the Lord Chancellor before the conclusion of the inquest that—
 - (a) a public inquiry conducted or chaired by a judge is being, or is to be, held into the events surrounding the death; and
 - (b) the Lord Chancellor considers that the cause of death is likely to be adequately investigated by the inquiry,the coroner shall, in the absence of any exceptional reason to the contrary, adjourn the inquest and, if a jury has been summoned, may, if he thinks fit, discharge them.
- (2) Where a coroner adjourns an inquest in compliance with subsection (1) above, he shall send to the registrar of deaths a certificate under his hand stating, so far as they have been ascertained at the date of the certificate, the particulars which under the 1953 Act are required to be registered concerning the death.
- (3) Where a coroner has adjourned an inquest in compliance with subsection (1) above, the Lord Chancellor shall send him the findings of the public inquiry as soon as reasonably practicable after their publication.
- (4) A coroner may only resume an inquest which has been adjourned in compliance with subsection (1) above if in his opinion there is exceptional reason for doing so; and he shall not do so—
 - (a) before the end of the period of 28 days beginning with the day on which the findings of the public inquiry are published; or
 - (b) if the Lord Chancellor notifies the coroner that this paragraph applies, before the end of the period of 28 days beginning with the day on which the public inquiry is concluded.
- (5) Where a coroner resumes an inquest which has been adjourned in compliance with subsection (1) above—
 - (a) the provisions of section 8(3) above shall not apply in relation to that inquest; and
 - (b) if he summons a jury (but not where he resumes without a jury, or with the same jury as before the adjournment), he shall proceed in all respects as if the inquest had not previously begun and the provisions of this Act shall apply accordingly as if the resumed inquest were a fresh inquest.
- (6) Where a coroner does not resume an inquest which he has adjourned in compliance with subsection (1) above, he shall (without prejudice to subsection (2) above) send to the registrar of deaths a certificate under his hand stating any findings of the public inquiry in relation to the death.]

Annotations:

Amendments (Textual)

F28 S. 17A inserted (1.1.2000) by S.I. 1999 c. 22, s. 71(1) (with s. 107, Sch. 14 para. 7(2)); S.I. 1999/3344, art. 2(b)

18 Inquests into road deaths in London.

- (1) Where an accident occurs within Greater London or the City resulting in the death of a person, and it is alleged that the accident was due to—

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

- (a) the nature or character of a road or road surface; or
- (b) a defect in the design or construction of a vehicle or in the materials used in the construction of a road or vehicle,

the coroner holding the inquest into the death shall send to the Secretary of State, or to such officer of his as the Secretary of State may direct, notice in writing of the time and place of holding the inquest, and of any adjourned inquest.

- (2) An officer appointed by the Secretary of State for the purpose shall be at liberty at any such inquest to examine any witness, subject nevertheless to the power of the coroner to disallow any question which in his opinion is not relevant or is otherwise not a proper question.
- (3) In this section “road” has the same meaning as in [^{F29}section 182 of the ^{M8}Road Traffic Act 1988].

Annotations:

Amendments (Textual)

F29 Words substituted by [Road Traffic \(Consequential Provisions\) Act 1988 \(c. 54, SIF 107:1\)](#), s. 4, [Sch. 3 para. 37\(3\)](#)

Marginal Citations

M8 [1988 c.52.](#)

Medical witnesses and post-mortem examinations etc.

19 Post-mortem examination without inquest.

- (1) Where a coroner is informed that the body of a person is lying within his district and there is reasonable cause to suspect that the person has died a sudden death of which the cause is unknown, the coroner may, if he is of opinion that a post-mortem examination may prove an inquest to be unnecessary—
 - (a) direct any legally qualified medical practitioner whom, if an inquest were held, he would be entitled to summon as a medical witness under section 21 below; or
 - (b) request any other legally qualified medical practitioner,
 to make a post-mortem examination of the body and to report the result of the examination to the coroner in writing.
- (2) For the purposes of a post-mortem examination under this section, the coroner and any person directed or requested by him to make the examination shall have the like powers, authorities and immunities as if the examination were a post-mortem examination directed by the coroner at an inquest into the death of the deceased.
- (3) Where a post-mortem examination is made under this section and the coroner is satisfied as a result of it that an inquest is unnecessary, he shall send to the registrar of deaths a certificate under his hand stating the cause of death as disclosed by the report of the person making the examination.
- (4) Nothing in this section shall be construed as authorising the coroner to dispense with an inquest in any case where there is reasonable cause to suspect that the deceased—
 - (a) has died a violent or an unnatural death; or

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

- (b) has died in prison or in such a place or in such circumstances as to require an inquest under any other Act.

20 Request to specially qualified person to make post-mortem and special examinations.

- (1) Without prejudice to the power of a coroner holding an inquest to direct a medical witness whom he may summon under section 21 below to make a post-mortem examination of the body of the deceased, the coroner may, at any time after he has decided to hold an inquest—
 - (a) request any legally qualified medical practitioner to make a post-mortem examination of the body or a special examination of the body or both such examinations; or
 - (b) request any person whom he considers to possess special qualifications for conducting a special examination of the body to make such an examination.
- (2) If any person who has made a post-mortem or special examination in pursuance of such a request is summoned by the coroner as a witness, he may be asked to give evidence as to his opinion upon any matter arising out of the examination, and as to how, in his opinion, the deceased came by his death.
- (3) Where a person states upon oath before the coroner that in his belief the death of the deceased was caused partly or entirely by the improper or negligent treatment of a medical practitioner or other person, that medical practitioner or other person—
 - (a) shall not be allowed to perform or assist at any post-mortem or special examination made for the purposes of the inquest into the death; but
 - (b) shall have the right, if he so desires, to be represented at any such post-mortem examination.
- (4) In this section “special examination”, in relation to a body, means a special examination by way of analysis, test or otherwise of such parts or contents of the body or such other substances or things as ought in the opinion of the coroner to be submitted to analyses, tests or other examination with a view to ascertaining how the deceased came by his death.

21 Summoning of medical witnesses and direction of post-mortem examinations.

- (1) In the case of an inquest into a death, the coroner may summon as a witness—
 - (a) any legally qualified medical practitioner appearing to him to have attended at the death of the deceased or during the last illness of the deceased; or
 - (b) where it appears to him that no such practitioner so attended the deceased, any legally qualified medical practitioner in actual practice in or near the place where the death occurred;and any medical witness summoned under this section may be asked to give evidence as to how, in his opinion, the deceased came by his death.
- (2) Subject to subsection (3) below, the coroner may, either in his summons for the attendance of a medical witness or at any time between the issuing of that summons and the end of the inquest, direct the medical witness to make a post-mortem examination of the body of the deceased.
- (3) Where a person states upon oath before the coroner that in his belief the death of the deceased was caused partly or entirely by the improper or negligent treatment of a

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

medical practitioner or other person, that medical practitioner or other person shall not be allowed to perform or assist at the post-mortem examination of the deceased.

- (4) If, in the case of an inquest with a jury, a majority of the jury are of opinion that the cause of death has not been satisfactorily explained by the evidence of the medical practitioner or of other witnesses brought before them, they may in writing require the coroner—
- (a) to summon as a witness some other legally qualified medical practitioner named by them; and
 - (b) to direct a post-mortem examination of the deceased to be made by a practitioner summoned under this subsection, whether or not such an examination has been previously made;
- and if the coroner fails to comply with such a requisition, he shall be liable on conviction on indictment to a term of imprisonment not exceeding two years or to a fine or to both.
- (5) Where a medical practitioner fails to obey a summons of a coroner issued in pursuance of this section, he shall, unless he shows a good and sufficient cause for not having obeyed the summons, be liable on summary conviction, on the prosecution of the coroner or of any two of the jury, to a fine not exceeding [^{F30}£1,000].

Annotations:

Amendments (Textual)

F30 Words in s. 21(5) substituted (1.10.1992) by [Criminal Justice Act 1991 \(c. 53, SIF 39:1\)](#), s. 17(3), [Sch. 4 Pt. I](#) (with s. 28); [S.I. 1992/333, art. 2\(2\)](#), [Sch. 2](#).

Modifications etc. (not altering text)

C7 [S. 21\(5\)](#): power to amend conferred (1.10.1992) by [Magistrates' Courts Act 1980 \(c. 43, SIF 82\)](#), s. 143, [Sch. 6A](#) (as substituted (1.10.1992) by [Criminal Justice Act 1991 \(c. 53, SIF 39:1\)](#), s. 17(3), [Sch. 4 Pt. IV](#) (with s. 28)); [S.I. 1992/333, art. 2\(2\)](#), [Sch. 2](#).

22 Removal of body for post mortem examination.

- (1) Subject to subsection (2) below, where by the direction or at the request of a coroner, a post-mortem examination of a body is to be made, the coroner may order the removal of the body to any place which may be provided for the purpose either within his district or within an adjoining district of another coroner.
- (2) A coroner shall not order the removal of a body upon which a post-mortem examination is to be made to any place other than a place within his district provided by a local authority except with the consent of the person or authority by whom the place is provided.
- (3) The removal of a body in pursuance of an order made by a coroner under this section to any place outside his district shall not affect his powers and duties in relation to the body or the inquest into the death nor shall it confer or impose any rights, powers or duties upon any other coroner.
- (4) Where a coroner—
 - (a) orders under this section the removal of a body to any place outside his district; and

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

- (b) does not authorise the disposal of the body after examination,
he shall order the removal of the body after examination to a place within his district.
- (5) The expenses of any removal ordered by a coroner under this section shall be defrayed as part of the expenses incurred by him in the course of his duties.
- (6) In this section—
“disposal” has the same meaning as in the 1953 Act;
“local authority” means the council of a [^{F31}district, London borough or Welsh principal area] or the Common Council.

Annotations:

Amendments (Textual)

F31 Words in s. 22(6) substituted (1.4.1996) by 1994 c. 19, s. 66(6), **Sch. 16 para. 82(6)** (with ss. 54(5)(7), 55(5), Sch. 17 paras. 22(1), 23(2)); S.I. 1996/396, art. 4, **Sch. 2**

23 Exhumation of body for examination.

- (1) A coroner may order the exhumation of the body of a person buried within his district where it appears to him that it is necessary for the body to be examined—
- (a) for the purpose of his holding an inquest into that person’s death or discharging any other function of his in relation to the body or the death; or
- (b) for the purposes of any criminal proceedings which have been instituted or are contemplated in respect of the death of that person or of some other person who came by his death in circumstances connected with the death of the person whose body is needed for examination.
- (2) The power of a coroner under this section shall be exercisable by warrant under his hand.
- (3) No body shall be ordered by a coroner to be exhumed except under this section.

Annotations:

Modifications etc. (not altering text)

C8 S. 23 modified (1.9.2001) by 2001 c. 17, s. 35 (with ss. 27(3), 39, 78); S.I. 2001/2161, art. 2

Expenses and returns of inquests

24 Fees and allowances payable on holding inquest.

- (1) The fees and allowances which may be lawfully paid by coroners—
- (a) to witnesses and persons summoned to attend as witnesses; and
- (b) to medical practitioners making post-mortem examinations by the coroner’s direction or at the coroner’s request,
- shall be such as may be determined by the Secretary of State with the consent of the Treasury; but nothing in this subsection shall apply in relation to the fees payable in respect of a special examination under section 20 above.

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

- (2) A relevant council—
- (a) may from time to time make a schedule of the fees, allowances and disbursements which may be lawfully paid or made by a coroner in the course of his duties, other than fees and allowances to which subsection (1) above applies;
 - (b) may at any time vary a schedule so made; and
 - (c) shall cause a copy of every schedule so made or so varied to be sent to every coroner concerned.
- (3) The Secretary of State may by rules made by statutory instrument prescribe—
- (a) the fees payable to coroners or other persons for furnishing copies of inquisitions, depositions or other documents in their custody relating to an inquest; and
 - (b) where in the opinion of the Secretary of State adequate provision is not made for them by a schedule under subsection (2) above, the fees, allowances and disbursements which may be lawfully paid or made by a coroner in the course of his duties, other than fees and allowances to which subsection (1) above applies.

25 Payments to jurors.

- (1) A person who serves as a juror in a coroner's court shall be entitled, in respect of his attendance at court for the purpose of performing jury service, to receive payments, at the rates determined by the Secretary of State with the consent of the Treasury and subject to any prescribed conditions, by way of allowance—
- (a) for travelling and subsistence; and
 - (b) for financial loss where in consequence of his attendance for that purpose—
 - (i) he has incurred any expenditure (otherwise than on travelling and subsistence) to which he would not otherwise be subject; or
 - (ii) he has suffered any loss of earnings which he would otherwise have made or any loss of benefit under the enactments relating to national insurance and social security which he would otherwise have received.
- (2) The amount due to any person in respect of such service shall be ascertained and paid over to him by the coroner.
- (3) For the purposes of this section a person who, in obedience to a summons to serve on a jury, attends for service as a juror shall be deemed to serve as a juror notwithstanding that he is not subsequently sworn.
- (4) In this section “prescribed” means prescribed by regulations made by statutory instrument by the Secretary of State with the consent of the Treasury.

26 Payment of expenses by coroner.

- (1) A coroner holding an inquest shall, immediately after the termination of the proceedings, pay—
- (a) the fees of every medical witness;
 - (b) the allowance of every juror; and
 - (c) all expenses reasonably incurred in and about the holding of the inquest,

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

not exceeding the fees, allowances and disbursements which may be lawfully paid or made under this Act.

- (2) Any fees, allowances or disbursements so paid or made shall be repaid to the coroner in manner provided by this Act.

27 Accounts to be laid before relevant council.

- (1) Every coroner shall within four months after paying or making any fees, allowances or disbursements in accordance with the provisions of this Act, cause a full and true account of all fees, allowances and disbursements so paid or made by him under this Act to be laid before the relevant council.

- (2) Every account under this section shall be accompanied by such vouchers as under the circumstances may to the relevant council seem reasonable; and the relevant council may, if they think fit, examine the coroner on oath as to any such account.

- (3) On being satisfied of the correctness of any such account, the relevant council shall order their treasurer to pay to the coroner the sum due; and the treasurer shall without any abatement or deduction pay that sum—

(a) in the case of a metropolitan district or London borough council, out of the general . . . ^{F32}fund;

[^{F33}(aa) in the case of a non-metropolitan district council, out of the general fund]

(b) in the case of a non-metropolitan county council [^{F34}in England], out of the county fund;

[^{F35}(bb) in the case of the council of a Welsh principal area, out of the council fund;] and

(c) in the case of the Common Council, out of the [^{F36}city fund],

and shall be allowed that sum on passing his accounts.

- (4) In the case of a coroner for a coroner's [^{F37}district—

(a) consisting of two or more metropolitan districts [^{F38}, special non-metropolitan districts] or London boroughs, or

(b) which lies partly in each of two or more Welsh principal areas, [^{F39}or

(c) which lies partly in each of two or more non-metropolitan counties in England,]

the expenses of the councils of those districts, boroughs [^{F40}areas or counties]] in respect of the coroner's service shall be apportioned between those councils in such manner as they may agree or, in default of agreement, as may be determined by the Secretary of State.

Annotations:

Amendments (Textual)

F32 Word repealed by S.I. 1990/1285, art. 2, Sch. Pt. I para. 9(a)

F33 S. 27(3)(aa) inserted (1.4.1996) by S.I. 1996/655, regs. 1, 2(6)

F34 Words in s. 27(3)(b) inserted (1.4.1996) by 1994 c. 19, s. 66(6), Sch. 16 para. 82(7) (with ss. 54(5)(7), 55(5), Sch. 17 paras. 22(1), 23(2)); S.I. 1996/396, art. 4, Sch. 2

F35 S. 27(3)(bb) inserted (1.4.1996) by 1994 c. 19, s. 66(6), Sch. 16 para. 82(7) (with ss. 54(5)(7), 55(5), Sch. 17 paras. 22(1), 23(2)); S.I. 1996/396, art. 4, Sch. 2

F36 Words substituted by S.I. 1990/1285, art. 2, Sch. Pt. I para. 9(b)

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

- F37** Words in s. 27(4) substituted (1.4.1996) by 1994 c. 19, s. 66(6), **Sch. 16 para. 82(8)** (with ss. 54(5)(7), 55(5), Sch. 17 paras. 22(1), 23(2)); S.I. 1996/396, art. 4, **Sch. 2**
- F38** Words in s. 27(4)(a) inserted (1.4.1998) by S.I. 1998/465, **regs. 1(2), 2(9)**
- F39** S. 27(4)(c) and the word preceding it inserted (1.4.1996) by S.I. 1996/655, **regs. 1, 2(7)(a)**
- F40** Words in s. 27(4) substituted (1.4.1996) by S.I. 1996/655, **regs. 1, 2(7)(b)**

[^{F41}27A Indemnity.

- (1) A coroner shall be indemnified by the relevant council (without having to lay before them an account under section 27 above) in respect of—
 - (a) any costs which he reasonably incurs in or in connection with proceedings in respect of anything done or omitted in the exercise (or purported exercise) of his duty as a coroner;
 - (b) any costs which he reasonably incurs in taking steps to dispute any claim which might be made in such proceedings;
 - (c) any damages awarded against him or costs ordered to be paid by him in any such proceedings; and
 - (d) any sums payable by him in connection with a reasonable settlement of any such proceedings or claim.
- (2) Subsection (1) above applies in relation to proceedings by a coroner only if and to the extent that the relevant council agrees in advance to indemnify him.
- (3) A coroner may appeal to the Secretary of State, or to any person appointed by the Secretary of State for the purpose, from any decision of the relevant council under subsection (2) above.
- (4) Any amount due to a coroner under this section shall be paid—
 - (a) in the case of a metropolitan or non-metropolitan district council or London borough council, out of the general fund;
 - (b) in the case of a non-metropolitan county council in England, out of the county fund;
 - (c) in the case of the council of a Welsh principal area, out of the council fund; and
 - (d) in the case of the Common Council, out of the City fund.
- (5) In the case of a coroner for a coroner's district which—
 - (a) consists of two or more metropolitan districts, special non-metropolitan districts or London boroughs;
 - (b) lies partly in each of two or more Welsh principal areas; or
 - (c) lies partly in each of two or more non-metropolitan counties in England,
 any amount due to the coroner under this section shall be apportioned between the councils of those districts, boroughs, areas or counties in such manner as they may agree or, in default of agreement, as may be determined by the Secretary of State.]

Annotations:

Amendments (Textual)

- F41** S. 27A inserted (27.9.1999) by 1999 c. 22, **ss. 104, 108(3)(d)** (with s. 107, Sch. 14 para. 2)

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

28 Annual returns to be made to Secretary of State.

- (1) Every coroner shall on or before 1st February in every year furnish to the Secretary of State a return in writing, in such form and containing such particulars as the Secretary of State may direct, of all cases in which an inquest has been held by him, or by some other person acting for him, during the year ending on the immediately preceding 31st December.
- (2) Every coroner shall also, as and when required by the Secretary of State, furnish to the Secretary of State returns in relation to inquests held and deaths inquired into by him in such form and containing such particulars as the Secretary of State may direct.

Miscellaneous

29 Coroner of the Queen's household.

- (1) The coroner of the Queen's household shall continue to be appointed by the Lord Steward for the time being of the Queen's household.
- (2) The coroner of the Queen's household shall have exclusive jurisdiction in respect of inquests into the deaths of persons whose bodies are lying—
 - (a) within the limits of any of the Queen's palaces; or
 - (b) within the limits of any other house where Her Majesty is then residing.
- (3) The limits of any such palace or house shall be deemed to extend to any courts, gardens or other places within the curtilage of the palace or house but not further; and where a body is lying in any place beyond those limits, the coroner within whose district the body is lying, and not the coroner for the Queen's household, shall have jurisdiction to hold an inquest into the death.
- (4) The jurors on an inquest held by the coroner of the Queen's household shall consist of officers of that household, to be returned by such officer of the Queen's household as may be directed to summon the jurors by the warrant of the coroner.
- (5) All inquisitions, depositions and recognizances shall be delivered to the Lord Steward of the Queen's household to be filed among the records of his office.
- (6) The coroner of the Queen's household—
 - (a) shall make his declaration of office before the Lord Steward of the Queen's household; and
 - (b) shall reside in one of the Queen's palaces or in such other convenient place as may from time to time be allowed by the Lord Steward of the Queen's household.
- (7) The provisions of Schedule 2 to this Act shall have effect with respect to the application of this Act and the law relating to coroners to the coroner of the Queen's household.

30 Treasure trove.

- A coroner shall continue to have jurisdiction—
- (a) to inquire into any treasure which is found in his district; and
 - (b) to inquire who were, or are suspected of being, the finders;

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

and the provisions of this Act shall, so far as applicable, apply to every such inquest.

Annotations:

Modifications etc. (not altering text)

- C9** S. 30 extended (24.9.1997) by 1996 c. 24, s. 7(1); S.I. 1997/1977, art. 2
C10 S. 30 excluded (24.9.1997) by 1996 c. 24, s. 7(2); S.I. 1997/1977, art. 2

31 Provision of accommodation.

[^{F42}The council (whether or not a relevant council) of any of the following, that is to say—

- (a) a metropolitan district,
- [^{F43}(aa) a special non-metropolitan district,]
- (b) a London borough,
- (c) a Welsh principal area, or
- (d) in the case of such a coroner's district as is mentioned in section 1(1)(b) above, a non-metropolitan county the whole or part of which is included in that coroner's district.]

may provide and maintain proper accommodation for the holding of inquests in their area.

Annotations:

Amendments (Textual)

- F42** Words in s. 31 substituted (1.4.1996) by S.I. 1996/655, reg. 2(8)
F43 S. 31(aa) inserted (1.4.1998) by S.I. 1998/465, reg. 2(10)

Supplemental

32 Power to make rules.

(1) The Lord Chancellor may, with the concurrence of the Secretary of State, make rules for regulating the practice and procedure at or in connection with inquests and post-mortem examinations and, in particular (without prejudice to the generality of the foregoing provision), such rules may provide—

- (a) as to the procedure at inquests held without a jury;
- (b) as to the issue by coroners of orders authorising burials;
- (c) for empowering a coroner or his deputy or assistant deputy to alter the date fixed for the holding of any adjourned inquest within the district of the coroner;
- (d) as to the procedure to be followed where a coroner decides not to resume an adjourned inquest; and
- (e) as to the notices to be given, and as to the variation or discharge of any recognisances entered into by jurors or witnesses, where the date fixed for an adjourned inquest is altered or where a coroner decides not to resume an adjourned inquest.

