Reform of the coroners’ system and death certification

Eighth Report of Session 2005–06

Volume II

Oral and written evidence

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The Constitutional Affairs Committee

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Witnesses

Tuesday 7 February 2006

Michael Burgess, HM Coroner for Surrey  Ev 1
Rt Hon Dame Janet Smith DBE  Ev 6

Tuesday 25 April 2006

Tom Luce CB, Chair, Fundamental Review of Death Certification and Investigation  Ev 14

Tuesday 13 June 2006

Victor Round, Honorary Secretary, Coroners’ Society of England and Wales  Ev 24

Chief Constable Peter Fahy, Cheshire Constabulary and Association of Chief Police Officers; Councillor Bryony Rudkin and Steve Charteris, Local Government Association and Christine Hurst, Chair, Coroners’ Officers Association  Ev 30

Tuesday 20 June 2006

Dr Michael Wilks, Chairman, Medical Ethics Committee, Dr John Grenville, General Practitioners Committee, Dr Anne Thorpe, Chair, Central Consultants and Specialists Committee Pathology Sub-Committee, and Dr Andrew Davison, Forensic Medicine Committee, British Medical Association  Ev 38

Dr Gina Radford, East of England Regional Director of Public Health, Department of Health  Ev 44

Tuesday 27 June 2006

Phillip Noyes, Director of Public Policy, Lucy Thorpe, Policy Manager, NSPCC, and Pip Finucane, Trustee, Victims Voice  Ev 48

Rt Hon Harriet Harman QC MP, Minister of State, Department for Constitutional Affairs  Ev 53
List of written evidence

Tom Luce CB Chair, Fundamental Review of Death Certification and Investigation, 2001–2003 Ev 60
Michael Burgess, HM Coroner for Surrey Ev 67
Coroner’s Officers Association (COA) Ev 75
Association of Chief Police Officers (ACPO) Ev 83
Local Government Association (LGA) Ev 85
Department of Health (DoH) Ev 89
British Medical Association (BMA) Ev 95
NSPCC Ev 98
Mrs Pip Finucane, Trustee, Victims' Voice Ev 102
Department for Constitutional Affairs (DCA) Ev 107
Rt Hon Harriet Harman QC MP, Minister of State Department for Constitutional Affairs Ev 112
INQUEST Ev 112
Foundation for the Study of Infant Deaths (FSID) Ev 118
Society for Local Authority Chief Executives and Senior Managers (SOLACE) Ev 119
Graeme Johnstone, State Coroner of Victoria and Associate Professor David Ranson, Deputy Director, Victorian Institute of Forensic Medicine Ev 121
Ian G McCreath MBE, HM Coroner for North Northumberland Ev 144
Caroline Beasley-Murray, HM Coroner for Essex and Thurrock Ev 147
The Law Society Ev 150
Victor Round, Honorary Secretary, The Coroners’ Society of England and Wales Ev 153
Coroners Services Public Accountability Group (CSPAAG) Ev 154
Mrs L H Lewy, Rigorous Analysis of Iatrogenic Death (RAID) Ev 165
Margaret Lockwood-Croft, Chair, Marchioness Action Group (MAG) Ev 166
Independent Police Complaints Commission (IPCC) Ev 168
The Oak Tree Surgery Ev 171
National Association of Funeral Directors Ev 171
Federation of British Cremation Authorities (FBCA) Ev 172
Health and Safety Executive (HSE) Ev 174
City of London Corporation, City Remembrancer’s Office Ev 179
Brethren Christian Fellowship (The Brethren) Ev 180
Committee on the Administration of Justice (CAJ) Ev 182
MRSA Action UK Ev 183
Judicial Studies Board (JSB) Ev 184
Royal College of Pathologists Ev 186
Epilepsy Bereaved Ev 190
Nigel Meadows, HM Coroner for Plymouth & South Devon Ev 192
Alan C Crickmore, HM Coroner for Gloucestershire Ev 202

Unprinted memoranda

Gerald Wright
Mr and Mrs B Morgan
Mrs E Guinee
Ivan Biddle
Oral evidence

Taken before the Constitutional Affairs Committee

on Tuesday 7 February 2006

Members present:

Mr Alan Beith, in the Chair

James Brokenshire
Barbara Keeley
Jessica Morden
Julie Morgan

Mr Andrew Tyrie
Keith Vaz
Dr Alan Whitehead

Witness: Michael Burgess, HM Coroner for Surrey, gave evidence.