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

- (2) Without prejudice to the generality of subsection (1) above, rules under this section may make provision for persons to be excused service as jurors at inquests in such circumstances as the rules may specify.
- (3) The power of the Lord Chancellor under this section to make rules with respect to any matter shall include power—
 - (a) to prescribe the forms to be used in connection with that matter;
 - (b) to revoke or amend, or substitute new forms for, any forms which are directed or authorised by or under any enactment to be used in connection with that matter.
- (4) The power to make rules under this section shall be exercisable by statutory instrument.

33 Savings for ex-officio coroners and judicial powers.

- (1) Nothing in this Act shall prejudice or affect the jurisdiction of a judge exercising the jurisdiction of a coroner by virtue of his office.
- (2) Nothing in this Act shall prejudice or affect—
 - (a) the jurisdiction of the Lord Chancellor or the High Court in relation to the removal of a coroner otherwise than in the manner provided by this Act; or
 - (b) the jurisdiction of the High Court in relation to or over a coroner or his duties.

34 Application of Act to Isles of Scilly.

- (1) Subject to subsection (2) below, this Act shall apply in relation to the Isles of Scilly as if those Isles were a non-metropolitan county and the Council of those Isles were the council of that county.
- (2) The power conferred on the Secretary of State by section 265 of the ^{M9}Local Government Act 1972 (application of that Act to the Isles of Scilly) shall include power to make an order providing for regulating the application of this Act to those Isles otherwise than as mentioned in subsection (1) above and such an order may amend or repeal that subsection accordingly.

Annotations:

Marginal Citations

M9 1972 c.70.

35 Interpretation.

- (1) In this Act, unless the context otherwise requires—
 - “the 1953 Act” means the ^{M10}Births and Deaths Registration Act 1953;
 - “administrative area” means [^{F44}, subject to subsection (1B) below,][^{F45}Wales,] a metropolitan or non-metropolitan county [^{F45}in England] or Greater London;
 - “the Common Council” means the Common Council of the City of London and “common councillor” shall be construed accordingly;

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

“the City” means the City of London (including the Inner Temple and the Middle Temple);

“Greater London” does not include the City;

“relevant council” has the meaning given by [F⁴⁶section 1(1A)] above.

[“Welsh principal area” means Welsh county or county borough]

[F⁴⁷(1A) In this Act any reference to a council of a non-metropolitan county includes in relation to an area for which there is a district council but no county council a reference to a district council, and any reference to a councillor of a non-metropolitan county shall be construed accordingly.

(1B) In the application of sections 4(5), 5(3) and 13(2) above to a non-metropolitan county part of which is included in such a coroner’s district as is mentioned in section 1(1)(b) above, any reference in those provisions to an administrative area shall be construed as a reference to so much of that county as is not so included.]

(2) In this Act references to an inquest held with a jury include, and references to an inquest held without a jury do not include, references to an inquest part of which is held with a jury.

Annotations:

Amendments (Textual)

F44 Words in s. 35(1) inserted (1.4.1996) by S.I. 1996/655, **regs. 1, 2(9)(a)**

F45 Words in s. 35(1) inserted (1.4.1996) by 1994 c. 19, ss. 66(6), **Sch. 16 para. 82(10)** (with ss. 54(5)(7), 55(5), Sch. 17 paras. 22(1), 23(2)); S. I. 1996/396, art. 4, Sch.2

F46 Words in S. 35(1) substituted (1.4.1996) by S.I. 1996/655, **regs. 1, 2(9)(b)**

F47 S. 35(1A)(1B) inserted (1.4.1996) by S.I. 1996/655, **regs. 1, 2(10)**

Marginal Citations

M10 1953 c.20.

36 Consequential amendments, repeals, transitional provisions and savings.

- (1) The enactments mentioned in Schedule 3 to this Act shall have effect subject to the amendments there specified, being amendments consequential on the provisions of this Act.
- (2) The enactments and instruments mentioned in Schedule 4 to this Act (which include some that are spent) are hereby repealed to the extent specified in the third column of that Schedule.
- (3) Where any period of time specified in an enactment repealed by this Act is current at the commencement of this Act, this Act shall have effect as if the corresponding provision of this Act had been in force when that period began to run.
- (4) Notwithstanding the repeal by this Act of section 13 of the ^{M11}Local Government Act 1985—
 - (a) any coroner holding office immediately before 1st April 1986 and assigned to a coroner’s district in a metropolitan county or in Greater London shall be deemed to have been duly appointed by the relevant council; and

Changes to legislation: *There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)*

- (b) any orders made under section 12 of the ^{M12}Coroners (Amendment) Act 1926 and in force immediately before that date shall, so far as they affect a metropolitan county or Greater London, have effect as if made under section 4(1) above.
- (5) Notwithstanding the repeal by this Act of the ^{M13}Coroners Act 1887, anything mentioned in subsection (5) of section 45 of that Act which, immediately before the commencement of this Act, was in force by virtue of that subsection shall, except so far as it is inconsistent with this Act, remain in force.
- (6) Nothing in this section shall be taken as prejudicing the operation of sections 15 to 17 of the ^{M14}Interpretation Act 1978 (which relate to the effect of repeals).

Annotations:

Marginal Citations

- M11** 1985 c.51.
M12 1926 c.59.
M13 1887 c.71.
M14 1978 c.30.

37 Short title, commencement and extent.

- (1) This Act may be cited as the Coroners Act 1988.
- (2) This Act shall come into force at the end of the period of two months beginning with the day on which it is passed.
- (3) This Act extends to England and Wales only.

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

SCHEDULES

SCHEDULE 1

Section 3(1).

SALARIES AND PENSIONS

Coroners' salaries

- 1 (1) Subject to the provisions of this paragraph, a coroner shall be paid by the relevant council an annual salary at such rate as may be fixed by agreement between the coroner and that council.
- (2) If at any time a coroner and the relevant council cannot agree with respect to any proposed alteration of the rate of his salary—
- (a) the Secretary of State may, on the application of either party, fix the rate of that salary at such rate as he thinks proper; and
 - (b) subject to sub-paragraph (4) below, the rate so fixed shall come into force as from such date as he may determine.
- (3) In fixing the rate of the salary payable to a coroner under this paragraph, regard shall be had to the nature and extent of his duties and to all the circumstances of the case.
- (4) A date determined under sub-paragraph (2) above shall be not less than three years from the date when the rate of the coroner's salary as last fixed came into force, unless in the opinion of the Secretary of State the coroner's district has in the meantime been materially altered.

Coroners' pensions

- 2 (1) On the retirement, after not less than five years' service, of a coroner—
- (a) who held office as a coroner immediately before 6th April 1978; and
 - (b) who did not elect in accordance with article 3(b) of the ^{M15}Social Security (Modification of Coroners (Amendment) Act 1926) Order 1978 that the provisions of the ^{M16}Coroners (Amendment) Act 1926 relating to pensions should not apply to him,
- (that is to say, a coroner who is not a pensionable employee for the purposes of the ^{M17}Local Government Superannuation Regulations 1986) the relevant council may, if either of the conditions mentioned in sub-paragraph (2) below is satisfied, grant to him a pension of such amount as may be agreed between him and the council not exceeding the scale contained in paragraph 3 below.
- (2) The said conditions are—
- (a) that the coroner has attained the age of sixty five years;
 - (b) that the relevant council is satisfied by means of a medical certificate that the coroner is incapable of discharging his duties whether on mental or physical grounds and that such incapacity is likely to be permanent.
- (3) A coroner to whom this paragraph applies—

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

- (a) shall, at any time after he has completed fifteen years' service and has attained the age of sixty-five years, vacate his office if required to do so by the relevant council; but
 - (b) shall, in that case and in the absence of any agreement to the contrary, be entitled to receive the maximum pension which the council is empowered to grant him under this paragraph having regard to the length of his service.
- (4) A pension payable to a coroner under this paragraph shall be reduced by the amount of any additional component of his retirement pension (within the meaning of section 6(1)(b) of the ^{M18}Social Security Pensions Act 1975) which is payable to him.
- (5) In this paragraph "service" means service, whether before or after the commencement of this Act, as a coroner in the same administrative area; and for this purpose "administrative area" includes the City.
- (6) Notwithstanding the reproduction of article 3 of the ^{M19}Social Security (Modification of Coroners (Amendment) Act 1926) Order 1978 as paragraphs (a) and (b) of sub-paragraph (1) above and of article 4 of that Order as sub-paragraph (4) above—
- (a) those provisions may be amended or repealed; and
 - (b) any question as to the validity of those provisions may be determined, as though they were contained in an order made under section 65 of the ^{M20}Social Security Act 1973.

Annotations:

Marginal Citations

- M15** S.I. 1978/374.
- M16** 1926 c.59.
- M17** S.I. 1986/24.
- M18** 1975 c.60.
- M19** S.I. 1978/374.
- M20** 1973 c.38.

Scale of pensions

- 3 (1) An annual pension not exceeding ten sixtieths of the last annual salary may be granted after the completion of five years' service.
- (2) Where the completed service exceeds five years, there may be granted an annual pension not exceeding the aggregate of—
- (a) ten-sixtieths of the last annual salary; and
 - (b) an amount not exceeding one-fortieth of that salary for each completed year's service after five years,
- so however that no such pension shall be of an amount exceeding two-thirds of that salary.
- (3) For the purposes of this paragraph the last annual salary of a coroner shall be taken to be the salary paid to him in his last completed year of service as coroner, after deducting so much (if any) of that salary as was paid to him with a view to his providing at his own expense for any necessary expenditure in connection with his duties as coroner.

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

- (4) If any dispute arises as to the amount to be deducted under sub-paragraph (3) above in computing the last annual salary of a coroner, the dispute shall be referred to the Secretary of State, whose decision shall be final.

Payment of salaries and pensions

- 4 The salary of a coroner and any pension payable to a person in respect of his service as coroner shall be deemed to accrue from day to day and, in the absence of agreement to the contrary, shall be payable quarterly.

SCHEDULE 2

Section 29(7).

CORONER OF THE QUEEN'S HOUSEHOLD

- 1 Sections 1 to 5 of this Act (except subsections (4) to (6) of section 3), sections 6 and 7 of this Act so far as relating to the appointment and functions of assistant deputy coroners and Schedule 1 to this Act shall not apply to the coroner of the Queen's household.
- 2 Sections 6 and 7 of this Act, so far as relating to the appointment and functions of deputy coroners, shall apply with the necessary modifications to the coroner of the Queen's household as they apply to other coroners and, in particular, with the following modifications, namely—
- (a) that the appointment of a deputy to the coroner of the Queen's household shall be subject to the approval of the Lord Steward of the Queen's household; and
 - (b) that copies of such appointments shall be sent to and kept by him.
- 3 Sections 9 and 32(2) of this Act shall not apply in relation to any inquest held by the coroner of the Queen's household.
- 4 Section 25 of this Act shall not apply in relation to service on a jury on an inquest held by the coroner of the Queen's household but that shall not affect any entitlement to payment that might otherwise be enjoyed by a juror for service on such a jury.
- 5 Subject to the provisions of this Schedule and section 29 of this Act, the coroner of the Queen's household shall, within the limits laid down in subsection (3) of that section—
- (a) have the same jurisdiction and powers; and
 - (b) be subject to the same obligations, liabilities and disqualifications; and
 - (c) generally be subject to the provisions of this Act and the law relating to coroners in the same manner,
- as any other coroner.

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

SCHEDULE 3

Section 36(1).

CONSEQUENTIAL AMENDMENTS

The City of London Municipal Elections Act 1849 (c.xciv)

- 1 Immediately before section 9 of the City of London Municipal Elections Act 1849 there shall be inserted the following section—

“8A A person shall, so long as he is a coroner or deputy coroner for the City of London, be disqualified for being elected to or holding any of the following offices in the City, namely, Lord Mayor, alderman and common councilman.”

The Cremation Act 1902 (c.8)

- 2 In section 10 of the Cremation Act 1902, for the words “the Coroners Act 1887, or any Act amending the same” there shall be substituted the words “the Coroners Act 1988”.

The Births and Deaths Registration Act 1953 (c.20)

- 3 In section 22(3) of the 1953 Act, for the words from the beginning to “1926” there shall be substituted the words “Except where an inquest is held into the death of the deceased person or a post-mortem examination of his body is made under section 19 of the Coroners Act 1988”.

- 4 (1) Subsection (1) of section 23 of the 1953 Act shall cease to have effect.
- (2) In subsection (2) of that section, for the words “On receiving a certificate under the foregoing subsection” there shall be substituted the words “Where an inquest is held into a death and the registrar receives under section 11(7) of the Coroners Act 1988 a certificate under the coroner’s hand—
- (a) giving information concerning the death; and
 - (b) specifying the finding with respect to the particulars required to be registered concerning the death and with respect to the cause of death.”.

- (3) After that subsection there shall be inserted the following subsection—

“(2A) Where an inquest into a death is adjourned under section 16 of the Coroners Act 1988 and the registrar receives from the coroner under subsection (4) of that section a certificate under his hand stating, so far as they have been ascertained at the date of the certificate, the particulars required to be registered concerning the death, the registrar shall in the prescribed form and manner register the death and the particulars.”

- (4) In subsection (3) of that section, for the words from the beginning to “examination, and” there shall be substituted the words “Where a post-mortem examination is made of a body under section 19 of the Coroners Act 1988 and the registrar receives from the coroner under subsection (3) of that section a certificate under his hand stating the cause of death as disclosed by the report of the person making the examination,”.

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

- 5 In section 29(4)(b) of that Act, for the words “section 20(4) of the Coroners (Amendment) Act 1926” there shall be substituted the words “section 16(4) of the Coroners Act 1988” and for the words “section 20(1)” there shall be substituted the words “section 16(1)”.

The Army Act 1955 (c.18)

- 6 In section 128(2) of the Army Act 1955, for the words “The Coroners Acts 1887 to 1926” there shall be substituted the words “The Coroners Act 1988”.
- 7 In section 214(4) of that Act, for the words “the Coroners Acts 1887 to 1926” there shall be substituted the words “the Coroners Act 1988”.
- 8 In section 215(5) of that Act, for the words “the Coroners Acts 1887 to 1926” there shall be substituted the words “the Coroners Act 1988”.

The Air Force Act 1955 (c.19)

- 9 In section 128(2) of the Air Force Act 1955, for the words “The Coroners Acts 1887 to 1926” there shall be substituted the words “The Coroners Act 1988”.
- 10 In section 212(5) of that Act, for the words “the Coroners Acts 1887 to 1926” there shall be substituted the words “the Coroners Act 1988”.
- 11 In section 213(5) of that Act, for the words “the Coroners Acts 1887 to 1926” there shall be substituted the words “the Coroners Act 1988”.

The Naval Discipline Act 1957 (c.53)

- 12 In section 82(1) of the Naval Discipline Act 1957, for the words “the Coroners Acts 1887 to 1926” there shall be substituted the words “the Coroners Act 1988”.
- 13 In section 123(5) of that Act, for the words “the Coroners Acts 1887 to 1926” there shall be substituted the words “the Coroners Act 1988”.

14 F48

Annotations:

Amendments (Textual)

F48 Sch. 3 para. 14 repealed by [Criminal Justice Act 1988 \(c. 33, SIF 39:1\)](#), ss. 123(6), 170(2), Sch. 8 para. 16, [Sch. 16](#)

The Pensions (Increase) Act 1971 (c.56)

- 15 In paragraph 61 of Schedule 2 to the Pensions (Increase) Act 1971, for the words “section 6 of the Coroners (Amendment) Act 1926 (county and borough coroners)” there shall be substituted the words “paragraph 2 of Schedule 1 to the Coroners Act 1988”.

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

The Juries Act 1974 (c.23)

- 16 (1) In subsection (2) of section 19 of the Juries Act 1974, for the words “the Coroners Act 1887, as amended by this Act” there shall be substituted the words “ the Coroners Act 1988”.
- (2) In subsection (5) of that section for the words “the Coroners Act 1887” there shall be substituted the words “ the Coroners Act 1988”.

The Magistrates’ Courts Act 1980 (c.43)

- 17 At the end of Schedule 6A to the Magistrates’ Courts Act 1980 there shall be added the following entry—
- “CORONERS ACT 1988 (c.13)
- Sections 10(1) and (2) and 21(5) (refusal to give evidence etc.). £400”.

The Local Government Act 1985 (c.51)

- 18 In section 60(4) of the Local Government Act 1985, for the words “section 6 of the Coroners (Amendment) Act 1926” there shall be substituted the words “ paragraph 2 of Schedule 1 to the Coroners Act 1988”.

SCHEDULE 4

Section 36(2).

REPEALS

Chapter	Short title	Extent of repeal
7 & 8 Vict. c.92.	The Coroners Act 1844.	The whole Act.
36 & 37 Vict. c.76.	The Railway Regulation Act (Returns of Signal Arrangements, Workings &c.) 1873.	The whole Act.
45 & 46 Vict. c.50.	The Municipal Corporations Act 1882.	Section 248(2). Section 255.
50 & 51 Vict. c.71.	The Coroners Act 1887.	The whole Act.
55 & 56 Vict. c. 56.	The Coroners Act 1892.	The whole Act.
16 & 17 Geo.5 c.59.	The Coroners (Amendment) Act 1926.	The whole Act.
1 & 2 Eliz.2 c.20.	The Births and Deaths Registration Act 1953.	Section 23(1).
2 & 3 Eliz.2 c.31.	The Coroners Act 1954.	The whole Act.
1967 c.80.	The Criminal Justice Act 1967.	In Schedule 6, paragraph 3.

Changes to legislation: There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details)

1972 c.20.	The Road Traffic Act 1972.	Section 28.
1972 c.70.	The Local Government Act 1972.	Section 220.
1974 c.23.	The Juries Act 1974.	Schedule 2.
1974 c.37.	The Health and Safety at Work etc. Act 1974.	In Schedule 9, paragraph 1.
1977 c.38.	The Administration of Justice Act 1977.	In Schedule 2, paragraph 1.
1977 c.45.	The Criminal Law Act 1977.	Section 56. Schedule 10.
S.I. 1978/374.	The Social Security (Modification of Coroners (Amendment) Act 1926) Order 1978.	The whole Order.
S.I. 1978/1844.	The Isles of Scilly Order 1978.	In the Schedule, the entry relating to section 220 of the Local Government Act 1972.
1980 c.38.	The Coroners Act 1980.	The whole Act.
1980 c.43.	The Magistrates' Courts Act 1980.	In Schedule 6A, the entry relating to the Coroners Act 1887.
1982 c.53.	The Administration of Justice Act 1982.	Section 62.
1983 c.31.	The Coroners' Juries Act 1983.	The whole Act.
1985 c.51.	The Local Government Act 1985.	Section 13.

Changes to legislation:

There are outstanding changes not yet made by the legislation.gov.uk editorial team to Coroners Act 1988. Any changes that have already been made by the team appear in the content and are referenced with annotations.

Changes and effects yet to be applied to :

- s. 1(1)(b) text amended by 2007 c. 28 Sch. 1 para. 15(a)
- s. 1(1A)(e) text amended by 2003 c. 10 Sch. para. 2
- s. 1(1A)(e) text amended by 2007 c. 28 Sch. 1 para. 15(b)
- s. 1(1A)(e) text amended by 2009 c. 20 Sch. 7 Pt. 4
- s. 3(4) substituted by 2005 c. 4 Sch. 4 para. 194(2)
- s. 3(5) words substituted by 2005 c. 4 Sch. 4 para. 194(3)
- s. 8(7) added by 2006 c. 52 Sch. 16 para. 110
- s. 8(7) modified by S.I. 2009/1059 Sch. 1 para. 29
- s. 9(2) repealed by 2003 c. 44 Sch. 37 Pt. 10
- s. 11(5)(c) substituted by 2005 c. 4 Sch. 1 para. 20
- s. 11(6) text amended by 2007 c. 19 Sch. 2 para. 1(2)(a)
- s. 16(1)(a) text amended by 2003 c. 39 Sch. 8 para. 302
- s. 16(1)(a) text amended by 2004 c. 28 Sch. 11
- s. 16(1)(a)(i) text amended by 2007 c. 19 Sch. 2 para. 1(2)(b)
- s. 16(1)(a)(ii) text amended by 2006 c. 49 s. 20(5)
- s. 16(1)(a)(ii) text amended by 2006 c. 49 s. 21(4)
- s. 16(1)(a)(iii) modified by 2009 c. 25 Sch. 22 para. 9(a)
- s. 16(1)(a)(iv) inserted by 2004 c. 28 Sch. 10 para. 26
- s. 16(1)(b) text amended by 2003 c. 44 Sch. 3 Pt. 2 para. 59(2)(a)
- s. 16(8) substituted by 2003 c. 44 Sch. 3 Pt. 2 para. 59(2)(b)
- s. 17(1)s. 17(2)(d) and word inserted by 2004 c. 28 Sch. 10 para. 27
- s. 17(1) text amended by 2003 c. 39 Sch. 8 para. 302
- s. 17(1)(2) text amended by 2004 c. 28 Sch. 11
- s. 17(1)(a) text amended by 2007 c. 19 Sch. 2 para. 1(2)(c)
- s. 17(1)(b) text amended by 2006 c. 49 s. 20(5)
- s. 17(1)(b) text amended by 2006 c. 49 s. 21(4)
- s. 17(1)(c) modified by 2009 c. 25 Sch. 22 para. 9(b)
- s. 17(2) text amended by 2003 c. 44 Sch. 3 Pt. 2 para. 59(3)(a)
- s. 17(2)(a) text amended by 2007 c. 19 Sch. 2 para. 1(2)(c)
- s. 17(2)(b) text amended by 2006 c. 49 s. 20(5)
- s. 17(2)(b) text amended by 2006 c. 49 s. 21(4)
- s. 17(2)(c) modified by 2009 c. 25 Sch. 22 para. 9(c)
- s. 17(3)(b) text amended by 2003 c. 44 Sch. 3 Pt. 2 para. 59(3)(b)
- s. 19(1A) inserted by 2004 c. 30 Sch. 6 para. 3(2)
- s. 19(4)(b) text amended by 2006 c. 52 Sch. 16 para. 111
- s. 21(4A) inserted by 2004 c. 30 Sch. 6 para. 3(3)
- s. 32(1) words substituted by 2005 c. 4 Sch. 1 para. 21(2)
- s. 32(3) words substituted by 2005 c. 4 Sch. 1 para. 21(3)
- s. 32(4) repealed by 2005 c. 4 Sch. 1 para. 21(4) Sch. 18 Pt. 1
- s. 33(2)(a) words repealed by 2005 c. 4 Sch. 4 para. 195 Sch. 18 Pt. 2
- s. 35(1) inserted by 2007 c. 19 Sch. 2 para. 1(3)

Changes and effects yet to be applied to the whole Act, associated Parts and Chapters:

- Act repealed by 2009 c. 25 Sch. 23 Pt. 1

Commencement Orders yet to be applied to the Coroners Act 1988:

Commencement Orders bringing legislation that affects this Act into force:

- S.I. 2004/829 art. 2-4 commences (2003 c. 44)
- S.I. 2005/579 art. 2 3 commences (2004 c. 28)
- S.I. 2005/910 art. 3 commences (2003 c. 39)
- S.I. 2005/1267 art. 2 Sch. commences (2003 c. 44)
- S.I. 2006/1014 art. 2 Sch. 1 2 commences (2005 c. 4)
- S.I. 2006/1997 art. 2 3 commences (2004 c. 30)
- S.I. 2006/2169 art. 2 amendment to earlier commencing SI 2006/1997
- S.I. 2007/3136 art. 2 commences (2007 c. 28)
- S.I. 2008/401 art. 2 commences (2007 c. 19)
- S.I. 2008/1918 art. 2 commences (2006 c. 49)
- S.I. 2009/812 art. 3 commences (2006 c. 52)
- S.I. 2009/1059 Order transitional provisions for effects of commencing SI 2009/812
- S.I. 2009/1167 art. 3 4 commences (2006 c. 52)
- S.I. 2009/3318 art. 2-4 commences (2009 c. 20)
- S.I. 2010/145 art. 2 Sch. commences (2009 c. 25)

APPENDIX E



Coroners and Justice Act 2009

2009 CHAPTER 25

An Act to amend the law relating to coroners, to investigation of deaths and to certification and registration of deaths; to amend the criminal law; to make provision about criminal justice and about dealing with offenders; to make provision about the Commissioner for Victims and Witnesses; to make provision relating to the security of court and other buildings; to make provision about legal aid and about payments for legal services provided in connection with employment matters; to make provision for payments to be made by offenders in respect of benefits derived from the exploitation of material pertaining to offences; to amend the Data Protection Act 1998; and for connected purposes. [12th November 2009]

BE IT ENACTED by the Queen's most Excellent Majesty, by and with the advice and consent of the Lords Spiritual and Temporal, and Commons, in this present Parliament assembled, and by the authority of the same, as follows:—

PART 1

CORONERS ETC

CHAPTER 1

INVESTIGATIONS INTO DEATHS

Duty to investigate

1 Duty to investigate certain deaths

- (1) A senior coroner who is made aware that the body of a deceased person is within that coroner's area must as soon as practicable conduct an investigation into the person's death if subsection (2) applies.
- (2) This subsection applies if the coroner has reason to suspect that—

- (a) the deceased died a violent or unnatural death,
 - (b) the cause of death is unknown, or
 - (c) the deceased died while in custody or otherwise in state detention.
- (3) Subsection (1) is subject to sections 2 to 4.
- (4) A senior coroner who has reason to believe that—
- (a) a death has occurred in or near the coroner’s area,
 - (b) the circumstances of the death are such that there should be an investigation into it, and
 - (c) the duty to conduct an investigation into the death under subsection (1) does not arise because of the destruction, loss or absence of the body,
- may report the matter to the Chief Coroner.
- (5) On receiving a report under subsection (4) the Chief Coroner may direct a senior coroner (who does not have to be the one who made the report) to conduct an investigation into the death.
- (6) The coroner to whom a direction is given under subsection (5) must conduct an investigation into the death as soon as practicable.
This is subject to section 3.
- (7) A senior coroner may make whatever enquiries seem necessary in order to decide—
- (a) whether the duty under subsection (1) arises;
 - (b) whether the power under subsection (4) arises.
- (8) This Chapter is subject to Schedule 10.