Chairman: Mr Burgess, we are very grateful to you for coming in to give us the benefit of your very considerable experience in this field. It is a fairly timely inquiry because after a long delay the Government produced its policy statement yesterday and we anticipate dealing with the draft bill when that comes along, but before we get to the draft bill we want to explore some of the wider issues and also some of the detail surrounding this. It is our practice to declare any possible interests that might be relevant so we will just do that first.

James Brokenshire: I am a non-practising solicitor.
Keith Vaz: I am a non-practising barrister. My wife holds a part-time judicial appointment.

Q1 Chairman: Could you briefly indicate to us the purposes, strengths and weaknesses of the coroner system as you see it?

Michael Burgess: Thank you, Chairman. The first point I would make is that there is no single system. We do not have a national coroners service. What we do have is a number of oYce holders each individually and exclusively responsible in their own districts for carrying out coroner duties. It is unclear from the minister’s statement yesterday whether and how that might be altered. One of the strengths is the loyalty that there may be on the parts of individual oYce holders to their own district. The great weakness that flows from that is that there will not be consistency of practice and the resources available to individual coroners will be very varied, ie some will be well resourced and others will not be so well resourced and some will be very badly resourced. The resource issue is something that constantly comes to the fore. Thinking things through before I met with you and before the minister’s statement yesterday, I formed the view that resources might be put into three broad categories. The first is the legal resources that are needed, the laws, the authorities and powers that coroners need to perform their function. Before one even looks at that though 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. So legal resources is certainly critical.

The second and equally important resource is the human resources, the coroners, the coroners’ officers and the deputies, that they are sufficient and well meaning as well as being properly trained and well disposed. I think we are fortunate in this country in that broadly speaking we have got a good cadre of coroners, even though on occasions they will fail, but we all fail at times. Coupled with that, of course, is that they have to have sufficient time to carry out their function. Many coroners I know spend long hours, well beyond the European time constraints that we are all supposed to work to, in order to get through their caseload and give attention to their cases. Then there are the other resources, which are the more inanimate, the financial and accommodation resources that we need. Certainly, so far as courts are concerned, we are very poorly off. We do not form part of the main court structure of the country and therefore when it comes to requiring and seeking court accommodation, we often are unable to use courts, we are very much at the back of the queue. Indeed I heard very recently of coroners who have had to adjourn inquests part-heard with juries for months because their allotted time had expired and the case had not finished and that cannot be good.

Q2 Chairman: Were you surprised when the minister said yesterday that the fairly substantive programme of reforms she had announced might be accomplished for £5 million?

Michael Burgess: Yes. I am not a mathematician but it does surprise me.

Q3 Chairman: Do you think coroners generally recognise that there is a case for substantial reform?

Michael Burgess: I have no doubt about that. Many of us, individually and together in the Coroners’ Society, have spent many hundreds of hours working with the two inquiries which resulted in the two reports. I think all of us see the need for reform. Maybe some of us see the need in quite different ways, but broadly speaking we have no difficulty at all in putting our hands up and saying reform is needed and the sooner the better.
Q4 Jessica Morden: We understand that referrals to coroners have risen in recent years. Why is this the case?
Michael Burgess: I surmise it is because since Harold Shipman has been exposed coroners are much more likely to have cases referred where doctors in the past were confident about not referring cases and about signing medical certificates. What we find quite often is that doctors have not the experience and indeed the training to sign medical certificates, it is not covered at most medical schools and they only come across it when they are out there in the field for the first time. One source of some consolation is coming to the coroner’s office, whether to an officer or to the coroner, and saying, “Can you help me here? How do we address this particular case?” and we will try and guide them through it. I think that certainly is one reason for the substantial increase, at least in my district it appears to be.

Q5 Jessica Morden: Overall coroner activity rates seem to be higher in England and Wales than in other countries. Why is that the case?
Michael Burgess: I suspect doctors abroad may be more confident than they are here, but other than that I cannot really explain that.

Q6 Jessica Morden: So they are doing the same work but they are just called something else?
Michael Burgess: We have a much more precise form of death certification over here. Certainly in Europe, for example, they do not have to be as precise on causes of death as we do or we are expected to be.

Q7 Jessica Morden: How well does the existing system of local authorities appointing coroners function in your view?
Michael Burgess: There is a broad common path that most appointment processes go through. There is an advertisement followed by a selection process, normally a paper sift and then an interview, but it will vary enormously because the members of the panel will be drawn from the local authority who probably have had no previous experience in making any judicial appointments of this sort. It is not an appointment which they can make conditional upon certain things being done. Once a coroner is appointed only the Lord Chancellor is able to remove him from office. It is not as easy as appointing somebody else, even quite a high senior officer in local government; it is a very different kind of appointment. So there are variations. That said, most councils approach it very seriously and take quite a long time and quite a lot of effort to try and get the choice right.

Q8 Jessica Morden: Do you think the system could be improved, and what would you like to see happening?
Michael Burgess: I have no doubt that consistency could be introduced if there was some central way of appointing coroners, maybe with some sort of local participation as well.

Q9 Chairman: Could it still happen, as I was told by a colleague yesterday it happened where he was serving a local authority, that a great argument arises on the appointment panel for the coroner between those who want a particular coroner appointed and those who say but it has always come from this particular practice, why should we change the practice?
Michael Burgess: I think those instances are now much fewer than they used to be. Certainly, you are right, in the past I have heard of firms that have kept the coronership in their firm for generations, Ie I am the seventh, eighth, ninth senior partner to be coroner for this particular district, but I would hope that that nepotism, for that is what it is, is now a thing of the past.

Q10 Keith Vaz: Mr Burgess, do you think that there is relief and delight at the fact that we are now in the middle of a reform process on the part of coroners? At the next coroners annual ball will you be raising a glass of cheer to the Lord Chancellor and saying, “At last, after all these years, we’re going to have a better system”?
Michael Burgess: I think we will wait until we see the detail.

Q11 Keith Vaz: What struck me yesterday—I do not know whether you were watching the proceedings in the House—was the criticism that there was from MPs of individual coroners and obviously the system as well. Were you struck by that?
Michael Burgess: I am afraid I was actually in court and therefore was not able to share the joys and the immediacy of television. However, I have seen the Hansard reports and I quite agree with you that there does appear to be redolent through them concerns and complaints about individual coroners. I am afraid I cannot address those as I am not familiar with them and I do not think it would be right for me to try and defend or prosecute them as the case may be. I am well aware that there are individuals in any forum who will have justifiable complaints and, as I say, we are human and we do err and when we do I think, quite justifiably, we should expect not only to apologise but recognise that we have failed. I think the other side of the coin is those who pass through the process and have found it uncomfortable but who come out the other side without a complaint and do not necessarily put pen to paper. So we are not necessarily seeing the other side and the numbers of people who have maybe no major complaint to make such that they would get in touch with their MP. I quite agree with you, there are a number of significant complaints that do not do the system and the holders of the office any good.

Q12 Keith Vaz: Do you think that there are examples of serious mistakes that have been made by coroners which would cause you, as a fellow member of the profession, problems? Have you heard of these errors?
Michael Burgess: I have heard of most of those that have occurred and were reflected in the questions in the House yesterday and certainly if and when I was
ever approached by these I was extremely concerned and expressed that concern to the individual concerned.