Investigation by other coroner

2 Request for other coroner to conduct investigation

- (1) A senior coroner (coroner A) who is under a duty under section 1(1) to conduct an investigation into a person’s death may request a senior coroner for another area (coroner B) to conduct the investigation.
- (2) If coroner B agrees to conduct the investigation, that coroner (and not coroner A) must conduct the investigation, and must do so as soon as practicable.
- (3) Subsection (2) does not apply if a direction concerning the investigation is given under section 3 before coroner B agrees to conduct the investigation.
- (4) Subsection (2) is subject to—
- (a) any direction concerning the investigation that is given under section 3 after the agreement, and
 - (b) section 4.
- (5) A senior coroner must give to the Chief Coroner notice in writing of any request made by him or her under subsection (1), stating whether or not the other coroner agreed to it.

3 Direction for other coroner to conduct investigation

- (1) The Chief Coroner may direct a senior coroner (coroner B) to conduct an investigation under this Part into a person’s death even though, apart from the

direction, a different senior coroner (coroner A) would be under a duty to conduct it.

- (2) Where a direction is given under this section, coroner B (and not coroner A) must conduct the investigation, and must do so as soon as practicable.
- (3) Subsection (2) is subject to—
 - (a) any subsequent direction concerning the investigation that is given under this section, and
 - (b) section 4.
- (4) The Chief Coroner must give notice in writing of a direction under this section to coroner A.
- (5) A reference in this section to conducting an investigation, in the case of an investigation that has already begun, is to be read as a reference to continuing to conduct the investigation.

Discontinuance of investigation

4 Discontinuance where cause of death revealed by post-mortem examination

- (1) A senior coroner who is responsible for conducting an investigation under this Part into a person's death must discontinue the investigation if—
 - (a) an examination under section 14 reveals the cause of death before the coroner has begun holding an inquest into the death, and
 - (b) the coroner thinks that it is not necessary to continue the investigation.
- (2) Subsection (1) does not apply if the coroner has reason to suspect that the deceased—
 - (a) died a violent or unnatural death, or
 - (b) died while in custody or otherwise in state detention.
- (3) Where a senior coroner discontinues an investigation into a death under this section—
 - (a) the coroner may not hold an inquest into the death;
 - (b) no determination or finding under section 10(1) may be made in respect of the death.

This subsection does not prevent a fresh investigation under this Part from being conducted into the death.

- (4) A senior coroner who discontinues an investigation into a death under this section must, if requested to do so in writing by an interested person, give to that person as soon as practicable a written explanation as to why the investigation was discontinued.

Purpose of investigation

5 Matters to be ascertained

- (1) The purpose of an investigation under this Part into a person's death is to ascertain—
 - (a) who the deceased was;
 - (b) how, when and where the deceased came by his or her death;

- (c) the particulars (if any) required by the 1953 Act to be registered concerning the death.
- (2) Where necessary in order to avoid a breach of any Convention rights (within the meaning of the Human Rights Act 1998 (c. 42)), the purpose mentioned in subsection (1)(b) is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death.
- (3) Neither the senior coroner conducting an investigation under this Part into a person's death nor the jury (if there is one) may express any opinion on any matter other than—
 - (a) the questions mentioned in subsection (1)(a) and (b) (read with subsection (2) where applicable);
 - (b) the particulars mentioned in subsection (1)(c).This is subject to paragraph 7 of Schedule 5.

Inquests

6 Duty to hold inquest

A senior coroner who conducts an investigation under this Part into a person's death must (as part of the investigation) hold an inquest into the death.
This is subject to section 4(3)(a).

7 Whether jury required

- (1) An inquest into a death must be held without a jury unless subsection (2) or (3) applies.
- (2) An inquest into a death must be held with a jury if the senior coroner has reason to suspect—
 - (a) that the deceased died while in custody or otherwise in state detention, and that either—
 - (i) the death was a violent or unnatural one, or
 - (ii) the cause of death is unknown,
 - (b) that the death resulted from an act or omission of—
 - (i) a police officer, or
 - (ii) a member of a service police force,in the purported execution of the officer's or member's duty as such, or
 - (c) that the death was caused by a notifiable accident, poisoning or disease.
- (3) An inquest into a death may be held with a jury if the senior coroner thinks that there is sufficient reason for doing so.
- (4) For the purposes of subsection (2)(c) an accident, poisoning or disease is "notifiable" if notice of it is required under any Act to be given—
 - (a) to a government department,
 - (b) to an inspector or other officer of a government department, or
 - (c) to an inspector appointed under section 19 of the Health and Safety at Work etc. Act 1974 (c. 37).

8 Assembling a jury

- (1) The jury at an inquest (where there is a jury) is to consist of seven, eight, nine, ten or eleven persons.
- (2) For the purpose of summoning a jury, a senior coroner may summon persons (whether within or without the coroner area for which that coroner is appointed) to attend at the time and place stated in the summons.
- (3) Once assembled, the members of a jury are to be sworn by or before the coroner to inquire into the death of the deceased and to give a true determination according to the evidence.
- (4) Only a person who is qualified to serve as a juror in the Crown Court, the High Court and the county courts, under section 1 of the Juries Act 1974 (c. 23), is qualified to serve as a juror at an inquest.
- (5) The senior coroner may put to a person summoned under this section any questions that appear necessary to establish whether or not the person is qualified to serve as a juror at an inquest.

9 Determinations and findings by jury

- (1) Subject to subsection (2), a determination or finding that a jury is required to make under section 10(1) must be unanimous.
- (2) A determination or finding need not be unanimous if –
 - (a) only one or two of the jury do not agree on it, and
 - (b) the jury has deliberated for a period of time that the senior coroner thinks reasonable in view of the nature and complexity of the case.Before accepting a determination or finding not agreed on by all the members of the jury, the coroner must require one of them to announce publicly how many agreed and how many did not.
- (3) If the members of the jury, or the number of members required by subsection (2)(a), do not agree on a determination or finding, the coroner may discharge the jury and another one may be summoned in its place.

Outcome of investigation

10 Determinations and findings to be made

- (1) After hearing the evidence at an inquest into a death, the senior coroner (if there is no jury) or the jury (if there is one) must –
 - (a) make a determination as to the questions mentioned in section 5(1)(a) and (b) (read with section 5(2) where applicable), and
 - (b) if particulars are required by the 1953 Act to be registered concerning the death, make a finding as to those particulars.
- (2) A determination under subsection (1)(a) may not 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.
- (3) In subsection (2) “criminal liability” includes liability in respect of a service offence.

Suspension

11 Duty or power to suspend or resume investigations

Schedule 1 makes provision about suspension and resumption of investigations.

Death of service personnel abroad

12 Investigation in Scotland

- (1) This section applies to the death outside the United Kingdom of a person within subsection (2) or (3).
- (2) A person is within this subsection if at the time of the death the person was subject to service law by virtue of section 367 of the Armed Forces Act 2006 (c. 52) and was engaged in –
 - (a) active service,
 - (b) activities carried on in preparation for, or directly in support of, active service, or
 - (c) training carried out in order to improve or maintain the effectiveness of those engaged in active service.
- (3) A person is within this subsection if at the time of the death the person was not subject to service law but –
 - (a) by virtue of paragraph 7 of Schedule 15 to the Armed Forces Act 2006 was a civilian subject to service discipline, and
 - (b) was accompanying persons subject to service law who were engaged in active service.
- (4) If –
 - (a) the person’s body is within Scotland or is expected to be brought to the United Kingdom, and
 - (b) the Secretary of State thinks that it may be appropriate for the circumstances of the death to be investigated under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (c. 14),
 the Secretary of State may notify the Lord Advocate accordingly.
- (5) If –
 - (a) the person’s body is within England and Wales, and
 - (b) the Chief Coroner thinks that it may be appropriate for the circumstances of the death to be investigated under that Act,
 the Chief Coroner may notify the Lord Advocate accordingly.

13 Investigation in England and Wales despite body being brought to Scotland

- (1) The Chief Coroner may direct a senior coroner to conduct an investigation into a person’s death if –
 - (a) the deceased is a person within subsection (2) or (3) of section 12,
 - (b) the Lord Advocate has been notified under subsection (4) or (5) of that section in relation to the death,
 - (c) the body of the deceased has been brought to Scotland,

- (d) no inquiry into the circumstances of the death under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (c. 14) has been held (or any such inquiry that has been started has not been concluded),
 - (e) the Lord Advocate notifies the Chief Coroner that, in the Lord Advocate's view, it may be appropriate for an investigation under this Part into the death to be conducted, and
 - (f) the Chief Coroner has reason to suspect that—
 - (i) the deceased died a violent or unnatural death,
 - (ii) the cause of death is unknown, or
 - (iii) the deceased died while in custody or otherwise in state detention.
- (2) The coroner to whom a direction is given under subsection (1) must conduct an investigation into the death as soon as practicable.
This is subject to section 3.

Ancillary powers of coroners in relation to deaths

14 Post-mortem examinations

- (1) A senior coroner may request a suitable practitioner to make a post-mortem examination of a body if—
 - (a) the coroner is responsible for conducting an investigation under this Part into the death of the person in question, or
 - (b) a post-mortem examination is necessary to enable the coroner to decide whether the death is one into which the coroner has a duty under section 1(1) to conduct an investigation.
- (2) A request under subsection (1) may specify the kind of examination to be made.
- (3) For the purposes of subsection (1) a person is a suitable practitioner if he or she—
 - (a) is a registered medical practitioner, or
 - (b) in a case where a particular kind of examination is requested, a practitioner of a description designated by the Chief Coroner as suitable to make examinations of that kind.
- (4) Where a person informs the senior coroner that, in the informant's opinion, death was caused wholly or partly by the improper or negligent treatment of a registered medical practitioner or other person, that practitioner or other person—
 - (a) must not make, or assist at, an examination under this section of the body, but
 - (b) is entitled to be represented at such an examination.

This subsection has no effect as regards a post-mortem examination already made.
- (5) A person who makes a post-mortem examination under this section must as soon as practicable report the result of the examination to the senior coroner in whatever form the coroner requires.

15 Power to remove body

- (1) A senior coroner who—
 - (a) is responsible for conducting an investigation under this Part into a person's death, or
 - (b) needs to request a post-mortem examination under section 14 in order to decide whether the death is one into which the coroner has a duty under section 1(1) to conduct an investigation,may order the body to be removed to any suitable place.
- (2) That place may be within the coroner's area or elsewhere.
- (3) The senior coroner may not order the removal of a body under this section to a place provided by a person who has not consented to its being removed there.

This does not apply to a place within the coroner's area that is provided by a district council, a county council, a county borough council, a London borough council or the Common Council.

Miscellaneous

16 Investigations lasting more than a year

- (1) A senior coroner who is conducting an investigation under this Part into a person's death that has not been completed or discontinued within a year—
 - (a) must notify the Chief Coroner of that fact;
 - (b) must notify the Chief Coroner of the date on which the investigation is completed or discontinued.
- (2) In subsection (1) "within a year" means within the period of 12 months beginning with the day on which the coroner was made aware that the person's body was within the coroner's area.
- (3) The Chief Coroner must keep a register of notifications given under subsection (1).

17 Monitoring of and training for investigations into deaths of service personnel

- (1) The Chief Coroner must—
 - (a) monitor investigations under this Part into service deaths;
 - (b) secure that coroners conducting such investigations are suitably trained to do so.
- (2) In this section "service death" means the death of a person who at the time of the death was subject to service law by virtue of section 367 of the Armed Forces Act 2006 (c. 52) and was engaged in—
 - (a) active service,
 - (b) activities carried on in preparation for, or directly in support of, active service, or
 - (c) training carried out in order to improve or maintain the effectiveness of those engaged in active service.

CHAPTER 2

NOTIFICATION, CERTIFICATION AND REGISTRATION OF DEATHS

18 Notification by medical practitioner to senior coroner

- (1) The Lord Chancellor may make regulations requiring a registered medical practitioner, in prescribed cases or circumstances, to notify a senior coroner of a death of which the practitioner is aware.
- (2) Before making regulations under this section the Lord Chancellor must consult—
 - (a) the Secretary of State for Health, and
 - (b) the Chief Coroner.

19 Medical examiners

- (1) Primary Care Trusts (in England) and Local Health Boards (in Wales) must appoint persons as medical examiners to discharge the functions conferred on medical examiners by or under this Chapter.
- (2) Each Trust or Board must—
 - (a) appoint enough medical examiners, and make available enough funds and other resources, to enable those functions to be discharged in its area;
 - (b) monitor the performance of medical examiners appointed by the Trust or Board by reference to any standards or levels of performance that those examiners are expected to attain.
- (3) A person may be appointed as a medical examiner only if, at the time of the appointment, he or she—
 - (a) is a registered medical practitioner and has been throughout the previous 5 years, and
 - (b) practises as such or has done within the previous 5 years.
- (4) The appropriate Minister may by regulations make—
 - (a) provision about the terms of appointment of medical examiners and about termination of appointment;
 - (b) provision for the payment to medical examiners of remuneration, expenses, fees, compensation for termination of appointment, pensions, allowances or gratuities;
 - (c) provision as to training—
 - (i) to be undertaken as a precondition for appointment as a medical examiner;
 - (ii) to be undertaken by medical examiners;
 - (d) provision about the procedure to be followed in connection with the exercise of functions by medical examiners;
 - (e) provision conferring functions on medical examiners;
 - (f) provision for functions of medical examiners to be exercised, during a period of emergency, by persons not meeting the criteria in subsection (3).
- (5) Nothing in this section, or in regulations under this section, gives a Primary Care Trust or a Local Health Board any role in relation to the way in which

medical examiners exercise their professional judgment as medical practitioners.

- (6) In this section “the appropriate Minister” means –
 - (a) in relation to England, the Secretary of State;
 - (b) in relation to Wales, the Welsh Ministers.
- (7) For the purposes of this section a “period of emergency” is a period certified as such by the Secretary of State on the basis that there is or has been, or is about to be, an event or situation involving or causing, or having the potential to cause, a substantial loss of human life throughout, or in any part of, England and Wales.
- (8) A certification under subsection (7) must specify –
 - (a) the date when the period of emergency begins, and
 - (b) the date when it is to end.
- (9) Subsection (8)(b) does not prevent the Secretary of State certifying a new period of emergency in respect of the same event or situation.

20 Medical certificate of cause of death

- (1) The Secretary of State may by regulations make the following provision in relation to a death that is required to be registered under Part 2 of the 1953 Act –
 - (a) provision requiring a registered medical practitioner who attended the deceased before his or her death (an “attending practitioner”) –
 - (i) to prepare a certificate stating the cause of death to the best of the practitioner’s knowledge and belief (an “attending practitioner’s certificate”), or
 - (ii) where the practitioner is unable to establish the cause of death, to refer the case to a senior coroner;
 - (b) provision requiring a copy of an attending practitioner’s certificate to be given to a medical examiner;
 - (c) provision allowing an attending practitioner, if invited to do so by the medical examiner or a registrar, to issue a fresh attending practitioner’s certificate superseding the existing one;
 - (d) provision requiring a senior coroner to refer a case to a medical examiner;
 - (e) provision requiring a medical examiner to make whatever enquiries appear to be necessary in order to confirm or establish the cause of death;
 - (f) provision requiring a medical examiner to whom a copy of an attending practitioner’s certificate has been given –
 - (i) to confirm the cause of death stated on the certificate and to notify a registrar that the cause of death has been confirmed, or
 - (ii) where the examiner is unable to confirm the cause of death, to refer the case to a senior coroner;
 - (g) provision for an attending practitioner’s certificate, once the cause of death has been confirmed as mentioned in paragraph (f), to be given to a registrar;
 - (h) provision requiring a medical examiner to whom a case has been referred by a senior coroner –

- (i) to issue a certificate stating the cause of death to the best of the examiner’s knowledge and belief (a “medical examiner’s certificate”) and to notify a registrar that the certificate has been issued, or
 - (ii) where the examiner is unable to establish the cause of the death, to refer the case back to the coroner;
 - (i) provision for a medical examiner’s certificate to be given to a registrar;
 - (j) provision allowing a medical examiner, if invited to do so by the registrar, to issue a fresh medical examiner’s certificate superseding the existing one;
 - (k) provision requiring a medical examiner or someone acting on behalf of a medical examiner –
 - (i) to discuss the cause of death with the informant or with some other person whom the examiner considers appropriate, and
 - (ii) to give him or her the opportunity to mention any matter that might cause a senior coroner to think that the death should be investigated under section 1;
 - (l) provision for confirmation to be given in writing, either by the informant or by a person of a prescribed description, that the requirement referred to in paragraph (k) has been complied with;
 - (m) provision prescribing forms (including the form of an attending practitioner’s certificate and of a medical examiner’s certificate) for use by persons exercising functions under the regulations, and requiring the forms to be made available to those persons;
 - (n) provision requiring the Chief Medical Officer of the Department of Health, after consulting –
 - (i) the Officer with corresponding functions in relation to Wales,
 - (ii) the Registrar General, and
 - (iii) the Statistics Board,
 to issue guidance as to how certificates and other forms under the regulations are to be completed;
 - (o) provision for certificates or other forms under the regulations to be signed or otherwise authenticated.
- (2) Regulations under subsection (1) imposing a requirement –
- (a) may prescribe a period within which the requirement is to be complied with;
 - (b) may prescribe cases or circumstances in which the requirement does, or does not, apply (and may, in particular, provide for the requirement not to apply during a period of emergency).
- (3) The power under subsection (1)(m) to prescribe forms is exercisable only after consultation with –
- (a) the Welsh Ministers,
 - (b) the Registrar General, and
 - (c) the Statistics Board.
- (4) Regulations under subsection (1) may provide for functions that would otherwise be exercisable by a registered medical practitioner who attended the deceased before his or her death to be exercisable, during a period of emergency, by a registered medical practitioner who did not do so.

- (5) The appropriate Minister may by regulations provide for a fee to be payable to a Primary Care Trust or Local Health Board in respect of –
 - (a) a medical examiner’s confirmation of the cause of death stated on an attending practitioner’s certificate, or
 - (b) the issue of a medical examiner’s certificate.
- (6) Section 7 of the Cremation Act 1902 (c. 8) (regulations as to burning) does not require the Secretary of State to make regulations, or to include any provision in regulations, if or to the extent that he or she thinks it unnecessary to do so in consequence of –
 - (a) provision made by regulations under this Chapter or by Coroners regulations, or
 - (b) provision contained in, or made by regulations under, Part 2 of the 1953 Act as amended by Part 1 of Schedule 21 to this Act.
- (7) In this section –
 - “the appropriate Minister” has the same meaning as in section 19;
 - “informant”, in relation to a death, means the person who gave particulars concerning the death to the registrar under section 16 or 17 of the 1953 Act;
 - “period of emergency” has the same meaning as in section 19;
 - “the Statistics Board” means the body corporate established by section 1 of the Statistics and Registration Service Act 2007 (c. 18).

21 National Medical Examiner

- (1) The Secretary of State may appoint a person as National Medical Examiner.
- (2) The National Medical Examiner is to have –
 - (a) the function of issuing guidance to medical examiners with a view to securing that they carry out their functions in an effective and proportionate manner;
 - (b) any further functions conferred by regulations made by the Secretary of State.
- (3) Before appointing a person as National Medical Examiner or making regulations under subsection (2)(b), the Secretary of State must consult the Welsh Ministers.
- (4) A person may be appointed as National Medical Examiner only if, at the time of the appointment, he or she –
 - (a) is a registered medical practitioner and has been throughout the previous 5 years, and
 - (b) practises as such or has done within the previous 5 years.
- (5) The appointment of a person as National Medical Examiner is to be on whatever terms and conditions the Secretary of State thinks appropriate.
- (6) The Secretary of State may pay to the National Medical Examiner –
 - (a) amounts determined by the Secretary of State by way of remuneration or allowances;
 - (b) amounts determined by the Secretary of State towards expenses incurred in performing functions as such.

- (7) The National Medical Examiner may amend or revoke any guidance issued under subsection (2)(a).
- (8) The National Medical Examiner must consult the Welsh Ministers before issuing, amending or revoking any such guidance.
- (9) Medical examiners must have regard to any such guidance in carrying out their functions.

CHAPTER 3

CORONER AREAS, APPOINTMENTS ETC

22 Coroner areas

Schedule 2 makes provision about coroner areas.

23 Appointment etc of senior coroners, area coroners and assistant coroners

Schedule 3 makes provision about the appointment etc of senior coroners, area coroners and assistant coroners.

24 Provision of staff and accommodation

- (1) The relevant authority for a coroner area –
 - (a) must secure the provision of whatever officers and other staff are needed by the coroners for that area to carry out their functions;
 - (b) must provide, or secure the provision of, accommodation that is appropriate to the needs of those coroners in carrying out their functions;
 - (c) must maintain, or secure the maintenance of, accommodation provided under paragraph (b).
- (2) Subsection (1)(a) applies to a particular coroner area only if, or to the extent that, the necessary officers and other staff for that area are not provided by a police authority.
- (3) Subsection (1)(c) does not apply in relation to accommodation the maintenance of which is the responsibility of a person other than the relevant authority in question.
- (4) In deciding how to discharge its duties under subsection (1)(b) and (c), the relevant authority for a coroner area must take into account the views of the senior coroner for that area.
- (5) A reference in subsection (1) to the coroners for an area is to the senior coroner, and any area coroners or assistant coroners, for that area.

CHAPTER 4

INVESTIGATIONS CONCERNING TREASURE

25 Coroner for Treasure and Assistant Coroners for Treasure

Schedule 4 makes provision about the appointment etc of the Coroner for Treasure and Assistant Coroners for Treasure.

26 Investigations concerning treasure

- (1) The Coroner for Treasure must conduct an investigation concerning an object in respect of which notification is given under section 8(1) of the Treasure Act 1996 (c. 24).
- (2) The Coroner for Treasure may conduct an investigation concerning an object in respect of which notification has not been given under that section if he or she has reason to suspect that the object is treasure.
- (3) The Coroner for Treasure may conduct an investigation concerning an object if he or she has reason to suspect that the object is treasure trove.
- (4) Subsections (1) to (3) are subject to section 29.
- (5) The purpose of an investigation under this section is to ascertain—
 - (a) whether or not the object in question is treasure or treasure trove;
 - (b) if it is treasure or treasure trove, who found it, where it was found and when it was found.
- (6) Senior coroners, area coroners and assistant coroners have no functions in relation to objects that are or may be treasure or treasure trove.
This is subject to paragraph 11 of Schedule 4 (which enables an assistant coroner acting as an Assistant Coroner for Treasure to perform functions of the Coroner for Treasure).

27 Inquests concerning treasure

- (1) The Coroner for Treasure may, as part of an investigation under section 26, hold an inquest concerning the object in question (a “treasure inquest”).
- (2) A treasure inquest must be held without a jury, unless the Coroner for Treasure thinks there is sufficient reason for it to be held with a jury.
- (3) In relation to a treasure inquest held with a jury, sections 8 and 9 apply with the following modifications—
 - (a) a reference to a senior coroner is to be read as a reference to the Coroner for Treasure;
 - (b) the reference in section 8(3) to the death of the deceased is to be read as a reference to the matters mentioned in section 26(5).

28 Outcome of investigations concerning treasure

Where the Coroner for Treasure has conducted an investigation under section 26, a determination as to the question mentioned in subsection (5)(a) of that section, and (where applicable) the questions mentioned in subsection (5)(b) of that section, must be made—

- (a) by the Coroner for Treasure after considering the evidence (where an inquest is not held),
- (b) by the Coroner for Treasure after hearing the evidence (where an inquest is held without a jury), or
- (c) by the jury after hearing the evidence (where an inquest is held with a jury).

29 Exception to duty to investigate

- (1) Where the Coroner for Treasure is conducting, or proposes to conduct, an investigation under section 26 concerning –
 - (a) an object that would vest in the Crown under the Treasure Act 1996 (c. 24) if the object was in fact treasure and there were no prior interests or rights, or
 - (b) an object that would belong to the Crown under the law relating to treasure trove if the object was in fact treasure trove,the Secretary of State may give notice to the Coroner for Treasure disclaiming, on behalf of the Crown, any title that the Crown may have to the object.
- (2) Where the Coroner for Treasure is conducting, or proposes to conduct, an investigation under section 26 concerning –
 - (a) an object that would vest in the franchisee under the Treasure Act 1996 if the object was in fact treasure and there were no prior interests or rights, or
 - (b) an object that would belong to the franchisee under the law relating to treasure trove if the object was in fact treasure trove,the franchisee may give notice to the Coroner for Treasure disclaiming any title that the franchisee may have to the object.
- (3) A notice under subsection (1) or (2) may be given only before the making of a determination under section 28.
- (4) Where a notice is given under subsection (1) or (2) –
 - (a) the object is to be treated as not vesting in or belonging to the Crown, or (as the case may be) the franchisee, under the Treasure Act 1996, or the law relating to treasure trove;
 - (b) the Coroner for Treasure may not conduct an investigation concerning the object under section 26 or, if an investigation has already begun, may not continue with it;
 - (c) without prejudice to the interests or rights of others, the object may be delivered to a person in accordance with a code of practice published under section 11 of the Treasure Act 1996.
- (5) For the purposes of this section the franchisee, in relation to an object, is the person who –
 - (a) was, immediately before the commencement of section 4 of the Treasure Act 1996, or
 - (b) apart from that Act, as successor in title, would have been,the franchisee of the Crown in right of treasure trove for the place where the object was found.

30 Duty to notify Coroner for Treasure etc of acquisition of certain objects

(1) After section 8 of the Treasure Act 1996 (c. 24) there is inserted –

“8A Duty to notify coroner of acquisition of certain objects

- (1) A person who –
 - (a) acquires property in an object, and
 - (b) believes or has reasonable grounds for believing –
 - (i) that the object is treasure, and
 - (ii) that notification in respect of the object has not been given under section 8(1) or this subsection,must notify the Coroner for Treasure before the end of the notice period.
- (2) The notice period is fourteen days beginning with –
 - (a) the day after the person acquires property in the object; or
 - (b) if later, the day on which the person first believes or has reason to believe –
 - (i) that the object is treasure; and
 - (ii) that notification in respect of the object has not been given under section 8(1) or subsection (1) of this section.
- (3) Any person who fails to comply with subsection (1) is guilty of an offence if –
 - (a) notification in respect of the object has not been given under section 8(1) or subsection (1) of this section; and
 - (b) there has been no investigation in relation to the object.
- (4) Any person guilty of an offence under this section is liable on summary conviction to –
 - (a) imprisonment for a term not exceeding 51 weeks;
 - (b) a fine of an amount not exceeding level 5 on the standard scale; or
 - (c) both.
- (5) In proceedings for an offence under this section, it is a defence for the defendant to show that he had, and has continued to have, a reasonable excuse for failing to notify the Coroner for Treasure.
- (6) If the office of Coroner for Treasure is vacant, notification under subsection (1) must be given to an Assistant Coroner for Treasure.
- (7) In determining for the purposes of this section whether a person has acquired property in an object, section 4 is to be disregarded.
- (8) For the purposes of an investigation in relation to an object in respect of which notification has been given under subsection (1), the object is to be presumed, in the absence of evidence to the contrary, to have been found in England and Wales after the commencement of section 4.
- (9) This section has effect subject to section 8B.
- (10) In this section “investigation” means an investigation under section 26 of the Coroners and Justice Act 2009.
- (11) In its application to Northern Ireland this section has effect as if –

- (a) in subsection (1), for “Coroner for Treasure” there were substituted “coroner for the district in which the object is located”;
 - (b) in subsection (3)(b), for “investigation” there were substituted “inquest”;
 - (c) in subsection (4)(a), for “51 weeks” there were substituted “three months”;
 - (d) in subsection (5), for “Coroner for Treasure” there were substituted “coroner”;
 - (e) in subsection (6), for the words from “Coroner for Treasure” to “Assistant Coroner for Treasure” there were substituted “coroner for a district is vacant, the person acting as coroner for that district is the coroner for the purposes of subsection (1)”;
 - (f) in subsection (8), for “investigation” there were substituted “inquest” and for “England and Wales” there were substituted “Northern Ireland”;
 - (g) in subsection (10), for ““investigation” means an investigation under section 26 of the Coroners and Justice Act 2009” there were substituted ““inquest” means an inquest held under section 7”.
- (2) In section 10 of that Act (rewards), in subsection (5) (persons to whom reward may be paid), at the end insert—
- “(d) any person who gave notice under section 8A in respect of the treasure.”
- (3) In relation to an offence under section 8A of that Act (inserted by subsection (1) above) committed before the commencement of section 280(2) of the Criminal Justice Act 2003 (c. 44), a reference in the inserted section to 51 weeks is to be read as a reference to three months.

31 Code of practice under the Treasure Act 1996

- (1) A code of practice under section 11 of the Treasure Act 1996 (c. 24) may make provision to do with objects in respect of which notice is given under section 29(1) or (2).
- (2) No civil liability on the part of the Coroner for Treasure arises where he or she delivers an object, or takes any other action, in accordance with a code of practice under section 11 of the Treasure Act 1996.

CHAPTER 5

FURTHER PROVISION TO DO WITH INVESTIGATIONS AND DEATHS

32 Powers of coroners

Schedule 5 makes provision about powers of senior coroners and the Coroner for Treasure.

33 Offences

Schedule 6 makes provision about offences relating to jurors, witnesses and evidence.

34 Allowances, fees and expenses

Schedule 7 makes provision about allowances, fees and expenses.

CHAPTER 6**GOVERNANCE ETC****35 Chief Coroner and Deputy Chief Coroners**

- (1) Schedule 8 makes provision about the appointment etc of the Chief Coroner and Deputy Chief Coroners.
- (2) The Lord Chief Justice may nominate a judicial office holder (as defined in section 109(4) of the Constitutional Reform Act 2005 (c. 4)) to exercise any of the functions of the Lord Chief Justice under Schedule 8.

36 Reports and advice to the Lord Chancellor from the Chief Coroner

- (1) The Chief Coroner must give the Lord Chancellor a report for each calendar year.
- (2) The report must cover –
 - (a) matters that the Chief Coroner wishes to bring to the attention of the Lord Chancellor;
 - (b) matters that the Lord Chancellor has asked the Chief Coroner to cover in the report.
- (3) The report must contain an assessment for the year of the consistency of standards between coroners areas.
- (4) The report must also contain a summary for the year of –
 - (a) the number and length of –
 - (i) investigations in respect of which notification was given under subsection (1)(a) or (b) of section 16, and
 - (ii) investigations that were not concluded or discontinued by the end of the year and in respect of which notification was given under subsection (1)(a) of that section in a previous year, as well as the reasons for the length of those investigations and the measures taken with a view to keeping them from being unnecessarily lengthy;
 - (b) the number, nature and outcome of appeals under section 40(1), (3), (4), (5) or (9);
 - (c) the matters recorded under paragraph 4 of Schedule 5;
 - (d) the matters reported under paragraph 7 of that Schedule and the responses given under sub-paragraph (2) of that paragraph.
- (5) A report for a year under this section must be given to the Lord Chancellor by 1 July in the following year.
- (6) The Lord Chancellor must publish each report given under this section and must lay a copy of it before each House of Parliament.

- (7) If requested to do so by the Lord Chancellor, the Chief Coroner must give advice to the Lord Chancellor about particular matters relating to the operation of the coroner system.

37 Regulations about training

- (1) The Chief Coroner may, with the agreement of the Lord Chancellor, make regulations about the training of –
- (a) senior coroners, area coroners and assistant coroners;
 - (b) the Coroner for Treasure and Assistant Coroners for Treasure;
 - (c) coroners’ officers and other staff assisting persons within paragraph (a) or (b).
- (2) The regulations may (in particular) make provision as to –
- (a) the kind of training to be undertaken;
 - (b) the amount of training to be undertaken;
 - (c) the frequency with which it is to be undertaken.

38 Medical Adviser and Deputy Medical Advisers to the Chief Coroner

Schedule 9 makes provision about the appointment etc of the Medical Adviser to the Chief Coroner and Deputy Medical Advisers to the Chief Coroner.

39 Inspection of coroner system

- (1) It is the duty of inspectors of court administration appointed under section 58(1) of the Courts Act 2003 (c. 39) (“the 2003 Act”) to inspect and report to the Lord Chancellor on the operation of the coroner system.
- (2) Subsection (1) is not to be read as enabling the inspectors –
- (a) to inspect persons making judicial decisions or exercising any judicial discretion;
 - (b) to inspect the Chief Coroner or a Deputy Chief Coroner carrying out any functions as such.
- (3) The Chief Inspector appointed under section 58(3) of the 2003 Act must report to the Lord Chancellor on any matter connected with the operation of the coroner system that the Lord Chancellor refers to the Chief Inspector.
- (4) An inspector exercising functions under subsection (1) may –
- (a) enter any place of work occupied by a senior coroner or the Coroner for Treasure or by an officer or member of staff provided for a senior coroner or the Coroner for Treasure;
 - (b) inspect and take copies of any records kept by any of those persons that relate to the operation of the coroner system and are considered by the inspector to be relevant to the discharge of his or her functions.

Paragraph 1(3) of Schedule 10 (under which a reference to a senior coroner may include the Chief Coroner) does not apply for the purposes of paragraph (a).

- (5) Subsection (4)(a) does not entitle an inspector –
- (a) to be present during an inquest, or a part of an inquest, from which people have been excluded by a direction given by virtue of section 45(3);

- (b) to attend any private deliberations of persons having jurisdiction to make any determination or finding.
- (6) Section 61(4) and (5) of the 2003 Act (records kept on computers) applies to inspections under subsection (4)(b) above as it applies to inspections under section 61(2) of that Act (power to inspect court support system records).
- (7) The powers conferred by subsection (4) or by virtue of subsection (6) may be exercised at reasonable times only.
- (8) If a report under subsection (1) or (3) recommends the taking of any action by a senior coroner or the Coroner for Treasure, the Lord Chancellor may give a direction requiring the coroner to take the action within a period specified in the direction.

40 Appeals to the Chief Coroner

- (1) An interested person may appeal to the Chief Coroner against a decision made by a senior coroner that falls within subsection (2).
- (2) The decisions that fall within this subsection are—
 - (a) a decision whether to conduct an investigation under this Part into a person's death;
 - (b) a decision whether to discontinue an investigation under section 4;
 - (c) a decision whether to resume, under Part 2 of Schedule 1, an investigation suspended under Part 1 of that Schedule;
 - (d) a decision not to request a post-mortem examination under section 14;
 - (e) a decision to request a post-mortem examination under that section of a body that has already been the subject of a post-mortem examination, unless the decision is to request an examination of a different kind from the one already carried out;
 - (f) a decision to give a notice under paragraph 1 of Schedule 5;
 - (g) a decision whether there should be a jury at an inquest;
 - (h) a decision whether to exercise a power conferred by virtue of section 45(3)(a) to exclude persons from all or part of an inquest;
 - (i) a decision embodied in a determination as to the questions mentioned in section 5(1)(a) and (b) (read with section 5(2) where applicable);
 - (j) a decision embodied in a finding as to the particulars required by the 1953 Act to be registered concerning a death.
- (3) An interested person may appeal to the Chief Coroner against a decision made by the Coroner for Treasure (or an Assistant Coroner for Treasure) in connection with—
 - (a) an object that is or may be treasure or treasure trove, or
 - (b) an investigation or inquest under Chapter 4 concerning such an object, including a decision embodied in the determination of a question mentioned in section 26(5)(a) or (b).
- (4) An interested person may appeal to the Chief Coroner against a failure to make—
 - (a) a decision that falls within subsection (2), or
 - (b) a decision of a kind mentioned in subsection (3).
- (5) A person who the coroner decides is not an interested person may appeal to the Chief Coroner against that decision.

- (6) The Lord Chancellor may by order amend subsection (2).
- (7) On an appeal under this section the Chief Coroner may consider evidence about any matter that appears to be relevant to the substance of the decision, determination or finding, including evidence that concerns a matter arising after the date of the decision, determination or finding.
- (8) On an appeal under this section the Chief Coroner may, if the appeal is allowed, do one or more of the following –
 - (a) in the case of an appeal against a decision embodied in a determination or finding –
 - (i) amend the determination or finding, or
 - (ii) quash the determination or finding and order a fresh investigation under this Part;
 - (b) in the case of an appeal against a decision not embodied in a determination or finding –
 - (i) substitute any other decision that could have been made, or
 - (ii) quash the decision and remit the matter for a fresh decision;
 - (c) in the case of an appeal against a failure to make a decision –
 - (i) make any decision that could have been made, or
 - (ii) remit the matter for a decision to be made;
 - (d) make any order (including an order as to costs) that the Chief Coroner thinks appropriate.
- (9) A party to an appeal under this section may appeal on a question of law to the Court of Appeal from a decision of the Chief Coroner.
- (10) On an appeal under subsection (9) the Court of Appeal may –
 - (a) affirm the decision;
 - (b) substitute for the decision any decision that the Chief Coroner could have made;
 - (c) quash the decision and remit the matter to the Chief Coroner for a fresh decision.

41 Investigation by Chief Coroner or Coroner for Treasure or by judge, former judge or former coroner

Schedule 10 makes provision for an investigation into a person's death to be carried out by the Chief Coroner or the Coroner for Treasure or by a judge, former judge or former coroner.

42 Guidance by the Lord Chancellor

- (1) The Lord Chancellor may issue guidance about the way in which the coroner system is expected to operate in relation to interested persons within section 47(2)(a).
- (2) Guidance issued under this section may include provision –
 - (a) about the way in which such persons are able to participate in investigations under this Part into deaths;
 - (b) about the rights of such persons to appeal under section 40;
 - (c) about the role of coroners' officers and other staff in helping such persons to participate in investigations and to exercise rights of appeal.This subsection is not to be read as limiting the power in subsection (1).

- (3) The Lord Chancellor may amend or revoke any guidance issued under this section.
- (4) The Lord Chancellor must consult the Chief Coroner before issuing, amending or revoking any guidance under this section.

CHAPTER 7

SUPPLEMENTARY

Regulations and rules

43 Coroners regulations

- (1) The Lord Chancellor may make regulations –
 - (a) for regulating the practice and procedure at or in connection with investigations under this Part (other than the practice and procedure at or in connection with inquests);
 - (b) for regulating the practice and procedure at or in connection with examinations under section 14;
 - (c) for regulating the practice and procedure at or in connection with exhumations under paragraph 6 of Schedule 5.

Regulations under this section are referred to in this Part as “Coroners regulations”.

- (2) Coroners regulations may be made only if –
 - (a) the Lord Chief Justice, or
 - (b) a judicial office holder (as defined in section 109(4) of the Constitutional Reform Act 2005 (c. 4)) nominated for the purposes of this subsection by the Lord Chief Justice,
 agrees to the making of the regulations.
- (3) Coroners regulations may make –
 - (a) provision for the discharge of an investigation (including provision as to fresh investigations following discharge);
 - (b) provision for or in connection with the suspension or resumption of investigations;
 - (c) provision for the delegation by a senior coroner, area coroner or assistant coroner of any of his or her functions;
 - (d) provision allowing information to be disclosed or requiring information to be given;
 - (e) provision giving to the Lord Chancellor or the Chief Coroner power to require information from senior coroners;
 - (f) provision requiring a summary of specified information given to the Chief Coroner by virtue of paragraph (e) to be included in reports under section 36;
 - (g) provision with respect to the preservation, retention, release or disposal of bodies (including provision with respect to reinterment and with respect to the issue of orders authorising burial);
 - (h) provision, in relation to authorisations under paragraph 3 of Schedule 5 or entry and search under such authorisations, equivalent to that made by any provision of sections 15 and 16 of the Police and Criminal

Evidence Act 1984 (c. 60), subject to any modifications the Lord Chancellor thinks appropriate;

- (i) provision, in relation to the power of seizure conferred by paragraph 3(4)(a) of that Schedule, equivalent to that made by any provision of section 21 of that Act, subject to any modifications the Lord Chancellor thinks appropriate;
- (j) provision about reports under paragraph 7 of that Schedule.

This subsection is not to be read as limiting the power in subsection (1).

- (4) Coroners regulations may apply any provisions of Coroners rules.
- (5) Where Coroners regulations apply any provisions of Coroners rules, those provisions –
 - (a) may be applied to any extent;
 - (b) may be applied with or without modifications;
 - (c) may be applied as amended from time to time.

44 Treasure regulations

- (1) The Lord Chancellor may make regulations for regulating the practice and procedure at or in connection with investigations under this Part concerning objects that are or may be treasure or treasure trove (other than the practice and procedure at or in connection with inquests concerning such objects). Regulations under this section are referred to in this Part as “Treasure regulations”.
- (2) Treasure regulations may be made only if –
 - (a) the Lord Chief Justice, or
 - (b) a judicial office holder (as defined in section 109(4) of the Constitutional Reform Act 2005 (c. 4)) nominated for the purposes of this subsection by the Lord Chief Justice,agrees to the making of the regulations.
- (3) Treasure regulations may make –
 - (a) provision for the discharge of an investigation (including provision as to fresh investigations following discharge);
 - (b) provision for or in connection with the suspension or resumption of investigations;
 - (c) provision for the delegation by the Coroner for Treasure (or an Assistant Coroner for Treasure) of any of his or her functions;
 - (d) provision allowing information to be disclosed or requiring information to be given;
 - (e) provision giving to the Lord Chancellor or the Chief Coroner power to require information from the Coroner for Treasure;
 - (f) provision requiring a summary of specified information given to the Chief Coroner by virtue of paragraph (e) to be included in reports under section 36;
 - (g) provision of the kind mentioned in paragraph (h) or (i) of section 43(3).This subsection is not to be read as limiting the power in subsection (1).
- (4) Treasure regulations may apply any provisions of Coroners rules.
- (5) Where Treasure regulations apply any provisions of Coroners rules, those provisions –

- (a) may be applied to any extent;
- (b) may be applied with or without modifications;
- (c) may be applied as amended from time to time.