Q13 Keith Vaz: Tell me a bit about the training regime that coroners have. At the moment obviously there are proposals that are before Parliament. Is it a good training system? What happens? Do you all have to go away on a coroner course where you share information and learn new techniques? How is it done?

Michael Burgess: First of all, there is no compulsory training. A coroner can be appointed by his relevant council today and be expected to be running a major district tomorrow without any training intervening and that does cause problems. The Lord Chancellor’s Department does run residential courses three times a year. They run for three days, normally on Fridays and ending on a Sunday. These have been taken over from the Home Office when the Home Office was responsible for coroners. They are primarily programmes that are worked through with coroners and with guest speakers coming in from other disciplines.

Q14 Keith Vaz: How effective are these training schemes?

Michael Burgess: The really big problem is that we have got a cadre of maybe 300 or 320 coroners, deputies and assistant deputies and only the capacity for about 150 people to pass through this per year.

Q15 Keith Vaz: Of the current 350 coroners, how many do you think have had the DCA training?

Michael Burgess: I would hope most of them at some time have passed through that training, but the training course is revised every 18 months or two years. We would expect a particular course to run for five or six repeats.

Q16 Keith Vaz: Would you have to bid for it?

Michael Burgess: You apply to be included on it and then hopefully you go on it. There are no fees, of course. It is not a compulsory course. In addition, the DCA and other groups, the Medical and Legal Society for example, run specific half-day or all-day training courses with a particular emphasis on topics that might be useful in the course of one’s professional life.

Q17 Keith Vaz: Do you think there is a case for a structured induction course at the start of an appointment and then continuing training after that appointment has taken place?

Michael Burgess: The DCA, taking over from the Home Office, does have an induction course but it is run irregularly depending on the number of applicants. We may find that a coroner, a deputy or assistant deputy has been in post for several months before an induction course is run. My ideal would be for a compulsory training scheme with all people inside this sector, including coroners’ officers, having training and regular professional development every year. It should not be left to when there is a vacancy and a two year waiting list.

Q18 Julie Morgan: Is there any specific training given to deal with people who are bereaved and who are in a state of shock and upset?

Michael Burgess: Outside the weekend residential course, no.

Q19 Julie Morgan: And that is a significant part of that course, is it?

Michael Burgess: It may or may not be in that in the past we have included elements that have focussed on particular groups, whether Muslim, Jewish or minority religions. We have also talked to people with particular experiences. It is not something that has monopolised a whole weekend but it has been an element in many training courses.

Q20 Julie Morgan: I feel very concerned about how some families cope with the whole process. The small amount of experience I have had with constituents has shown that there have been difficulties about communication with a court, for example, when it is not the court in their home city. It did seem to me that the whole process could be made much easier for the families of the bereaved if bereavement training was built into the system and all the officers of the Coroner’s Court were aware that their task was to ease the system as much as possible, which does not always seem to happen.

Michael Burgess: You are right. I think that the bereavement and the counselling and the way in which those who are bereaved are managed is something that the whole system has to accommodate, it is not just the coroner. He/she may set the tone for it, but ultimately I have to let my officers develop their own personal skills in addressing and meeting with and dealing with those who are bereaved because they have much more personal contact with relatives than I ever do, and most of them are prepared to learn and they learn probably as much by their own mistakes as by anything else. I am reasonably content that broadly speaking they do a good job, not least because they spend time on it and I think time is the one thing that people do need. I am afraid it does not look very well on their overtime sheets, but the reality is that unless they spend time with people they give the impression of being rushed. If they give the impression of being rushed then one impression that relatives may be left with is these people do not care and that is the last thing in the world that we want.

Q21 Julie Morgan: One of the things that have caused a lot of distress is the long delays that sometimes occur. For example, I have a constituent who is waiting for a decision on whether there will be an inquest or not 15 months after the death of her 18-year old son. Delays and a lack of information sometimes cause as much distress to families as anything else. Is there anything that can be built into the system that can help the families understand why there are delays?