45 Coroners rules

- (1) Rules may be made in accordance with Part 1 of Schedule 1 to the Constitutional Reform Act 2005 (c. 4) –
- (a) for regulating the practice and procedure at or in connection with inquests;
 - (b) as to the way in which, and the time within which, appeals under section 40(1), (3), (4), (5) or (9) are to be brought;
 - (c) for regulating the practice and procedure at or in connection with appeals under that section.

Rules under this section are referred to in this Part as “Coroners rules”.

- (2) Coroners rules may make –
- (a) provision about evidence (including provision requiring evidence to be given on oath except in prescribed cases);
 - (b) provision for the discharge of a jury (including provision as to the summoning of new juries following discharge);
 - (c) provision for the discharge of an inquest (including provision as to fresh inquests following discharge);
 - (d) provision for or in connection with the adjournment or resumption of inquests;
 - (e) provision for a senior coroner to have power to give a direction, in proceedings at an inquest, allowing or requiring a name or other matter not to be disclosed except to persons specified in the direction;
 - (f) provision for the delegation by –
 - (i) a senior coroner, area coroner or assistant coroner, or
 - (ii) the Coroner for Treasure (or an Assistant Coroner for Treasure),of any of his or her functions, except for functions that involve making judicial decisions or exercising any judicial discretion;
 - (g) provision with respect to the disclosure of information;
 - (h) provision for persons to be excused from service as jurors at inquests in cases specified in the rules;
 - (i) provision as to the matters to be taken into account by the Coroner for Treasure in deciding whether to hold an inquest concerning an object that is or may be treasure or treasure trove;
 - (j) provision for requiring permission to be given for the making of an appeal to the Court of Appeal under any provision of this Part.
- (3) Coroners rules may make provision conferring power on a senior coroner or the Coroner for Treasure –
- (a) to give a direction excluding specified persons from an inquest, or part of an inquest, if the coroner is of the opinion that the interests of national security so require;
 - (b) to give a direction excluding specified persons from an inquest during the giving of evidence by a witness under the age of 18, if the coroner is of the opinion that doing so would be likely to improve the quality of the witness’s evidence.

In this subsection “specified persons” means persons of a description specified in the direction, or all persons except those of a description specified in the direction.

- (4) Subsections (2) and (3) are not to be read as limiting the power in subsection (1).
- (5) Coroners rules may apply –
 - (a) any provisions of Coroners regulations;
 - (b) any provisions of Treasure regulations;
 - (c) any rules of court that relate to proceedings other than inquests.
- (6) Where any provisions or rules are applied by virtue of subsection (5), they may be applied –
 - (a) to any extent;
 - (b) with or without modifications;
 - (c) as amended from time to time.
- (7) Practice directions may be given in accordance with Part 1 of Schedule 2 to the Constitutional Reform Act 2005 (c. 4) on any matter that could otherwise be included in Coroners rules.
- (8) Coroners rules may, instead of providing for a matter, refer to provision made or to be made by practice directions under subsection (7).
- (9) In this section “rules of court” include any provision governing the practice and procedure of a court that is made by or under an enactment.

Coroner of the Queen’s household

46 Abolition of the office of coroner of the Queen’s household

The office of coroner of the Queen’s household is abolished.

Interpretation

47 “Interested person”

- (1) This section applies for the purposes of this Part.
- (2) “Interested person”, in relation to a deceased person or an investigation or inquest under this Part into a person’s death, means –
 - (a) a spouse, civil partner, partner, parent, child, brother, sister, grandparent, grandchild, child of a brother or sister, stepfather, stepmother, half-brother or half-sister;
 - (b) a personal representative of the deceased;
 - (c) a medical examiner exercising functions in relation to the death of the deceased;
 - (d) a beneficiary under a policy of insurance issued on the life of the deceased;
 - (e) the insurer who issued such a policy of insurance;
 - (f) a person who may by any act or omission have caused or contributed to the death of the deceased, or whose employee or agent may have done so;
 - (g) in a case where the death may have been caused by –

- (i) an injury received in the course of an employment, or
 - (ii) a disease prescribed under section 108 of the Social Security Contributions and Benefits Act 1992 (c. 4) (benefit in respect of prescribed industrial diseases, etc),a representative of a trade union of which the deceased was a member at the time of death;
 - (h) a person appointed by, or representative of, an enforcing authority;
 - (i) where subsection (3) applies, a chief constable;
 - (j) where subsection (4) applies, a Provost Marshal;
 - (k) where subsection (5) applies, the Independent Police Complaints Commission;
 - (l) a person appointed by a Government department to attend an inquest into the death or to assist in, or provide evidence for the purposes of, an investigation into the death under this Part;
 - (m) any other person who the senior coroner thinks has a sufficient interest.
- (3) This subsection applies where it appears that a person has or may have committed –
- (a) a homicide offence involving the death of the deceased, or
 - (b) a related offence (other than a service offence).
- (4) This subsection applies where it appears that a person has or may have committed –
- (a) the service equivalent of a homicide offence involving the death of the deceased, or
 - (b) a service offence that is a related offence.
- (5) This subsection applies where the death of the deceased is or has been the subject of an investigation managed or carried out by the Independent Police Complaints Commission in accordance with Part 3 of Schedule 3 to the Police Reform Act 2002 (c. 30), including that Part as extended or applied by or under any statutory provision (whenever made).
- (6) “Interested person”, in relation to an object that is or may be treasure or treasure trove, or an investigation or inquest under Chapter 4 concerning such an object, means –
- (a) the British Museum, if the object was found or is believed to have been found in England;
 - (b) the National Museum of Wales, if the object was found or is believed to have been found in Wales;
 - (c) the finder of the object or any person otherwise involved in the find;
 - (d) the occupier, at the time the object was found, of the land where it was found or is believed to have been found;
 - (e) a person who had an interest in that land at that time or who has had such an interest since;
 - (f) any other person who the Coroner for Treasure thinks has a sufficient interest.
- (7) For the purposes of this section, a person is the partner of a deceased person if the two of them (whether of different sexes or the same sex) were living as partners in an enduring relationship at the time of the deceased person’s death.

48 Interpretation: general

- (1) In this Part, unless the context otherwise requires –
- “the 1953 Act” means the Births and Deaths Registration Act 1953 (c. 20);
 - “the 1988 Act” means the Coroners Act 1988 (c. 13);
 - “active service” means service in –
 - (a) an action or operation against an enemy (within the meaning given by section 374 of the Armed Forces Act 2006 (c. 52)),
 - (b) an operation outside the British Islands for the protection of life or property, or
 - (c) the military occupation of a foreign country or territory;
 - “area”, in relation to a senior coroner, area coroner or assistant coroner, means the coroner area for which that coroner is appointed;
 - “area coroner” means a person appointed under paragraph 2(3) of Schedule 3;
 - “assistant coroner” means a person appointed under paragraph 2(4) of Schedule 3;
 - “Assistant Coroner for Treasure” means an assistant coroner, designated under paragraph 7 of Schedule 4, acting in the capacity of Assistant Coroner for Treasure;
 - “body” includes body parts;
 - “chief constable” means –
 - (a) a chief officer of police (within the meaning given in section 101(1) of the Police Act 1996 (c. 16));
 - (b) the Chief Constable of the Ministry of Defence Police;
 - (c) the Chief Constable of the Civil Nuclear Constabulary;
 - (d) the Chief Constable of the British Transport Police;
 - “the Chief Coroner” means a person appointed under paragraph 1 of Schedule 8;
 - “the Common Council” means the Common Council of the City of London, and “common councillor” is to be read accordingly;
 - “coroner area” is to be read in accordance with paragraph 1 of Schedule 2;
 - “the Coroner for Treasure” means a person appointed under paragraph 1 of Schedule 4;
 - “Coroners regulations” means regulations under section 43;
 - “Coroners rules” means rules under section 45;
 - “the coroner system” means the system of law and administration relating to investigations and inquests under this Part;
 - “the court of trial” means –
 - (a) in relation to an offence (other than a service offence) that is tried summarily, the magistrates’ court by which the offence is tried;
 - (b) in relation to an offence tried on indictment, the Crown Court;
 - (c) in relation to a service offence, a commanding officer, a Court Martial or the Service Civilian Court (depending on the person before whom, or court before which, it is tried);
 - “Deputy Chief Coroner” means a person appointed under paragraph 2 of Schedule 8;
 - “document” includes information stored in an electronic form;

- “enforcing authority” has the meaning given by section 18(7) of the Health and Safety at Work etc. Act 1974 (c. 37);
- “functions” includes powers and duties;
- “homicide offence” has the meaning given in paragraph 1(6) of Schedule 1;
- “interested person” is to be read in accordance with section 47;
- “land” includes premises within the meaning of the Police and Criminal Evidence Act 1984 (c. 60);
- “local authority” means –
- (a) in relation to England, a county council, the council of any district comprised in an area for which there is no county council, a London borough council, the Common Council or the Council of the Isles of Scilly;
 - (b) in relation to Wales, a county council or a county borough council;
- “medical examiner” means a person appointed under section 19;
- “person”, in relation to an offence of corporate manslaughter, includes an organisation;
- “prosecuting authority” means –
- (a) the Director of Public Prosecutions, or
 - (b) a person of a description prescribed by an order made by the Lord Chancellor;
- “related offence” has the meaning given in paragraph 1(6) of Schedule 1;
- “relevant authority”, in relation to a coroner area, has the meaning given by paragraph 3 of Schedule 2 (and see paragraph 2 of Schedule 22);
- “senior coroner” means a person appointed under paragraph 1 of Schedule 3;
- “the service equivalent of a homicide offence” has the meaning given in paragraph 1(6) of Schedule 1;
- “service offence” has the meaning given by section 50(2) of the Armed Forces Act 2006 (c. 52) (read without regard to any order under section 380 of that Act) and also includes an offence under –
- (a) Part 2 of the Army Act 1955 (3 & 4 Eliz. 2 c. 18) or paragraph 4(6) of Schedule 5A to that Act,
 - (b) Part 2 of the Air Force Act 1955 (3 & 4 Eliz. 2 c. 19) or paragraph 4(6) of Schedule 5A to that Act, or
 - (c) Part 1 or section 47K of the Naval Discipline Act 1957 (c. 53) or paragraph 4(6) of Schedule 4A to that Act;
- “service police force” means –
- (a) the Royal Navy Police,
 - (b) the Royal Military Police, or
 - (c) the Royal Air Force Police;
- “state detention” has the meaning given by subsection (2);
- “statutory provision” means provision contained in, or in an instrument made under, any Act (including this Act);
- “treasure” means anything that is treasure for the purposes of the Treasure Act 1996 (c. 24) (and accordingly does not include anything found before 24 September 1997);
- “Treasure regulations” means regulations under section 44;

“treasure trove” does not include anything found on or after 24 September 1997.

- (2) A person is in state detention if he or she is compulsorily detained by a public authority within the meaning of section 6 of the Human Rights Act 1998 (c. 42).
- (3) For the purposes of this Part, the area of the Common Council is to be treated as including the Inner Temple and the Middle Temple.
- (4) A reference in this Part to a coroner who is responsible for conducting an investigation under this Part into a person’s death is to be read as a reference to the coroner who is under a duty to conduct the investigation, or who would be under such a duty but for the suspension of the investigation under this Part.
- (5) A reference in this Part to producing or providing a document, in relation to information stored in an electronic form, is to be read as a reference to producing or providing a copy of the information in a legible form.

Northern Ireland and Scotland amendments

49 Amendments to the Coroners Act (Northern Ireland) 1959

- (1) In section 13 of the Coroners Act (Northern Ireland) 1959 (c. 15) (coroner may hold inquest), in subsection (1), for the words from “a coroner within whose district” to “an unexpected or unexplained death” substitute “a coroner –
 - (a) who is informed that the body of a deceased person is lying within his district; or
 - (b) in whose district an unexpected or unexplained death”.
- (2) Schedule 11 inserts provisions into the Coroners Act (Northern Ireland) 1959 corresponding to certain provisions in Schedules 5 and 6.

50 Amendments to the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

- (1) The Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (c. 14) is amended as follows.

- (2) After section 1 insert –

“1A Death of service personnel abroad

- (1) Subsection (4) applies where –
 - (a) the Lord Advocate is notified under section 12(4) or (5) of the Coroners and Justice Act 2009 in relation to a death,
 - (b) the death is within subsection (2) or (3), and
 - (c) the Lord Advocate –
 - (i) decides that it would be appropriate in the public interest for an inquiry under this Act to be held into the circumstances of the death, and
 - (ii) does not reverse that decision.
- (2) A death is within this subsection if the person who has died was, at the time of the death, in legal custody (as construed by reference to section 1(4)).

-
- (3) A death is within this subsection if it appears to the Lord Advocate that the death –
 - (a) was sudden, suspicious or unexplained, or
 - (b) occurred in circumstances such as to give rise to serious public concern.
 - (4) The procurator fiscal for the appropriate district must –
 - (a) investigate the circumstances of the death, and
 - (b) apply to the sheriff for the holding of an inquiry under this Act into those circumstances.
 - (5) But subsection (4) does not extend to a death within subsection (2) if the Lord Advocate is satisfied that the circumstances of the death have been sufficiently established in the course of any criminal proceedings against any person in respect of the death.
 - (6) An application under subsection (4)(b) –
 - (a) is to be made to the sheriff of the appropriate sheriffdom,
 - (b) must narrate briefly the circumstances of the death so far as known to the procurator fiscal,
 - (c) may relate to more than one death if the deaths occurred in the same or similar circumstances.
 - (7) It is for the Lord Advocate to determine the appropriate district and appropriate sheriffdom for the purposes of subsections (4) and (6)(a).”
 - (3) In section 2 (citation of witnesses for precognition), in subsection (1), after “section 1(1)” insert “or 1A(4)”.
 - (4) In section 3 (holding of public inquiry), in subsections (1) and (3), after “section 1” insert “or 1A”.
 - (5) In section 6 (sheriff’s determination etc), in subsection (4)(a)(i), after “section 1” insert “or 1A”.

Amendments of Access to Justice Act 1999

51 Public funding for advocacy at certain inquests

- (1) Schedule 2 to the Access to Justice Act 1999 (c. 22) (Community Legal Service: excluded cases) is amended as follows.
- (2) In paragraph 2, at the end insert “, and
 - (5) proceedings at an inquest under Part 1 of the Coroners and Justice Act 2009 to which sub-paragraph (1), (2) or (3) of paragraph 4 applies.”
- (3) After paragraph 3 there is inserted –
 - “4 (1) This sub-paragraph applies to an inquest into the death of a person who at the time of the death –
 - (a) was detained at a custodial institution or in a custody area at a court or police station,
 - (b) was detained at a removal centre or short-term holding centre,

- (c) was being transferred or held in pursuance of prison escort arrangements or immigration escort arrangements,
 - (d) was detained in secure accommodation,
 - (e) was a detained patient, or
 - (f) was in service custody.
- (2) This sub-paragraph applies to an inquest into the death of a person that occurred in the course of the person’s arrest by a constable or otherwise in the course of the execution or purported execution of any functions by a constable.
- (3) This sub-paragraph applies to an inquest into the death of a person who at the time of the death was subject to service law by virtue of section 367 or 369(2)(a) of the Armed Forces Act 2006 and was engaged in active service.
- (4) Paragraph 2(5) does not authorise the funding of the provision of services to anyone who is not an interested person within section 47(2)(a) of the Coroners and Justice Act 2009.
- (5) In this paragraph –
- “active service” means service in –
 - (a) an action or operation against an enemy (within the meaning given by section 374 of the Armed Forces Act 2006),
 - (b) an operation outside the British Islands for the protection of life or property, or
 - (c) the military occupation of a foreign country or territory;
 - “custodial institution” means a prison, a young offender institution, a secure training centre or a remand centre;
 - “detained patient” means a person who is detained in any premises under Part 2 or 3 or section 135(3B) or 136(4) of the Mental Health Act 1983;
 - “immigration escort arrangements” means arrangements made under section 156 of the Immigration and Asylum Act 1999;
 - “prison escort arrangements” means arrangements made under section 80 of the Criminal Justice Act 1991 or under section 102 or 118 of the Criminal Justice and Public Order Act 1994;
 - “removal centre” and “short-term holding facility” have the meaning given by section 147 of the Immigration and Asylum Act 1999;
 - “secure accommodation” means accommodation, not consisting of or forming part of a custodial institution, provided for the purpose of restricting the liberty of persons under the age of 18.”

APPENDIX F



Catherine R. McGowan

London School of Hygiene & Tropical Medicine
Keppel Street London WC1E 7HT
Catherine.McGowan@lshtm.ac.uk

09 August 2009

Dear _____,

I am a doctoral student at the London School of Hygiene & Tropical Medicine (LSHTM) and am conducting my research on the coroner system and the current reform initiatives. I have spoken to many individuals involved in the reform process but would very much benefit from your opinions on this matter. I would also like to talk with you about your background, your experience as a coroner and your thoughts on the future of the service.

I propose to speak to you privately and at a location of your choosing. I would require approximately an hour of your time and would be happy to meet you entirely at your convenience. Our interview would, of course, be entirely confidential and I will not divulge to anyone that we have met, nor will I refer to you by name in my work. My research has been approved by the Research Ethics Committee at the LSHTM.

Should you wish to meet for an interview please let me know and we can arrange a time and a place of your choosing. I can be reached at the e-mail address above or at 079 9066 5658. Please do feel free to contact me should you have any questions or concerns. If I do not hear from you I may follow up with a phone call in case you find yourself too busy to respond to this letter.

Thank you,

Catherine R. McGowan BA, MPH, PhD candidate

APPENDIX G



LETTER OF INFORMATION

Dear Sir or Madam,

09 August 2009

I am a doctoral student at the London School of Hygiene & Tropical Medicine and am requesting your participation in the research that I am currently conducting for the purpose of completing my PhD in Public Health. My research involves the functioning of the coroner system in England and Wales – specifically with reference to current reform initiatives. You have been chosen to participate in this study due to your lengthy experience as a coroner in the UK.

I am requesting a single interview with you which is likely to last approximately one hour. This research is based upon qualitative data collection and, as such, there will be very little structure in this interview. You may discuss whatever you feel is relevant to the research topic. There are no right or wrong answers to any questions I might pose, though I do request that you respond to questions thoughtfully and honestly.

Please understand that *your participation is voluntary*. If you choose not to take part, you will not be affected in any way. If, however, you do agree to participate, please understand that you may stop the interview at any time. You may also decline to respond to particular questions. If you answer a question, or make a comment that you do not wish to appear on the transcript of your interview, you may let me know and I will omit this portion of the interview from the transcript – I will not make reference to any omitted material in my thesis.

The interview will be conducted privately and will be confidential. I will be making an audio recording of the interview – this recording will be deleted as soon as your interview has been transcribed. Your name will not appear anywhere on the transcript, nor will you be identified in my thesis or in any subsequent publications of this research. The information you give will not be disclosed to any of your colleagues.

This study has been reviewed by, and has received ethical clearance from, the Research Ethics Committee that the London School of Hygiene & Tropical Medicine.

I would very much appreciate your participation in this study. If you have any questions or concerns, please do not hesitate to contact me.

Catherine R. McGowan

London School of Hygiene & Tropical Medicine
Keppel Street London WC1E 7HT
Catherine.McGowan@lshtm.ac.uk

APPENDIX H

Questionnaire

How long have you been a coroner?

Are you full or part-time?

What is your background?

How did you become a coroner?

What, currently is the coroner's purpose?

Why?

Do you see yourself as an instrument of public health?

How can the coroner promote public health?

If so, have you ever acted in support of public health? Describe.

What *should* the coroner be doing?

Tell me what you see as the problems with the current system?

How do you feel about reform?

APPENDIX I



Catherine R. McGowan

London School of Hygiene & Tropical Medicine
Keppel Street London WC1E 7HT
Catherine.McGowan@lshtm.ac.uk

10 September 2010

Dear _____,

I am a PhD student at the London School of Hygiene & Tropical Medicine (LSHTM) and am conducting my doctoral research on the coroner system in England and Wales. I am writing to you at the suggestion of Mr. Keith Huntingford of the Coroners and Burials Division at the Ministry of Justice.

As part of my dissertation I would like to have access to a subset of coroners' verdicts. I would, therefore, appreciate being provided with all *open verdicts* in your region from **July 01, 2009 to December 31, 2009**. I would very much like to see the *narrative verdicts* on all open verdict decisions. I do not require verdicts rendered by a jury; decisions made by the coroner alone will suffice.

I shall *not* include in my dissertation, or in any subsequent publications, any personal or otherwise identifying information regarding the deceased or his/her family including the name, address or date/place of death of the deceased. If the deceased has come about their death in a manner which would identify them (e.g. under sufficiently publicised, unique or peculiar circumstances) then I will *not* make any reference to the manner or circumstances of that death should it be indicated in the narrative verdict.

My research has been formally approved by the Research Ethics Committee at the LSHTM.

I would be grateful if you could respond to my request by **15 November 2010**. Please do let me know if I can provide you with any further guidance.

Thank you,

Catherine R. McGowan BA, MPH, PhD candidate

APPENDIX J

**LONDON SCHOOL OF HYGIENE
& TROPICAL MEDICINE**

ETHICS COMMITTEE



APPROVAL FORM

Application number: 5431

Name of Principal Investigator Catherine McGowan

Department Public Health and Policy

Head of Department Professor Anne Mills

Title: The Coronial System in England & Wales and Its Role in the Management of Emerging Infections Disease Risk

This application is approved by the Committee.

Chair of the Ethics Committee *T. W. Meade*

Date 12 February 2009

Approval is dependent on local ethical approval having been received.

Any subsequent changes to the application must be submitted to the Committee via an E2 amendment form.

APPENDIX K



Ministry of Community
Safety And Correctional
Services

Office of the Chief
Coroner

Institutional Patient Death Record - Version 3

Procedure for Registered Nursing Homes, Homes for the Aged, Charitable Institutions and Hospitals to Report Deaths of Residents to the Office of the Chief Coroner

ALL deaths of residents of registered Nursing Homes, Homes for the Aged and Charitable Institutions must be reported by submission of the Institutional Patient Death Record -Version 3 (IPDR) to the Office of the Chief Coroner. The IPDR must be faxed (416-314-0888) or mailed (address located at the bottom of the IPDR) to the Office of the Chief Coroner within 48 hours of the death.

Some deaths **MUST ALSO** be reported **directly and immediately** to a local coroner at the time of the death. The IPDR is intended to assist persons responsible for completing the record to determine if a local coroner should be called **in addition to** providing information about the death to the Office of the Chief Coroner through submission of the IPDR.

A local coroner must be directly and immediately notified:

- **For all deaths resulting from an accident, a suicide, or a homicide.**

An accident is an event that caused unintended injuries that begin the process leading to death. The time interval between the injury and death may be minutes to years. For example, a hip fracture is a common injury that begins the process that leads to death in the elderly. If there is a possible connection between a fracture or an injury and the events leading to death, the death should be reported to a coroner.

A suicide is a death due to an external factor initiated by the deceased.

A homicide is a death due to an external factor initiated by someone other than the deceased.

A local coroner must be directly and immediately notified - cont'd:

- **For all deaths that are considered sudden and unexpected.** (i.e. the death was not reasonably foreseeable).
- **If the family or care providers raised concerns about the care provided to the deceased.**
- **If there has been a recent increase in the number of deaths at the Nursing Home, Home for the Aged or Charitable Institution.** (This is intended to alert the facility and the coroner to the possibility of a cluster of deaths).
- **If there has been a recent increase in the number of residents transferred to hospital.** (This is intended to alert the facility and the coroner to the possibility of a cluster of deaths).
- **For all deaths believed to be related to a declared disease outbreak.**

The death is to be reported regardless of whether or not the deceased person was thought to have been infected or their death attributable to the declared infectious disease outbreak.

- **For a threshold case (for most institutions this is every 10th death) whether or not a local coroner investigated any of the previous nine deaths.**

The Administrator of the registered residential facility (or his or her delegate) is responsible for advising relevant staff if the institution has a different threshold number, in order that deaths are accurately reported to the local coroner.

All registered residential facilities are required to keep track of the following:

1. the number of deaths in the facility;
2. the number of transfers to hospitals from the facility;
3. the average number of deaths and transfers for the facility in a given time period.

This information must be kept current and accessible to staff responsible for notifying the local coroner and providing information to hospital administrators. Most registered residential facilities have developed tracking systems (or utilize the “*Resident Death or Transfer Record*” provided by the Office of the Chief Coroner) for their institutions in order to enable staff to properly answer questions 7 through 10 on the IPDR. The record of deaths and transfers must also be made available to the local coroner to review each time he/she is at the residential facility conducting an investigation of a death.

All IPDRs will be reviewed for completeness at the Office of the Chief Coroner. Any institution submitting an incomplete IPDR will be advised of the deficiency and requested to immediately submit a revised IPDR.

The Regional Supervising Coroner, for the area, will be notified of any IPDRs where the information provided is inconsistent (e.g. “yes” response(s) but a local coroner’s name is **not** recorded) and will follow up with the institution to clarify the matter.

Please note that the IPDR may be photocopied.

PUBLICATION ONE

COVER SHEET FOR EACH RESEARCH PAPER INCLUDED IN A RESEARCH THESIS

1. For a research paper already published

1.1. Where was the work published? Public Health (Elsevier)

1.2. When was the work published? 26 March 2011 (available online)

1.2.1. If the work was published prior to registration for your research degree, give a brief rationale for its inclusion n/a

1.3. Was the work subject to academic peer review? Yes

1.4. Have you retained the copyright for the work? No

If no, or if the work is being included in its published format, attach evidence of permission from copyright holder (publisher or other author) to include work Attached

2. For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)

I am the primary author of this paper. I have met all of the authorship requirements as stated by the *International Committee of Medical Journal Editors* (a.k.a. the *Vancover Group*)¹:

“The ICJME has recommended the following criteria for authorship; these criteria are still appropriate for journals that distinguish authors from other contributors.

1) substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;

2) drafting the article or revising it critically for important intellectual content; and

3) final approval of the version to be published.

Authors should meet conditions 1, 2, and 3”.

My co-author, Mr. Adrian Viens (School of Law, QMUL) is responsible for providing guidance on the relevant points of law and public health ethics. He was involved in the drafting of the article and was consulted on the final draft prior to submission and subsequent publication. The section titled ‘moral requirement to facilitate public health measures’ was written by Mr. Viens. I contributed to the revision of this section and had final approval over the article in its entirety prior to submission and publication. He is listed as the second author as this accurately reflects the extent of his contribution.

Candidate’s signature 

Supervisor or senior author’s signature to confirm role as stated in (2)



¹ http://www.icmje.org/ethical_1author.html

Thank You For Your Order!

Dear Ms. Catherine McGowan,

Thank you for placing your order through Copyright Clearance Center's RightsLink service. Elsevier has partnered with RightsLink to license its content.

Your order details and publisher terms and conditions are available by clicking the link below:

http://s100.copyright.com/CustomerAdmin/PLF.jsp?IID=2011040_1302623384953

Order Details

Licensee: Catherine R McGowan

License Date: Apr 12, 2011

License Number: 2646561112953

Publication: Public Health

Title: Coroners and the obligation to protect public health: The case of the failed UK vCJD study

Type Of Use: reuse in a thesis/dissertation



Total: 0.00 USD



To access your account, please visit <https://myaccount.copyright.com>.

Please note: Credit cards are charged immediately after order confirmation; invoices are issued daily and are payable immediately upon receipt.

To ensure we are continuously improving our services, please take a moment to complete our [customer satisfaction survey](#).

B.1:v4.2

 +1-877-622-5543  / Tel:

 +1-978-646-2777 

customercare@copyright.com

<http://www.copyright.com>



available at www.sciencedirect.com

Public Health

journal homepage: www.elsevier.com/puhe

Review Paper

Coroners and the obligation to protect public health: The case of the failed UK vCJD study

C.R. McGowan^{a,*}, A.M. Viens^{b,c}

^a Department of Public Health and Policy, London School of Hygiene and Tropical Medicine, University of London, 15–17 Tavistock Place, London WC1H 9SH, UK

^b School of Law, Queen Mary, University of London, London, UK

^c Joint Centre for Bioethics, University of Toronto, Toronto, Ontario, Canada

ARTICLE INFO

Article history:

Received 20 May 2010

Received in revised form

18 November 2010

Accepted 8 December 2010

Available online 26 March 2011

Keywords:

Death investigation

Coroners

Public health

Surveillance

Ethics

SUMMARY

The Health Protection Agency has recently attempted to create a postmortem tissue archive to determine the prevalence of abnormal prion protein. The success of this archive was prevented because the Health Protection Agency could not convince coroners to support the study's methodology and participate on that basis. The findings of this paper detail and support the view that the Coroners' Society of England and Wales's refusal to participate was misguided and failed to appreciate that coroners have a moral obligation to protect public health. Measures to assist coroners in fulfilling this role are proposed.

© 2010 The Royal Society for Public Health. Published by Elsevier Ltd. All rights reserved.

Introduction

In light of new evidence that variant Creutzfeldt–Jakob disease (vCJD) has the potential to emerge as a second-wave infection resulting from human-to-human transmission, the Health Protection Agency (HPA) proposed the creation of a postmortem tissue archive to determine the prevalence of abnormal prion protein (a marker for vCJD infection) in the UK.¹ This study required tissue from a large number of autopsies, necessitating the participation of coroners in England and Wales. Following a protracted correspondence (available at: www.coronersociety.org.uk) with the Chief Medical Officer (CMO), and despite efforts

by the HPA to accommodate coroners' concerns, the Coroners' Society of England and Wales (CSEW) declined to participate in the study, citing various issues including its legality, cost and the feasibility of the proposed methodology. The CSEW concluded that to participate in this public health measure on the proposed basis would "adversely affect the independence of the coronial service and would further erode public confidence". In the authors' opinion, declining to participate in this study was misguided and illustrates a considerable failure by the CSEW to recognize coroners' moral obligation to protect public health. Suggestions which may facilitate the participation of coroners in future public health measures are proposed.

* Corresponding author. Tel.: +44 2079272908.

E-mail address: Catherine.McGowan@lshtm.ac.uk (C.R. McGowan).

0033-3506/\$ – see front matter © 2010 The Royal Society for Public Health. Published by Elsevier Ltd. All rights reserved.

doi:10.1016/j.puhe.2010.12.001

Background

By the time bovine spongiform encephalopathy (BSE) was identified in 1986, it was thought that up to 50,000 cattle had been infected with the disease.² Owing to suspicions that ingestion of meat from BSE-infected cattle might result in prion infection in humans, the Specified Bovine Offals Ban was imposed in November 1989. However, by this time, a significant proportion of the human population was believed to have been exposed to BSE.³ Back calculations have estimated that the number of infected cattle that entered the human food chain may be as high as 2–3 million.⁴ In March 1996, the Government stated that a number of recent CJD cases in young people had likely been the result of exposure to BSE.

Until 2003, dietary exposure to BSE was the cause of all cases of vCJD in humans. However, four more recent infections are thought to have resulted from blood transfusions from asymptomatic donors infected with vCJD.^{5,6} It is also believed that iatrogenic transmission may occur as a result of contaminated plasma products, surgical instruments, dental procedures and transplanted tissue. All of these scenarios suggest the possibility of a second wave of vCJD infections resulting from human-to-human transmission.

As of December 2010, 170 cases of vCJD have been identified in the UK.⁷ A lengthy preclinical period is typical of vCJD infection, suggesting that there may be many potential carriers in the population and that these people may not exhibit signs of infection. Tests on animal models suggest that infection by a subclinical carrier may result in clinical disease.⁸ It has been suggested that the number of clinical cases only represents a small proportion of the total number of vCJD infections.⁹ The Spongiform Encephalopathy Advisory Committee (SEAC), which is responsible for advising the Department of Health (DH) on matters pertaining to vCJD, has concluded that it is very important to establish the prevalence of subclinical vCJD infection in order to assess the risk of transmission, determine the efficacy of current precautionary measures, and determine if further measures are necessary to reduce the risk of human-to-human transmission.¹⁰

In November 2006, SEAC suggested that tissue collected at autopsy would provide valuable, complimentary data to that of the National Anonymous Tonsil Archive, and that these two tissue archives could together constitute ‘the best route to estimating the prevalence of subclinical vCJD’.¹¹ The HPA, at the request of the DH, subsequently convened a Working Group, the recommendations of which were presented to the CMO (Sir Liam Donaldson) in May 2007.¹ The Working Group concluded that since the study required tissue from a large number of autopsies, it would be necessary to secure the participation of both coroners (in England and Wales) and procurators fiscal (in Scotland); there were no plans, at the time, to extend the study to Northern Ireland. It was suggested that the study should initially be implemented in England and Wales as further arrangements were deemed necessary before Scotland could be included. The Working Group proposed that coroners’ officers obtain – on behalf of the coroner – consent for the retention of tissue from the spleen and, if possible, the brain following autopsy. The low prevalence of subclinical vCJD in the population led the Working

Group to propose a sample size of approximately 100,000 people, which would be obtained over a 3-year period.

The Coroners’ Society’s position

In July 2007, the CMO wrote to the Honorary Secretary of the CSEW, Mr. André Rebello, to communicate the recommendations of the Working Group and to endorse their implementation. The CMO acknowledged the pressures under which coroners operate, but noted that it was important to secure the participation of a large number of coroners.

The Secretary replied to the CMO and, after acknowledging the importance of the study, raised two issues with coroners’ officers obtaining consent for tissue retention. First, he stated that it was beyond the jurisdiction of coroners to have their officers ask families to consent to tissue removal that does not directly bear upon the determination of cause of death, or the identification of the deceased. Second, the Secretary stated that there was no spare capacity to facilitate the recommendation that coroners’ staff obtain consent for tissue retention. He further indicated that “it was spelled out before the [HPA] report was written that it would be unfair if unrealistic expectations are raised by the report’s recommendations, resulting in criticism for the [c]oroner’s system if this study cannot be delivered”. In a subsequent letter addressed to the Infectious Disease and Policy Branch of the DH, the Secretary confirmed that it would not be against the law for coroners or their officers to take part in the study; however, in his view (on behalf of the CSEW), to do so would be ‘inappropriate’. He raised the additional concern that it was not the role of coroners or their officers to seek consent for any purpose other than the statutory duties of coroners, and that “coroners, and those who work with coroners, are not trained to obtain consent”. The fact that some coroners and their officers recently participated in research studies for which coroners’ officers were, in fact, obtaining consent from next of kin^{12,13} was not referred to by the Secretary.

The DH subsequently wrote to the CSEW Advisory Group in September 2008, including a copy of a revised methodology, addressing the Secretary’s earlier concerns that it was beyond the remit of coroners to participate, that coroners’ officers were not trained to obtain consent, and that there was no additional funding to execute the study. The letter confirmed that the DH was prepared to pay for any “administrative costs needed to undertake the survey”, and reiterated that it was “extremely important for protecting public health”, and was key to “reducing large uncertainties around current risk assessments”. The revisions were intended to minimize interference with coroners’ activities and proposed that coroners’ officers, upon being informed of a death, contact the National Health Service Blood and Transplant’s (NHSBT) tissue service to pass on contact details of the next of kin. The NHSBT would then contact the next of kin to discuss tissue retention and to obtain formal consent. The DH stated that it had taken legal advice which indicated that the proposed methodology, and requisite data transfer from coroners’ officers to the NHSBT, did not constitute a violation of the terms of either the Data Protection Act (1998) or the Coroners Act (1988).

The DH’s letter was considered at the Ministry of Justice Coroners Advisory Group meeting in October 2008. The Secretary

of the CSEW replied to the CMO on behalf of the Group, indicating that the “main concern is that the methodology would require the coroner to disclose contact details which are only held as a result of the coronial investigation”. In the Secretary’s view, this disclosure would be “bound to raise questions for the public as to the independence of the coroner and the real reason for the autopsy”, which he believed would “adversely affect the independence of the coronial service” and would likely “bring the office of the coroner into disrepute and adversely affect the coronial statutory function”. In addition, the Secretary recorded his “grave doubts” as to the lawfulness of the Secretary of State’s powers under Section 28(2) of the Coroners Act to request the information required by the study from the coroner. The Secretary closed by noting that, of the 118 coroners, deputy coroners and assistant deputy coroners in attendance at the 2008 Annual General Meeting of the CSEW, all voted unanimously that to follow the HPA methodology “would be to adversely affect the independence of the coronial service and would further erode public confidence in the service”. Despite the reservations expressed in October 2008, subsequent studies involving coroners have used precisely the method proposed in the revised study.¹⁴

Moral requirement to facilitate public health measures

Coroners are often described as independent judicial officers, meaning that they are not required to take instructions from other government agencies or officials in the conduct of their duties. Even if coroners are understood to be part of the judicial branch, and not the legislative or executive branches, of government, they are still public officials. In the context of law and public health, Parmet notes that both share an appeal to the venerable common law maxim, *salus populi suprema lex*, the wellbeing of the community is the law.¹⁵ The maxim reminds us that government officials and the law exist, at least in part, to serve the common good, and every reasonable means to contribute to protecting the health, safety and welfare of the population should be undertaken. Coroners have obligations that bind them despite their independence from central government. One such moral obligation – some might say an over-riding moral obligation – is to participate in collective interventions aimed at protecting the common good. Indeed, certain types of good, such as public health, are almost always produced by governmental action, with some scholars making it definitional of public health action that it involves governmental officials.¹⁶ The protection of public health is an appropriate and vital obligation of government officials as such protection helps to ensure the conditions necessary for individuals and groups to live healthy and safe lives.

Elsewhere, the authors have argued that the legal orientation of the coroner service is problematic for a number of reasons, and that the service would be improved if it embraced a clear public health mandate.¹⁷ Public health measures, as well as public health research, are necessary for disease detection, impact and control. Coroners, through death investigation and certification, already play an important role in disease surveillance by providing data used to calculate cause-specific mortality.¹⁸ Currently, the role of coroners in

public health measures, including those intended to help assess and manage risk, is less clear. The nature of many public health measures often makes their implementation difficult; consequently, the coroner service will not be able to accommodate all requests by governmental bodies, such as the DH or HPA. However, where obstacles or challenges exist, governmental officials are morally obligated to seek reasonable accommodations or alternative means to attempt to comply with requests aimed at protecting public health.

The correspondence between the CSEW and the CMO does not appear to reveal such an effort. This is puzzling in light of, firstly, the Secretary’s enthusiastic recognition of the importance of the vCJD study: “I, along with I suspect, every coronial office holder agree that there is national importance in being able to identify as accurately as possible the population prevalence of subclinical vCJD”; and secondly, coroners’ participation in public health research based on methods explicitly rejected by the CSEW.^{12,13,14}

Conclusions

The authors believe that the reasons for refusal provided by the Secretary of the CSEW are insufficient to justify not participating in this study. Various future changes to the system may foster coronial participation in public health in general, and subclinical vCJD studies in particular.

First, the new Coroners and Justice Act (2009) calls for the creation of the post of Chief Coroner. Strong central guidance could help re-orient the coroner system, standardise practice and increase co-operation with other government agencies. One example of such guidance is illustrated in a recent Scottish study. The support of the Chief Procurator Fiscal (i.e. the Scottish equivalent to the Chief Coroner) was cited as a positive factor when it came to organizing and implementing a recent tissue and organ donation study; one which resulted in 96% of families, all of whom were approached by procurator fiscal staff, consenting to tissue retention (with 17% consenting to retention of the entire brain).¹⁹ Also, Section 38 of the new Coroners and Justice Act provides for the appointment of a medical advisor, and several deputy medical advisors to the Chief Coroner.²⁰ These individuals would be in a position to better support the public health role of coroners, and would be able to help steer future studies.

Second, the coroner system would also benefit from a clear and appropriate mandate which prioritizes the pursuit of public health. Current research suggests that there is little consensus among coroners as to the ultimate purpose of the coroner’s investigation.²¹ A clearly mandated directive would undoubtedly help to re-orient the system towards public health and, in so doing, would encourage the participation of coroners in public health measures in the future.

Third, amendments to primary legislation (i.e. Coroners and Justice Act, Human Tissue Act (2004)) and secondary legislation (i.e. Coroners Rules (1984)) could help extend the coroner’s remit. Independent of providing coroners more professional latitude to assist meeting their moral obligations, there are other ethical arguments generally associated with measures intended to protect public health (e.g. detecting and

monitoring harms, aiding priority setting within budgets and departmental objectives, and motivating policy interventions).

Finally, since the Coroners and Justice Act allows the Chief Coroner to make regulations as to the nature, amount and frequency of training within the service, he/she could require that coroners and coroners' officers be trained to request consent for tissue retention. On 14 October 2010, the newly formed Coalition Government announced that 192 public bodies would be abolished in an attempt to cut costs and improve accountability.²² Regrettably, the position of Chief Coroner is to be abolished as part of this reform and will no longer be a statutory body.²³

While it is clear that some coroners do embrace a public health role, this would seem to be the exception rather than the rule.²⁴ The failure of the vCJD study illustrates the pressing need to review what has occurred in this particular case, and to suggest a wider review of coroners' participation in future public health measures.

Acknowledgements

The authors would like to thank Dr. Shirley Huchcroft, Dr. Angus Dawson and Professor Tony Barnett for their extremely useful comments and suggestions.

Ethical approval

None sought.

Funding

C.R. McGowan is partly funded by the Canadian Centennial Scholarship Fund UK. A.M. Viens is funded by the School of Law, Queen Mary, University of London.

Competing interests

None declared.

REFERENCES

1. Health Protection Agency. *A national human post-mortem tissue archive to study the prevalence of abnormal prion protein*. London: Health Protection Agency; 2007.
2. Phillips MJ, Bridgeman J, Ferguson-Smith M. *The BSE inquiry: findings and conclusions*. Contract No.: 887-1. London: The Stationery Office; 2000.
3. Dato V, Shephard R, Wagner M. Outbreaks and investigations. In: Wagner M, Moore AW, Aryel R, editors. *Handbook of biosurveillance*. London: Elsevier Academic Press; 2006. p. 13–26.
4. Smith PG, Bradley R. Bovine spongiform encephalopathy (BSE) and its epidemiology. *Br Med Bull* 2003;**66**:185–98.
5. Llewelyn CA, Hewitt PE, Knight RS, Amar K, Cousens S, Mackenzie J, et al. Possible transmission of variant Creutzfeldt–Jakob disease by blood transfusion. *Lancet* 2004;**363**:417–21.
6. Peden AH, Head MW, Ritchie DL, Bell JE, Ironside JW. Preclinical vCJD after blood transfusion in a PRNP codon 129 heterozygous patient. *Lancet* 2004;**364**:527–9.
7. University of Edinburgh. *The National Creutzfeldt–Jakob Disease Surveillance Unit (NCJDSU)*. Edinburgh: University of Edinburgh. Available at: <http://www.cjd.ed.ac.uk/>; 2010 [last accessed 22.12.10].
8. Bishop MT, Hart P, Aitchison L, Baybutt HN, Plinston C, Thomson V, et al. Predicting susceptibility and incubation time of human-to-human transmission of vCJD. *Lancet Neurol* 2006;**5**:393–8.
9. Clarke P, Ghani AC. Projections of the future course of the primary vCJD epidemic in the UK: inclusion of subclinical infection and the possibility of wider genetic susceptibility. *J R Soc Interface* 2005;**2**:19–31.
10. Spongiform Encephalopathy Advisory Committee. *Position statement on prevalence of subclinical variant Creutzfeldt–Jakob disease infections*. London: SEAC; 2008.
11. Spongiform Encephalopathy Advisory Committee. *SEAC Epidemiology Subgroup position statement on the vCJD epidemic*. London: SEAC; 2006.
12. Womack C, Jack AL. Family attitudes to research using samples taken at coroner's postmortem examinations: review of records. *BMJ* 2003;**327**:781–2.
13. *Call for tests after sudden death*. London: BBC. Available at: <http://news.bbc.co.uk/1/hi/health/8346901.stm>; 2009 [last accessed 07.11.09].
14. Thayyil S, Robertson NJ, Scales A, Weber MA, Jacques TS, Sebire NJ, et al. Prospective parental consent for autopsy research following sudden unexpected childhood deaths: a successful model. *Arch Dis Child* 2009;**94**:354–8.
15. Parmet WE. *Populations, public health, and the law*. Washington, DC: Georgetown University Press; 2009.
16. Rothstein MA. Rethinking the meaning of public health. *J Law Med Ethics* 2002;**30**:144–9.
17. McGowan CR, Viens AM. Reform of the coroner system: a potential public health failure. *J Public Health* 2010;**32**(3): 427–30.
18. Noah N. *Controlling communicable disease. Understanding public health*. Maidenhead: Open University Press; 2006.
19. Millar T, Walker R, Arango JC, Ironside JW, Harrison DJ, MacIntyre DJ, et al. Tissue and organ donation for research in forensic pathology: the MRC Sudden Death Brain and Tissue Bank. *J Pathol* 2007;**213**:369–75.
20. Coroners and Justice Act 2009 (c. 25).
21. McGowan CR, Viens AM. What is the point of the coroner service? Unpublished manuscript.
22. BBC. *Quango list shows 192 to be axed*. London: BBC. Available at: <http://www.bbc.co.uk/news/uk-politics-11538534>; 2010 [last accessed 14.10.10].
23. Directgov. *Public bodies reform – proposals for change*. London: Directgov. Available at: http://www.direct.gov.uk/prod_consum_dg/groups/dg_digitalassets/@dg/@en/documents/digitalasset/dg_191543.pdf; 2010 [last accessed 14.10.10].
24. McGowan CR, Viens AM. Death investigation systems and disease surveillance. *Epidemiol Infect*; 2010;. doi:10.1017/S0950268810002840.