Michael Burgess: I think we would all like to encourage those who have day-to-day contact with relatives to make sure it is day-to-day and not year-to-year. I think at the end of it we do have to reflect
Michael Burgess: We all feel—I am sure I speak for practice?—that many of us are short of resources and that does mean having the ability to bring cases forward quickly. In part that is because we may not have the court accommodation but, equally, it may be because we have not got the human resources to move cases forward. We have to try and move the whole thing forward in tandem and I am afraid it does not always work. It would certainly help if it were possible to develop some discipline to require communications to be delivered every so often.

Julie Morgan: I think that would be a huge help. Thank you.

Q22 Keith Vaz: You have already mentioned to the Committee that you felt that the £5 million figure that was put on the cost of reforms by the minister yesterday was a surprise to you, which presumably means you think it is going to cost more. One of the other proposals that were put forward was an acceptance of the recommendation by Lord Luce that there should be a Chief Coroner appointed, someone to give leadership to the profession. Would you agree with that?

Michael Burgess: I think we all support the concept of a Chief Coroner. He will be publicly recognised as a respected figurehead for the national service, but that presupposes this is going to be a national service. It should result in some sort of consistency, but unless there is the consistency of resources the consistency may not be as all-encompassing as one might hope. Yes, I think somebody that coroners who are working in the field so to speak could look up to we would welcome.

Q23 Keith Vaz: I have to correct myself. I think I have promoted Tom Luce to the Lords. Well, maybe he will be eventually but certainly he is not at the moment. At the moment do you feel that the coroners are too isolated, that there is no interaction between people in different areas and therefore any change is going to increase the sharing of good practice?

Michael Burgess: We all feel—I am sure I speak for nearly everybody—very isolated in our own place. In my area we meet regularly with our neighbours in order to exchange information and to ensure that we are consistent so far as we can be. I am a ‘whole-time’ coroner. I have those on three of my five sides so to speak that are part-time coroners who do not have resources even as meagre as mine and therefore in that sense it is not necessarily possible to be as consistent across the board as we would like. We know each other, we get on with each other on a personal basis and I think on a professional basis too, but inevitably there are difficulties because of the differences in resources.

Q24 James Brokenshire: Mr Burgess, let me move you on to the inquest system in detail. Do you think the current system works?

Michael Burgess: I think it depends what you expect it to do. At present the inquest is expected to be a non-partisan, non-adversarial, inquisitorial process. Back in 1982 the then Lord Chief Justice identified it as a hearing without defence, without prosecution and so on. It is expected to produce some factual detail, somewhat limited probably by many standards today but, nevertheless, those are set in statute and we strive to achieve that. The difficulty really comes when feelings are running very high, as very often they are and the coroner is very often in the middle trying to draw everybody’s attention to the fact that we are a fact finding process and not a blame process and that itself causes difficulty. Last Friday Mr Justice Collins in the Administrative Court wondered whether the time had not come to abolish unlawful killing. He was saying this in the context of judicial review of a coroner’s decision, and he went on to say that it was not possible for a coroner to decide which conclusions to leave to a jury by excluding evidence that could not be admitted in the criminal trial as an inquest was not a criminal trial. We keep on drifting back towards an adversarial decision and then being directed away from it. I think inquests can be very difficult to run, particularly when feelings are running very high and there appears to be a perception of inequality between the different persons who may be interested and that inequality may arise because some are represented by lawyers with lots of paper and others are unrepresented. Certainly that is another way in which the perception may suggest an unlevel playing field.

Q25 James Brokenshire: You mentioned this issue about the adversarial tension that may arise in an inquest and I hear the comments of the judge in that particular case. What recommendations would you make to try and dissipate that tension or to seek to give a greater emphasis towards the factual, inquisitorial type of approach that may lend itself more readily to the current inquest system?

Michael Burgess: I am not sure that in the time allotted I could necessarily fully address that. What I would say is that some of the biggest difficulties arise where there are suggestions that the inquests should become an Article 2 inquiry. Article 2 places the responsibility on the state to carry out an extensive inquiry, a much fuller one than an inquest normally should be, to address the broader circumstances in which somebody has died.

Q26 Chairman: Are you talking about the ECHR?

Michael Burgess: Yes.

Q27 Chairman: That is a circumstance in which the state is involved in some way.

Michael Burgess: Yes, so deaths in prison, deaths in police shootings and some hospital deaths as well. The European courts seem to be quite enthusiastic about applying Article 2 in areas that maybe the English courts have not yet made a decision on but where they probably may have to follow the European courts. It is an expanding area. This unnerves many of us because the resource implications again are much wider if one is trying to run an Article 2 inquiry than if one is running a rather narrower inquiry. We quite often receive applications that the inquest should be regarded as an Article 2 inquiry so that the scope of the inquest...
can be broadened. One way that many of us have tried to deal with this issue in very general terms is to follow the House of Lords case in Middleton who said it was no bad thing if we went into what we call a narrative verdict, ie we went outside the narrower confines of the suggested form of an inquisition verdict and launched into an explanation written in factual, non-judgmental terms to try and explain things, and provided that that process is followed logically and flows from the evidence that is heard that could be no bad thing. It does bring other problems and that is that the narrative itself requires the evidence to support it and the moment you open that door then time is one of those things that seems to run away. Those sorts of inquests tend to run much longer. Other than that, I personally quite often meet families normally before inquests and sit them down and explain what the process is going to be or, if it is after an inquest, what the process has been and try in that way to clear a bit of the mystery for them.

Q28 James Brokenshire: Obviously one of the issues is whether an inquest should be held at all, and I noted your comment about the involvement of the state and one would argue, therefore, the issue of public interest. The Luce Review recommended that inquests effectively should only take place where there is some sort of public interest in doing so. Do you agree with that approach?

Michael Burgess: I am not sure I would go quite as far as Mr Luce and his team went. Some years ago, long before the reform process was ever started, I put a paper to ministers suggesting that some inquests should be held in camera, so outside the public gaze because the evidence was not something that necessarily needed to be pored over by the public. The law requires that all inquests be held in public and I was suggesting that this change in the rule, which is a statutory instrument rule, it is not in primary legislation, could well make it easier for families to address things like suicides or domestic accidents that have resulted in a death. The response that I got, if I did get a response, I am not sure I did, was that the law is set in stone, we are not changing that door then time is one of those things that seems to run away. Those sorts of inquests tend to run much longer. Other than that, I personally quite often meet families normally before inquests and sit them down and explain what the process is going to be or, if it is after an inquest, what the process has been and try in that way to clear a bit of the mystery for them.

Q29 Keith Vaz: Just following on the line of thinking of the Luce Review, do you think that would reduce the number of inquests that would actually be held or would it have an impact at all? What do you think might be the impact of having some sort of direct public interest test before determining whether to go for an inquest itself rather than just examining the issue on paper from the factual evidence presented?

Michael Burgess: I think it depends how wide you draw the public interest scenario, where you put the brackets exactly. Certainly I think there could be quite a reduction.

Q30 Chairman: Scotland gets by with a relatively small number of fatal accident inquiries and no inquests at all.

Michael Burgess: Exactly, Chairman, yes.

Q31 Dr Whitehead: I want to ask you some questions about the system of death certification. What weaknesses do you think there are in the existing system, if you believe there are weaknesses at all?