PUBLICATION TWO

COVER SHEET FOR EACH RESEARCH PAPER INCLUDED IN A RESEARCH THESIS

1. For a research paper already published

1.1. Where was the work published? *Journal of Public Health (Oxford)*

1.2. When was the work published? *23 March 2010 (Advance Access)*

1.2.1. If the work was published prior to registration for your research degree, give a brief rationale for its inclusion *n/a*

1.3. Was the work subject to academic peer review? *Yes*

1.4. Have you retained the copyright for the work? *No*

If no, or if the work is being included in its published format, attach evidence of permission from copyright holder (publisher or other author) to include work *Attached*

2. For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)

I am the primary author of this paper. I have met all of the authorship requirements as stated by the *International Committee of Medical Journal Editors* (a.k.a. the *Vancover Group*)¹:

“The ICJME has recommended the following criteria for authorship; these criteria are still appropriate for journals that distinguish authors from other contributors.

1) substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;

2) drafting the article or revising it critically for important intellectual content; and

3) final approval of the version to be published.

Authors should meet conditions 1, 2, and 3”.

My co-author, Mr. Adrian Viens (School of Law, QMUL) is responsible for providing guidance on the relevant points of law and public health ethics. He was involved in the drafting of the article and was consulted on the final draft prior to submission and subsequent publication. No sections of this article were written entirely by Mr. Viens. He is listed as the second author as this accurately reflects the extent of his contribution.

Candidate’s signature 

Supervisor or senior author’s signature to confirm role as stated in (2)



¹ http://www.icmje.org/ethical_1author.html

Thank You For Your Order!

Dear Catherine,

Thank you for placing your order through Copyright Clearance Center's Rightslink service. Oxford University Press has partnered with Rightslink to license its content.

Your order details and publisher terms and conditions are available by clicking the link below:

[http://s100.copyright.com/CustomerAdmin/PLF.jsp?
IID=2010110_1288633806146](http://s100.copyright.com/CustomerAdmin/PLF.jsp?IID=2010110_1288633806146)

Order Details

Licensee: Catherine R McGowan

License Date: Nov 01, 2010

License Number: 2540321422146

Publication: Journal of Public Health

Title: Reform of the coroner system: a potential public health failure:

Type Of Use: Thesis/Dissertation

Total: 0.00 GBP

To access your account, please visit <https://myaccount.copyright.com>.

Invoices are issued daily and are payable immediately upon receipt.

To ensure we are continuously improving our services, please take a moment to complete our [customer satisfaction survey](#).

E.1:v4.2

 +1-877-622-5543  / Tel:  +1-978-646-2777 

customercare@copyright.com

<http://www.copyright.com>



Occasional Article

Reform of the coroner system: a potential public health failure

C.R. McGowan¹, A.M. Viens²

¹Department of Public Health and Policy, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT, UK

²School of Law, Queen Mary, University of London, 67-69 Lincoln's Inn Fields, London WC2A 3JB, UK; Joint Centre for Bioethics, University of Toronto
Address correspondence to: C.R. McGowan, E-mail: Catherine.McGowan@lshtm.ac.uk

ABSTRACT

The Coroners and Justice Act (2009) represents the latest in a long series of legislative and policy measures aimed at reforming the coroner system. Unfortunately, the Act represents a continued failure to recognize that the legal orientation of the coroner system threatens its capability to contribute to adequate cause-specific disease surveillance and, in doing so, to fulfil its proper role in a public health system.

Keywords communicable diseases, government and law, public health

The *Coroners and Justice Act*—which received royal assent on 12 November 2009—represents the latest in a long series of legislative and policy measures aimed at reforming the coroner system.^{1–5} The Act comprises nine sections with the first section relating exclusively to the reform of the coroner system in England and Wales. Reforms in the Act are intended to address the shortcomings of the current death investigation and certification systems, as identified by the Luce Review and the Third Report of the Shipman Inquiry.^{3,4} Unfortunately, the Act represents a continued failure to recognize that the legal orientation of the coroner system threatens its capability to contribute to adequate cause-specific disease surveillance and, in doing so, to fulfil its proper role in a public health system.

Determination of cause of death matters for public health

An accurate representation of the cause and circumstances of death is integral to exploring societal risks, and helps in developing preventive measures and promoting the public's health and safety. This representation, in aggregate, can be used to: understand the distribution and determinants of mortality in the population; identify at-risk populations;

understand the natural history of disease; inform service quality improvement; and identify disease outbreaks.⁶ Accurate and timely disease surveillance can detect: outbreaks of infectious diseases, increasing incidence of chronic disease, environmental hazards and, potentially, bioterrorist attacks.^{7–9}

The coroner as a key contributor to cause of death statistics

Nearly half of all deaths in England and Wales fall under the purview of the coroner.¹⁰ The coroner is involved in the determination of cause of death when the death is suspected to have been the result of unnatural or unknown causes, and/or when a doctor is unwilling or unable to certify the cause of death.¹¹ Emerging infectious diseases can appear suddenly and unexpectedly, affecting the elderly, the sick and the less socially mobile; producing a disproportionate number of deaths outside hospital; and thus increasing the likelihood of coronial investigation.

C.R. McGowan, PhD Candidate

A.M. Viens, PhD Candidate, Research Scholar

Reasons for reform

Dame Janet Smith began the Shipman Inquiry by stating:

It is said that [the coroner system] does not satisfy the public interest in the discovery of the true causes of death in the population. It does not contribute, to the extent that it should, to the improvement of public health and safety. (Ref. 4, p. v)

The shortcomings of the system in terms of its lack of attention to public health were elaborated upon further in the Luce Review:

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. (Ref. 3, p. 17)

Most coroners in England and Wales are legally, not medically, qualified, hence, most may not understand fully the medical circumstances of death.^{2,4} Moreover, the coroners' officers undertaking much of the initial death investigation are also not required to be medically trained. Data collected at scenes of death by the police or coroners' officers may not, therefore, include data on known biological, social, cultural and/or behavioural disease risk factors. A lack of understanding of the clinical symptoms and epidemiology of infectious diseases will undoubtedly result in death investigations that may not document and detect 'signal events' caused by an infectious agent. It has been well-documented that the quality and thoroughness of an autopsy is compromised when the pathologist is either misinformed or uninformed as to the relevant circumstances of death before the autopsy.^{11,12}

In her *Proposals for Change*, Dame Janet envisioned a new coroner system administered by three senior coroners who together would be able to provide medical, investigative and legal expertise 'within' the system. She proposed that the following duties might appropriately define the role of the Chief Medical Coroner:

He or she would establish links at a high level with those concerned with public health and public safety. The position would call for a doctor with administrative ability and some knowledge of or experience in the fields of public health and forensic medicine. (Ref. 4, p. 494)

The Coroners and Justice Act

Under the new legislation, the system is to be restructured, in part, by the appointment of a chief, deputy chief, senior,

area and assistant coroners as well as medical examiners (MEs). The chief coroner will be responsible for: setting national standards, arranging for the training of coroners, hearing appeals against the decisions of coroners and overseeing the system in general. To qualify for the position, the chief coroner must be a Circuit or High Court Judge. The positions of deputy chief coroners are likewise to be filled by Circuit or High Court Judges, or by persons who have experience as a senior coroner, or as a coroner for treasure. The duties of the deputy chief coroners are expected to mirror those of the chief coroner.

The new Act also calls for the creation of independent MEs to provide scrutiny to the certification process (thereby increasing the accuracy of mortality data) and to be available for consultation should the coroner have any questions relating to the medical aspects of death. According to the Department of Health, the newly proposed MEs will submit a list of deaths and their associated causes to the Office for National Statistics (ONS) monthly.¹³

Current reforms are inadequate to protect public health

In England and Wales, the risk of dying from disease vastly eclipses that of dying from homicide or negligence. According to the National Risk Register, pandemic flu is deemed to be more likely to occur and have a greater impact than terrorism, climate change or attacks on critical national infrastructure.¹⁴ It is, therefore, perplexing that the Act focuses predominantly on matters of criminal justice: needs of victims and witnesses, pornographic images, sentencing of terrorists, rights of bereaved families and data protection. Although these are important and understandable inclusions, given the Act's source in the Ministry of Justice, it is striking that public health is given short shrift.

Despite the conclusions of both the Luce Review and the Shipman Inquiry—that the capacity to support public health must be incorporated into any reformed system—there is no mention of disease surveillance in either the Act or its accompanying schedules. No statutory requirement has been made requiring a public health official in the system. No provisions, beyond the independent scrutiny of death certificates offered by the newly proposed MEs, are proposed to protect public health and safety. As the local Primary Care Trust will appoint the ME, it seems unlikely that he/she would have the appropriate population perspective to notice mortality trends because the MEs will only be responsible for reviewing deaths in their appointed region. It is unclear whether MEs, or the newly proposed National Medical Examiner, will be able to offer adequate guidance for the

purpose of re-orienting the entire system towards the pursuit of public health.

Furthermore, it is unclear whether coroners will consult with the MEs. The information provided to the ME, should he/she be consulted at all, will presumably include only the information that the coroner deems important or relevant to the determination of cause of death. If the ME chooses to enquire further about the circumstances of death, it is entirely possible that evidence that might have been of epidemiological importance may no longer be easy, or even possible, to obtain.

The focus on coroner system reform has very much become about preventing another Shipman—about protecting the public from the exceedingly improbable circumstance wherein a doctor wantonly kills his/her patients—which plays to a legally oriented death investigation system whose ethos and expertise neglects the role of disease surveillance, risk reduction and health service quality improvement in society.

Moving forward: a public health focus in the coroner system

One of the aspects of the coroner system that was uniformly deemed deficient by all those consulted on its reform was the lack of central guidance.^{15–19} Senior officials in the new system should oversee the system, introduce national standards and set training requirements from a public health perspective. They should guide the system in terms of its mandate as an organization devoted to public health—one responsible to current government priorities in terms of mitigating the risks deemed to pose imminent threat to life, health and safety. A public health official in the system would contribute to the training of coroners' officers and would ensure that all scene investigators are familiar with disease risk factors and the information that can be collected at a scene to better inform the coroner/ME/GP and/or pathologist about the context for the cause of death.

The inclusion of such an officer should be statutory, making his/her presence mandatory under the law. It seems entirely consistent with the purpose of the reformed coroner system—and the requirements of any effective and efficient mortality surveillance system—to have, at the very least, one senior-level public health professional in the coroner system, most appropriately as the newly proposed Medical Advisor to the Chief Coroner or a Deputy Chief Coroner.

If the new coroner system is to be guided by the principles of public health, then certainly someone operating in

the system needs to be responsible for exercising various duties such as liaising with the Department of Health and the Health Protection Agency to ensure that all current and important public health issues are understood by all in the coroner system. As we have seen with the recent spread of H1N1, outbreaks of emerging infectious diseases are unlikely to be confined to specific geographic locations. Cases of an infectious disease, for example, may be spread over more than one coroner/ME region, making it difficult for a single ME to notice a trend. Although the ME would be required to submit regular, once-monthly reports to the ONS so that unusual trends in mortality can be detected, this arrangement can hardly be considered an effective component of sentinel surveillance, as an outbreak of, for example, pandemic influenza needs to be detected early for effective containment.²⁰

It is just this type of concern that has inspired several death investigation systems to implement coroners' databases for the 'real-time' documentation of death for the purpose of 'providing a valuable hazard identification and death prevention tool for coroners and research agencies'.²¹ Should this type of programme be considered in England and Wales, a public health official inside the coroner system would be best suited to spearhead such an initiative.

Changes in the manner and the extent to which data are collected or created need to be well documented, as even minor changes in procedure may have a significant impact on surveillance data. For instance, a public health official would be able to monitor and feed back to the ONS and other public health officials any notable changes in data collection. Additionally, the coroner system should be responsible for facilitating health research, liaising with health researchers, and ensuring that research ethics are observed. None of these latter considerations are anywhere close to being adequately reflected in the new Coroners and Justice Act.

There are two key messages. First, the legal orientation of the coroner system threatens its capability to contribute to adequate cause-specific disease surveillance. Second, the omissions from the Act concerning the structuring and staffing requisite for coroners to fulfil their proper role in a public health system present clear implications for health and safety of population of the UK—particularly when it comes to effectively addressing emerging infectious diseases.

Acknowledgements

We would like to thank Shirley Huchcroft, Tony Barnett, Joyce Tait and Gill Walt for their extremely helpful comments and suggestions.

Funding

CRM is partly funded by the Canadian Centennial Scholarship Fund UK. AMV is funded by the School of Law, Queen Mary, University of London.

References

- 1 Committee on Death Certification. *Report of the Committee on Death Certification and Coroners*. London: HMSO, 1971.
- 2 Home Office. *The Wright Report: Report of the Departmental Committee on Coroners*. London: Home Office, 1936.
- 3 Secretary of State for the Home Department. *Death Certification and Investigation in England, Wales and Northern Ireland*. London: The Stationery Office, 2003.
- 4 Smith J. *The Shipman Inquiry: Third Report (Death Certification and the Investigation of Deaths by Coroners)*. Manchester: The Shipman Inquiry, 2003.
- 5 Coroners and Justice Act, Stat. c. 25. 2009.
- 6 Noah N. *Controlling Communicable Disease. Understanding Public Health*. Maidenhead, Berkshire: Open University Press, 2006.
- 7 Department of Health. *Pandemic influenza: guidance on the management of death certification and cremation certification*. 2008, Contract no.: 102781.
- 8 Nolte K, Yoon S, Pertowski C. Medical examiners, coroners, and bioterrorism. *Emerg Infect Dis [Letters]* 2000;**6**(5):559–60.
- 9 Schoch-Spana M. Implications of pandemic influenza for bioterrorism response. *Clin Infect Dis* 2000;**31**(6):1409–13.
- 10 Ministry of Justice. *Statistics on Deaths Reported to Coroners England and Wales, 2008*. London: Ministry of Justice, 2009.
- 11 Lucas SB, Cooper H, Emmett S *et al*. *The Coroner's Autopsy: Do We Deserve Better?* London: National Confidential Enquiry into Patient Outcome and Death, 2006.
- 12 Sampson H, Johnson A, Carter N *et al*. Information before coronial necropsy: how much should be available? *J Clin Pathol* 1999;**52**(11):856–9.
- 13 Department of Health. *Improving the Process of Death Certification in England and Wales: Overview of Programme*. London: Department of Health, 2008. Report No.: 10797.
- 14 Cabinet Office. *National Risk Register*. London: Cabinet Office, 2008.
- 15 House of Commons. *Reform of the Coroners' System and Death Certification. Eighth Report of Session 2005–06*. London: The Constitutional Affairs Committee, 2006.
- 16 British Medical Association. *Coroner Reform—the Government's Draft Bill: Response of the British Medical Association 2006*. [http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/WORDBMAfullreponseCoronerReformBillAug06FINAL/\\$FILE/BMAfullreponseCoronerReformBillAug06FINAL.doc](http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/WORDBMAfullreponseCoronerReformBillAug06FINAL/$FILE/BMAfullreponseCoronerReformBillAug06FINAL.doc).
- 17 Department for Constitutional Affairs. *Coroner Reform: The Government's Draft Bill (Response to Consultation)*. London: The Stationery Office, 2006,18.
- 18 Harman H. *Reform of the Coroners' System: Oral Ministerial Statement*. London: Department for Constitutional Affairs, 2006.
- 19 Secretary of State for Constitutional Affairs and Lord Chancellor. *Reform of the Coroners' System and Death Certification: Government Response to the Constitutional Affairs Select Committee's Report*. London: The Stationery Office, 2006.
- 20 World Health Organization. *Global Surveillance During an Influenza Pandemic*. Geneva: World Health Organization, 2009.
- 21 Victorian Institute of Forensic Medicine, Australasian Coroners Society. *The National Coroners Information System (NCIS)*. Victoria: Victorian Institute of Forensic Medicine, 2009. <http://www.vifp.monash.edu.au/ncis/>.

PUBLICATION THREE

COVER SHEET FOR EACH RESEARCH PAPER INCLUDED IN A RESEARCH THESIS

1. For a research paper already published

1.1. Where was the work published? Epidemiology & Infection (Cambridge)

1.2. When was the work published? 15 December 2010 (FirstView)

1.2.1. If the work was published prior to registration for your research degree, give a brief rationale for its inclusion n/a

1.3. Was the work subject to academic peer review? Yes

1.4. Have you retained the copyright for the work? No

If no, or if the work is being included in its published format, attach evidence of permission from copyright holder (publisher or other author) to include work Attached

2. For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)

I am the primary author of this paper. I have met all of the authorship requirements as stated by the *International Committee of Medical Journal Editors* (a.k.a. the *Vancover Group*)¹:

“The ICJME has recommended the following criteria for authorship; these criteria are still appropriate for journals that distinguish authors from other contributors.

1) substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;

2) drafting the article or revising it critically for important intellectual content; and


3) final approval of the version to be published.

Authors should meet conditions 1, 2, and 3”.

My co-author, Mr. Adrian Viens (School of Law, QMUL) is responsible for providing guidance on the relevant points of law and public health ethics. He was involved in the drafting of the article and was consulted on the final draft prior to submission and subsequent publication. No sections of this article were written entirely by Mr. Viens. He is listed as the second author as this accurately reflects the extent of his contribution.

Candidate's signature 

Supervisor or senior author's signature to confirm role as stated in (2)



¹ http://www.icmje.org/ethical_1author.html



CAMBRIDGE
UNIVERSITY PRESS

Catherine McGowan
Research Degree Student
Faculty of Public Health & Policy
London School of Hygiene & Tropical Medicine
15-17 Tavistock Place
London
WC1H 9SH

April 11, 2011

The Edinburgh Building
Shaftesbury Road
Cambridge CB2 8RU, UK

www.cambridge.org

Telephone +44 (0)1223 312393

Fax +44 (0)1223 315052

Email information@cambridge.org

Dear Ms McGowan

**C. R. McGowan and A. M. Viens “Death investigation systems and disease surveillance”.
Epidemiology and Infection, 2010 (please include volume number and page references
once known).**

Thank you for your recent permission request to include the above extract(s) in:

*your forthcoming doctoral dissertation at the London School of Hygiene and Tropical
Medicine.*

Non-exclusive permission is granted free of charge for this specific use on the
understanding that you have checked that we do not acknowledge another
source for this material.

Please ensure full acknowledgement (author, title, publication date, name of
journal and Cambridge University Press).

Yours sincerely

Linda Nicol
Permissions Manager
email lnicol@cambridge.org

REVIEW ARTICLE

Death investigation systems and disease surveillance

C. R. MCGOWAN^{1*} AND A. M. VIENS²

¹ *Faculty of Public Health & Policy, London School of Hygiene & Tropical Medicine, University of London, London, UK*

² *School of Law, Queen Mary, University of London, London, UK*

(Accepted 10 November 2010; first published online 15 December 2010)

SUMMARY

Medico-legal death investigation systems have the potential to play an important role in disease surveillance. While these systems are in place to serve a public function, the degree to which they are independent of central government can vary depending on jurisdiction. How these systems use this independence may present problems for public health initiatives, as it allows death investigators to decline to participate in government-led surveillance regardless of how critical the studies may be to public health and safety. A recent illustration of this problem in the UK is examined, as well as general lessons for removing impediments to death investigation systems participating in public health research.

Key words: Creutzfeldt–Jakob disease (CJD), death investigation, public health, surveillance.

Introduction

In most developed countries there is a system in place for investigating both cause and circumstances of sudden and/or unexplained deaths. In nearly all such jurisdictions death investigation is a statutory function and is inherently both medical and legal in scope. Generally, the determination of the cause of death is a strictly biomedical issue, while a determination of the circumstances of death is based upon an investigative process defined under the law.

Death investigation, beyond fulfilling the purely legal requirement that deaths be appropriately certified, has the potential to contribute a great deal to disease surveillance (for both cause-specific and all-cause mortality) and public health research [1–5]. Many death investigations require the collation of

an individual's social, behavioural and medical history in addition to standard demographic data. This documentation, in addition to information collected at the post-mortem examination, has the potential to yield important data, not only relating to mortality, but to morbidity as well.

Medico-legal post-mortems are performed at the request of the principal death investigator and do not require consent. They are intended to ascertain those facts pertaining to the death that are directly related to the death investigation process defined in law. Consented post-mortems are conducted at the request of the deceased in advance of their death, or by the next-of-kin; these investigations are not limited to the ascertainment of the cause of death and may instead focus on understanding disease processes and the effects of clinical intervention. The recent decline in consented post-mortems has been well documented in the literature [6, 7]. In most countries the number of medico-legal post-mortems performed vastly

* Author for correspondence: C. R. McGowan, Faculty of Public Health & Policy, London School of Hygiene & Tropical Medicine, 15-17 Tavistock Place, London WC1H 9SH, UK.
(Email: Catherine.McGowan@lshtm.ac.uk)

outweighs that of consented procedures. Thus, death investigators may have jurisdiction over a proportionately large number of bodies thereby making these investigators an essential point-of-contact for researchers requiring access to post-mortem information and/or material.

Death investigation systems, which operate under the purview of a government department, may be required by the director or minister to participate in government-led research projects. However, when a death investigation system is located outside of central government, and is afforded the sort of independence normally reserved for the judiciary, it may be the prerogative of the death investigator to decide if s/he will participate. Thus, the viability of a disease surveillance study often does not depend upon the feasibility of the study itself; it is contingent on the willingness of the death investigator to participate – or the government's ability to direct such participation [8].

The importance of disease surveillance and post-mortem tissue to public health and safety

Disease surveillance is absolutely essential to controlling threats to public health and safety. It is the primary means of: measuring the impact of these threats, detecting changes in incidence and prevalence, monitoring preventive and control measures, highlighting intervention priorities, building evidence for costing studies and providing aetiological clues about emergent diseases [9]. Complete and accurate reporting is essential in situations involving bioterrorism-related agents [10] and

highly contagious diseases for which contact tracing is required, serious infections such as botulism and rabies; and some new diseases such as variant CJD, very rare diseases which are not necessarily preventable, but for which more information is required, and conditions for which public health measures such as quarantine/isolation, chemoprophylaxis, vaccination or immunoglobulin are necessary [9, p. 15].