Michael Burgess: Undoubtedly there are weaknesses and the weaknesses were fully explored and explained by Dame Janet in her third report. That has highlighted the difficulties that all those who have an input into the system see, whether it is the doctors themselves, whether it is the cremation referees or those who are signing as doctors parts of the cremation forms, or indeed coroners and the registrars. The document at the moment is relatively simple and yet it does not seem necessarily to be understood by all the users. As I explained a few moments ago, many of the referrals that come to us seem to be brought by doctors who are unfamiliar with or cannot put their open case into the narrow confines of the certification system and so inevitably we do get a lot of referrals which may well then result in post-mortem examinations and others being done because the system is not flexible enough to allow us to find some other accommodation to avoid post-mortem examination. Dame Janet in her report, as I am sure she will explain, fully assessed the situation. Doctors are required by law, if they have been in attendance, to complete a medical certificate, but then if they go on holiday they cannot complete it, so that sort of scenario there, unavailability, inevitably brings to coroners a lot of cases that otherwise should not come at all. The fact that we have a system where doctors use referral services at night and out-of-hours inevitably means that a doctor attending when somebody has died may not themselves be familiar with the patient and indeed their only duty towards that patient is to confirm that they are no longer alive and then they hand it back to the practice at the next working time. These are features that have been introduced into the system because of the way that medicine is now
practised. I certainly would be in favour of a radical overhaul of the medical certification process. I am not sure I necessarily would go all the way that Dame Janet suggests, but I would certainly go a long way further than we have got at the moment.

**Q32 Dr Whitehead:** I would be interested to hear what you might support in terms of an alternative system. As you said, Dame Janet proposed a double-death certification system. Would you favour that system or would you consider it is workable?

**Michael Burgess:** I would suggest that we should apply the same criteria to cremations as to burials. The theory, of course, is that if a burial has taken place and if there is any doubt then we can have an exhumation. The reality is that exhumations are only carried out in extreme circumstances. It would be much better to make sure that as much information is gathered from the body of the person who has died before it is buried—in exactly the same way as is done in a cremation. They have tightened up the cremation regulations and I would have thought these should be mirrored inside the burial process as well. It is a process that clearly needs to be supervised and disciplined and I am not sure that is possible with the present level of training that most doctors have got. I may be maligning them, for which I apologise, I think they could find it very difficult without extra training.

**Q33 Dr Whitehead:** There have been proposals put forward in the document “Reforming the Coroner and Death Certification Service” which appeared to suggest essentially a three-tier system. Firstly, a verifer of the death and you have mentioned a doctor who is not that person’s doctor may simply verify the death, and then, secondly, the certificate of the medical cause of death, as is the case at present, and then, thirdly, a medical examiner who would be employed within the coroner system. Would you favour that distinction in stages? Do you think the idea that there might be a system of medically trained personnel in the coroner service would be a good system?

**Michael Burgess:** I certainly believe that we should have more medical experienced input than we have got at the moment. At the moment we rely very much upon the input that individual practitioners give us when they tell us about a particular case coupled with the pathologists that we use. If they are medically qualified, and most coroners are not, then of course they have their own medical knowledge as well to fall back on. That said, many of us who have been in the service a long time have got quite a lot of knowledge, even if it is merely from seeing the papers passing across our desks. We certainly would support having more medical help. I do not know precisely how that medical help can be brought in. I did see in the minister’s statement yesterday and in the briefing paper a suggestion that the Department of Health was going to make a contribution. Precisely what form that contribution would take and how it would ease the lot of coronors on an individual case-by-case and a day-to-day basis I would not know, but it would certainly seem to me that there should be some cross-relationship between the medical services locally and the coroner service without it being too cosy.

**Q34 Chairman:** Mr Burgess, thank you very much for your help this afternoon. It may be that as these things develop you might want to submit some further benefit of your experience to us by way of written evidence and we would not know, but it would certainly seem to me that as the detail starts to be examined.

**Michael Burgess:** Thank you very much indeed, Chairman. If you feel I can offer anything else, please let me know.

**Chairman:** Thank you very much indeed.

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**Witness:** Rt Hon Dame Janet Smith DBE, gave evidence.