Some disease surveillance initiatives rely either entirely or in part on material collected at post-mortem. The vast majority of post-mortems are performed as part of a medico-legal death investigation and are done so under the direction of the principal death investigator (e.g. the coroner) who effectively has dominion over post-mortem data and tissue (including documentation pertaining to the death). In England and Wales, for example, more than 95% of post-mortems are performed at the request of the coroner

which, in 2009, represented 105 354 post-mortem examinations [6, 11].

Disease surveillance studies (including prevalence surveys), which are intended to measure the prevalence of rare conditions, may be particularly dependent upon data from medico-legal post-mortems as large sample sizes are crucial to the precision of prevalence estimates. As consented post-mortems generally show a skewed age distribution they may be entirely unsuitable for surveillance studies that rely on a representative sample. Thus, the participation of the death investigator becomes integral to the implementation of any large-scale disease surveillance programme based upon post-mortem data requiring a representative sample.

Elsewhere it has been suggested that the advancement of public health and safety is one of the main purposes of a medico-legal death investigation [2, 4, 12–14]. This fact is evident in the many disease surveillance studies that have been successfully implemented within death investigation systems. For example, systems in the USA have participated in various public health and safety initiatives including: the Medical Examiner and Coroner Alert Project (involving fatalities and commercial products), the Drug Abuse Warning Network, the Fatal Accident Reporting System, Census of Fatal Occupational Injuries, the Food and Drug Administration's adverse drug and medical device fatality reporting system, and the National Violent Death Reporting System [2, 4]. In England and Wales, a few individual coroners have sought consent from families to retain DNA for a sudden arrhythmic death syndrome study [15] and, in Scotland, the chief procurators fiscal agreed to participate in the Medical Research Council's Sudden Death Brain and Tissue Bank project [16].

Independence of death investigation systems

While many disease surveillance studies are initiated by central government, the implementation of these initiatives is often delegated to other government agencies or to subordinate levels of government. In 1993, for example, the Minister of Health and the Attorney General for British Columbia, Canada appointed the Chief Coroner to conduct an inquiry into heroin-associated deaths in the province, which resulted in the ground-breaking and controversial Report of the Task Force Into Illicit Narcotic Overdose Deaths in British Columbia [17]. Cooperation between government officials is expected and, indeed,

necessary for the execution of such studies. Thus, if central government administers a death investigation system, there are few barriers to implementing disease surveillance programmes beyond issues of funding and feasibility. The same is not true for systems of death investigation that are outside of the direction of central government. When a public organization, such as a death investigation system, is largely independent from government control, there are few means through which government can compel such organizations to participate.

Death investigation systems can take various forms – depending on the jurisdiction – and can be administered by a coroner, medical examiner or procurator fiscal, as well as by the military or police. These systems may vary in terms of, for example, the qualifications of the primary investigator, the method by which the relevant information about a death is determined, and the means through which the system maintains legitimacy. Death investigation systems maintain different degrees of independence from central government. Some systems afford paramount value to substantive independent inquiry (e.g. England, Wales, Northern Ireland, the Republic of Ireland, Hong Kong, Singapore, Jamaica), situating the death investigation system within the judicial branch. Other systems, particularly medical examiner systems in North America (e.g. Alaska, Alberta, Delaware, Manitoba, North Carolina, Nova Scotia, Tennessee, Utah, Vermont, Virginia, West Virginia), are afforded procedural independence, although the executive and/or legislative branches of government retain a considerable degree of administrative control.

In England and Wales, coroners consider themselves independent judicial officers whose allegiance lies not with government but with the Crown. Their appointment and remuneration is the responsibility not of central government, but of local authorities [18]. The coronial system relies on the formal inquest as the primary method through which the cause and circumstances of deaths are determined. In systems such as this, and in many derivative coronial systems, the primary death investigator is generally a lawyer or, in some cases, a judge who presides over the inquest, which is conducted in a court setting. The justification for treating coroners as independent judicial officers is that it constitutes an important safeguard for society and its citizens (i.e. it offers an independent investigation of deaths precipitated by state officials or in state custody) [18]. In England and Wales, however, the executive or legislative

branches of government have no authority to instruct the death investigator in matters pertaining to the investigation, or to require that they participate in disease surveillance programmes or public health research.

An alternative to near absolute independence from government is a death investigation system situated within a government department or ministry. In these systems the death investigator's statutory function – the investigation of the cause and circumstances of reported deaths – is provided substantive independence from central government. The investigator's non-statutory functions are, however, subject to oversight by the ministry or department through which they are administered. The primary death investigator is considered a 'quasi-judicial investigator' and conducts investigations 'independent from all law enforcement agencies and health authorities' [19]. In such systems, the ministry has the authority to direct the Chief Coroner/Medical Examiner to implement policies provided they do not compromise the death investigator's independence when it comes to the execution of the death investigator's statutory function. In addition, when a death investigation system falls under the auspices of a government department it is bound by the mandate of that department or ministry, which imposes a certain duty on the investigator particularly when that mandate, for example, explicitly implies a duty to 'protect the living' [20]. Under such death investigation systems, it is much more likely that disease surveillance programmes can be successfully implemented and that public health and safety will be promoted.

The abnormal prion protein survey in England and Wales

One recent example from the UK provides a poignant illustration of how important, well-intentioned and sufficiently funded public health initiatives can fall victim to a death investigation system that puts its independence from government ahead of protecting public health and safety.

In light of new evidence that variant Creutzfeldt–Jakob disease (vCJD) had the potential to emerge as a second-wave infection resulting from human-to-human transmission, the UK Health Protection Agency (HPA) proposed the creation of a post-mortem tissue archive to study the prevalence of abnormal prion protein (a marker for vCJD infection) in the UK [21]. The study required tissue from a large

number of post-mortems, necessitating the participation of coroners in England and Wales. Following a protracted correspondence of over a year – and despite efforts by the HPA to accommodate the coroners' concerns – the Coroners' Society of England and Wales (CSEW) declined to participate in the study, citing various issues including its putative legality, cost and feasibility. The CSEW concluded that to participate in the study would, 'adversely affect the independence of the coronial service and would further erode public confidence' [22].

Elsewhere, we have argued that concerns over the study's legality, cost and feasibility were misplaced [23]. The HPA and Chief Medical Officer provided the CSEW with ways to participate in the study that would alleviate or mitigate such concerns. The driving consideration appeared to be the CSEW's concern that an agency of central government was attempting to direct them in the conduct of their duties, and that efforts to have them participate in this research project posed a threat to coronial independence. Without the participation of coroners, this study has become entirely unfeasible, as there is no other realistic way to obtain the necessary tissue. The HPA, and other government committees, such as the Spongiform Encephalopathy Advisory Committee, continue to try to find ways of conducting further research to determine the prevalence of abnormal prion protein in the UK population; however, all subsequent options are methodologically inferior to the study as it was originally proposed.

One of the primary reasons given for the importance of coronial independence in modern times stems from the coroner's role in meting out the government's procedural obligation under Article 2 of the European Convention on Human Rights (ECHR) to protect the right to life. What is problematic is that it appears the CSEW has interpreted this obligation in negative terms, and seems to view any direction from a government agency as a possible threat to its independence. Given that government policy in the UK was deemed complicit, at least in part, in the initial outbreak of vCJD [24], and that the proposed vCJD study was intended to control the spread of iatrogenic infection through medical and dental procedures made available by the state, it could reasonably be argued that the vCJD study also fulfils the government's obligation to protect life under the ECHR. Article 2 not only requires that member states not deprive life, but also imposes the positive obligation to, according to Lord Bingham, 'establish a

framework of laws, precautions, procedures and means of enforcement which will, to the greatest extent reasonably practicable, protect life' [25]. The participation of coroners in the vCJD surveillance programme should be understood as contributing to the observance of Article 2; however, it would seem the independence that is deemed necessary for the protection of human life has become an end unto itself – one much divorced from the principle upon which it has been granted.

Conclusion

The above case provides a vivid illustration of some of the problems that can result for disease surveillance and public health research in jurisdictions where the independence of the death investigation system is given supreme priority. Independence is not an end in itself – it is a means by which such systems are protected from the possibility of undue influence or nefarious interference by central government. It is the independence from central government that is supposed to ensure that death investigation systems can perform their statutory and non-statutory duties. Death investigation systems should be structured in a way that the value of the independence we accord to them in fulfilling their function does not become an impediment to the government's obligation to protect public health and safety.

The independence of death investigation systems from central government is important for a number of reasons. However, since death investigation systems with substantial independence are not directly answerable to central government, they cannot be instructed to participate in any disease surveillance programme regardless of how crucial it is to the protection of human health and safety. Coroners in, for instance, England, Wales, Northern Ireland, and Hong Kong are not required to participate in any public health and safety initiatives owing to their independence from government, nor are they required to provide justification for not doing so. This presents a serious concern for obtaining useful epidemiological data and employing successful programmes to promote and protect public health. Systems currently fielding the possibility of reforming existing death investigation systems (e.g. the Republic of Ireland, India, Singapore, Jamaica) should be wary of valuing independence to such a substantial degree that it can become an impediment to government-led public health and safety initiatives.

ACKNOWLEDGEMENTS

C. R. McGowan is partly funded by the Canadian Centennial Scholarship Fund UK. A. M. Viens is funded by the School of Law, Queen Mary, University of London. We thank Dr Shirley Huchcroft, Professor Tony Barnett, and Lisa Graham (of the British Columbia Coroners Service) for their extremely useful comments and suggestions.

DECLARATION OF INTEREST

None.

REFERENCES

1. **Kung HC, Hanzlick R, Spittler JF.** Abstracting data from medical examiner/coroner reports: concordance among abstractors and implications for data reporting. *Journal of Forensic Sciences* 2001; **46**: 1126–1131.
2. **Hanzlick R, Parrish G.** Coroners and public health. *Lancet* 1995; **345**: 194–195.
3. **Graitcer PL, et al.** An evaluation of the use of medical examiner data for epidemiologic surveillance. *American Journal of Public Health* 1987; **77**: 1212–1214.
4. **Hanzlick R.** Medical examiners, coroners, and public health: a review and update. *Archives of Pathology and Laboratory Medicine* 2006; **130**: 1274–1282.
5. **Hanzlick R, Parrish RG.** The role of medical examiners and coroners in public health surveillance and epidemiologic research. *Annual Review of Public Health* 1996; **17**: 383–409.
6. **Lucas SB, et al.** The coroner's autopsy: do we deserve better? London: National Confidential Enquiry into Patient Outcome and Death, 2006.
7. **The Royal College of Pathologists of Australasia Autopsy Working Party.** The decline of the hospital autopsy: a safety and quality issue for healthcare in Australia. *Medical Journal of Australia* 2004; **180**: 281–285.
8. **Thayyil S, et al.** Prospective parental consent for autopsy research following sudden unexpected childhood deaths: a successful model. *Archives of Diseases in Childhood* 2009; **94**: 354–358.
9. **Noah N.** *Controlling Communicable Disease. Understanding Public Health.* Maidenhead: Open University Press, 2006.
10. **Nolte KD, et al.** Medical examiners, coroners, and biologic terrorism: a guidebook for surveillance and case management. *Morbidity and Mortality Weekly Reports. Recommended Reports* 2004; **53**: 1–27.
11. **Ministry of Justice.** Statistics on deaths reported to coroners in England and Wales, 2009. London, 2010.
12. **Freckelton I.** Reforming coronership: international perspectives and contemporary developments. *Journal of Law and Medicine* 2008; **16**: 379–392.
13. **The Law Commission (New Zealand).** Coroners: a review. Wellington: The Law Commission, 1999.
14. **McGowan CR, Viens AM.** Reform of the coroner system: a potential public health failure. *Journal of Public Health* 2010; **32**: 427–430.
15. **BBC.** Call for tests after sudden death. BBC, E-edition. London: BBC, 2009.
16. **Millar T, et al.** Tissue and organ donation for research in forensic pathology: the MRC Sudden Death Brain and Tissue Bank. *Journal of Pathology* 2007; **213**: 369–375.
17. **Cain V.** Report of the task force into illicit narcotic overdose deaths in British Columbia. Victoria, Canada: Office of the Chief Coroner of British Columbia, 1994.
18. **Dorries C.** *Coroners' Courts: A Guide to Law and Practice.* Oxford: Oxford University Press, 2004.
19. **British Columbia Coroners Service.** The role of the coroner in BC. British Columbia Coroners Service, 2008.
20. **Office of the Chief Coroner.** Office of the Chief Coroner: About the Office. Toronto: Ontario Ministry of Community Safety & Correctional Services (http://www.mcscs.jus.gov.on.ca/english/office_coroner/about_office/coroner_what.html). Accessed 27 November 2010.
21. **Health Protection Agency.** A national human post-mortem tissue archive to study the prevalence of abnormal prion protein. London: Health Protection Agency, 2007.
22. **Rebello A.** Correspondence with the CSEW concerning research into subclinical vCJD. Liverpool: Honorary Secretary of the Coroners' Society of England and Wales, 2007.
23. **McGowan CR, Viens AM.** Coroners and the obligation to protect public health: the case of the failed UK vCJD study (in press).
24. **Phillips MJ, Bridgeman J, Ferguson-Smith M.** *The BSE Inquiry: Findings and Conclusions.* London, 2000.
25. **R** (on the application of Middleton) v. West Somerset Coroner [2004] UKHL 10, [2004] 2 All ER 465.

PUBLICATION FOUR

COVER SHEET FOR EACH RESEARCH PAPER INCLUDED IN A RESEARCH THESIS

1. For a research paper already published

1.1. Where was the work published? *Epidemiology & Infection (Cambridge)*

1.2. When was the work published? *15 March 2011 (Advance Access)*

1.2.1. If the work was published prior to registration for your research degree, give a brief rationale for its inclusion *n/a*

1.3. Was the work subject to academic peer review? *Yes*

1.4. Have you retained the copyright for the work? *No*

If no, or if the work is being included in its published format, attach evidence of permission from copyright holder (publisher or other author) to include work *Attached*

2. For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)

I am the primary author of this paper. I have met all of the authorship requirements as stated by the *International Committee of Medical Journal Editors* (a.k.a. the *Vancover Group*)¹:

“The ICJME has recommended the following criteria for authorship; these criteria are still appropriate for journals that distinguish authors from other contributors.

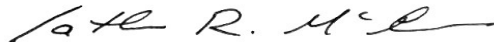
1) substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;

2) drafting the article or revising it critically for important intellectual content; and

3) final approval of the version to be published.

Authors should meet conditions 1, 2, and 3”.

My co-author, Mr. Adrian Viens (School of Law, QMUL) is responsible for providing guidance on the relevant points of law and public health ethics. He was consulted on the final draft of the correspondence prior to submission and subsequent publication. He is listed as the second author as this accurately reflects the extent of his contribution.

Candidate’s signature 

Supervisor or senior author’s signature to confirm role as stated in (2)



¹ http://www.icmje.org/ethical_1author.html



CAMBRIDGE
UNIVERSITY PRESS

Catherine McGowan
Research Degree Student
Faculty of Public Health & Policy
London School of Hygiene & Tropical Medicine
15-17 Tavistock Place
London
WC1H 9SH

The Edinburgh Building
Shaftesbury Road
Cambridge CB2 8RU, UK

www.cambridge.org

Telephone +44 (0)1223 312393

Fax +44 (0)1223 315052

Email information@cambridge.org

April 11, 2011

Dear Ms McGowan

C. R. McGowan and A. M. Viens Correspondence re: "Death investigation systems and disease surveillance". Epidemiology and Infection, 2011 (please include volume number and page references once known).

Thank you for your recent permission request to include the above extract(s) in:

your forthcoming doctoral dissertation at the London School of Hygiene and Tropical Medicine.

Non-exclusive permission is granted free of charge for this specific use on the understanding that you have checked that we do not acknowledge another source for this material.

Please ensure full acknowledgement (author, title, publication date, name of journal and Cambridge University Press).

Yours sincerely

Linda Nicol
Permissions Manager
email lnicol@cambridge.org

Correspondence

Epidemiol. Infect. (2011).
doi:10.1017/S0950268811000288
First published online 15 March 2011

Death investigation systems and disease surveillance

To the Editor:

The Review Article ‘Death investigation systems and disease surveillance’ [1] makes an important point concerning institutional impediments to public health research, citing how the England & Wales coroners reacted negatively to the proposal that autopsy material be collected routinely for CJD research. Moreover, it suggests that this could have enabled a more precise estimate of the burden of latent prion infection in the community, with valuable information on the potential of a second, iatrogenic epidemic of variant CJD.

The Review states that the main reason the coroners did not participate in the study was that it would adversely affect their independence; and proceeds to criticize this view as unreasonable. However, the particular point the coroners were making was that relatives could then believe that the main reason an autopsy was being performed on a deceased person was to obtain spleen samples for the study – rather than for the standard medico-legal criteria.

There is a second important reason why the coroners did not participate, and I can state this since I was a member of the committee that proposed the autopsy study. Because of the requirements imposed by the Human Tissue Act 2004, for each coronial autopsy the coroner’s officer would have had to read through to relatives a prepared statement and request for the tissue material (spleen), indicating what the research was, and offering relatives an opt-in or opt-out. Furthermore, they would have to be able to justify how useful the research would be for public health, and end by stating that since the research programme would be anonymized and unlinked, no individual test results would be available to relatives. All this would have to occur in a multi-ethnic and

multi-lingual society. Not surprisingly, coroners decided that their already stretched resources could be applied to more appropriate and practical daily uses.

My personal opinion, given at the time, was that these particular sections of the Human Tissue Act 2004 were (and are) a major impediment to public health; if government wanted the autopsy study to progress, they should rescind those parts of the Act for the duration of the study, and just collect the material as a matter of course. Ministers did not agree.

Declaration of Interest

None.

Reference

1. McGowan CR, Viens AM. Death investigation systems and disease surveillance. *Epidemiology and Infection*. Published online: 15 December 2010. doi:10.1017/S09502688110002840.

PROFESSOR SEBASTIAN LUCAS

*Department of Histopathology, KCL School of Medicine,
North Wing, St Thomas’ Hospital, Lambeth Palace Rd,
London SE1 7EH, UK*
(Email: sebastian.lucas@kcl.ac.uk)

The authors reply

In response to Professor Lucas’ comment on our article ‘Death investigation systems and disease surveillance’ [1] we would like to raise the following points:

- disease surveillance is important for the protection of health;
- some surveys necessarily rely on post-mortem tissue, or on information collected at, or around, the time of death;

- many jurisdictions, by law, grant custodial powers over deceased persons to death investigators who may, or more likely may not, realize the importance of disease surveillance, and their critical role in its execution;
- vast numbers of deaths, depending on the jurisdiction, may come under the control of such investigators making them gatekeepers for large numbers (and largely representative samples) of human bodies;
- in many jurisdictions, the death investigator is situated outside of government control which effectively absolves them of any procedural obligation to participate in or facilitate disease surveillance, which may rely entirely on their cooperation;
- owing to this independence they are not required to provide a reason or rationale – spurious or otherwise – for refusing to participate;
- and, that this independence, though purportedly necessary for the protection of citizens from government, can put us all at risk when it allows for the obstruction of critical public health measures.

Although we hope that Professor Lucas would concur on many of the above points, it would seem that we disagree on the legitimacy of the rationale put forward by the Coroners' Society of England and Wales (CSEW) for not participating in the Health Protection Agency's (HPA) subclinical vCJD survey [2]. Professor Lucas has speculated on what is perhaps the primary reason for the CSEW's refusal to participate, this being the possibility that 'relatives could then believe that the main reason an autopsy was being performed [...] was to obtain spleen samples for the study – rather than for the standard medico-legal criteria'. We wish to point out that this claim is entirely unsupported by the public health literature. For example, a recent Scottish study demonstrated that, 'the vast majority of families are willing to support research use of post mortem tissues even in the context of sudden bereavement and despite previous adverse publicity' [3, p. 369] and that the next-of-kin, in most cases, believe that, 'all bereaved families should be offered, as their right, the opportunity of donating for research' [3, p. 372]. Not all of the next-of-kin referred to in the study consented to tissue donation; however, of the 4% who chose *not* to give consent, none stated the possibility of conspiracy or impropriety on the part of the death investigator as the reason for doing so [3].

Professor Lucas also suggests that the study methodology would have placed a considerable burden on the coroner's officer who, owing to the provisions of the Human Tissue Act 2004, would take responsibility for obtaining consent. It is well known that some coroners do lack sufficient resources to carry out their statutory duties effectively, let alone support a large and on-going surveillance survey. However, in response to this concern, the HPA had obligingly adapted the research methodology in order to minimize the involvement of both the coroners and their officers. The revised methodology required that coroners' officers merely forward the contact details of the next-of-kin to the NHS Blood & Transplant's tissue service – that this data transfer was lawful and in compliance with the Data Protection Act 1998 was noted by the Chief Medical Officer, as was the following assurance, 'The Department of Health is also prepared to pay for any additional administrative support needed to undertake the survey, in those coroner's jurisdictions that agree to participate' [4, 5].

In closing, although we agree with Professor Lucas that there are institutional impediments to public health research we seem to disagree on what those impediments are. Regardless, we argue that, given the regrettable immutability of the Human Tissue Act, the impediment to the protection of public health in this instance relates to the fact that government cannot direct coroners to participate in disease surveillance. Coronial independence, although purportedly necessary for the protection of citizens from government, can put us all at risk when it allows for the obstruction of critical public health measures. Coronial independence should not be thought of as an absolute principle. The consequences of making any public official entirely independent from government needs to be carefully considered as the health and safety of everyone is potentially at stake.

References

1. **McGowan CR, Viens AM.** Death investigation systems and disease surveillance. *Epidemiology and Infection*. Published online: 15 December 2010 doi:10.1017/S0950268810002840
2. **Health Protection Agency.** A national human post-mortem tissue archive to study the prevalence of abnormal prion protein. London: Health Protection Agency, 2007.
3. **Millar T, et al.** Tissue and organ donation for research in forensic pathology: the MRC Sudden Death Brain and Tissue Bank. *Journal of Pathology* 2007; **213**: 369–375.

4. **Donaldson L.** Correspondence with the CSEW concerning research into subclinical vCJD. London: Department of Health, 2007.
5. **Rebello A.** Correspondence with the CSEW concerning research into subclinical vCJD. Liverpool: Coroners' Society of England and Wales, 2007.

C. R. MCGOWAN¹, A. M. VIENS²

¹ *Faculty of Public Health & Policy, London School of Hygiene & Tropical Medicine, London, UK*

² *School of Law, Queen Mary, University of London, London, UK*

(Email: Catherine.McGowan@lshtm.ac.uk)