**Q35 Chairman:** Good afternoon, Dame Janet, and welcome. We are very glad to have your help in this matter. You presided over and did an enormous amount of work on a very major inquiry into a quite horrific series of deaths which I suppose you could say tested the system to destruction and demonstrated its most serious weakness although one hopes in a very untypical set of circumstances. Having heard the exchanges that we have just had, perhaps you would like to start us off by saying what functions you think the death investigation and certification system needs to perform.

**Dame Janet Smith:** Historically, of course, it has always been there to detect wrongdoing and that is still a very important function. In wrongdoing I would include not just deliberate wrongdoing such as Shipman but wrongdoing by neglect, wrongdoing by error because it is important that those things should be discovered as well. In modern society there are other important functions that are served by a system of death certification. For example, much medical research and epidemiology is based upon cause of death and if we do not have cause of death established accurately then that research and epidemiology is inaccurate. That research and epidemiology serves and informs to a great extent the disposal of resources, particularly in the Health Service and they are enormous as you will know. If that research and epidemiology is at fault then the ways in which those functions are carried out also fail. There are important and direct functions and purposes behind death certification but there are also broader ones which in my view are no less important.

**Q36 Chairman:** Do we need coroners as a key element, having got the certification system right?

**Dame Janet Smith:** I recommended that we should keep the coroner system although I wanted to see it radically reformed. The inquiry looked at a number of foreign systems, some of which depended wholly on the medical examiner making decisions about the
cause of death and also in some jurisdictions the medical examiner gives an opinion as to the circumstances to some extent, but essentially it is a medical process in those jurisdictions. It seemed to me that one needs somebody who can make decisions about circumstances and, in particular, where the circumstances are disputed, as they sometimes are. The best person to do that is a coroner who should be a judicial figure as opposed to a medical figure. I see an important role for both doctors and lawyers as judicial coroners in the system. I am a great believer in professional horses for courses. I would like to see the medical tasks being performed by doctors and the judicial tasks being performed by legally qualified coroners.

Q37 Dr Whitehead: In your third report on the Shipman Inquiry you effectively stated that the whole coronial system had failed as far as Harold Shipman was concerned and as a result you called for the whole-scale reform of the entire system. Do you think that the failure in one case, admittedly a very significant case, really justifies the whole-scale reform of the system which over and above that considered over 226,000 deaths in 2004?

Dame Janet Smith: I have been listening to Michael Burgess and it does not appear to me that, quite apart from Shipman, there is a great deal to be proud of in many aspects of the coronial system. I was very careful during the inquiry when, of course, I had to focus on the Shipman events, but I was determined that the recommendations that I had made would be of general application and general usefulness. It is true that I pointed to the ways in which the system had failed to detect or deter Shipman. I do want to impress upon this committee that the announcements that were made yesterday in the House would go no way at all towards remedying the defects that failed to catch or deter Shipman. If these reforms go through—and they are good in themselves and I have no criticism of them in themselves—there could still be a Shipman out there still killing patients, still certifying their deaths, handing the MCCDs to the member of the family who takes it to the Registrar’s Office to register the death. Nothing will have changed and I think that is a cause for significant concern. I hope this committee will agree with that. I am not suggesting we have a new system just because one wants to make sure that one would catch another Shipman, but if you have a new system and it cannot catch a Shipman it seems to me that something is wrong.

Q38 Chairman: Was it the individual nature of the registrar system as much as the individual nature of the coroner system which is the key gap here? What is the key change it does not address?

Dame Janet Smith: I think the key difficulty and problem is that too much is left to the individual doctor. The individual doctor’s decision warrants two things. He is saying I warrant that I know the cause of death and I warrant that the circumstances of the death do not require referral to the coroner. It was Shipman’s ability to certify false causes of death and avoid the coroner system completely that is the point because not one single death of Shipman’s victims was reported to the coroner. Occasionally he would have a quick telephone call with somebody in the coroner’s office saying that he proposed to certify the death as due to such-and-such and would that be alright and the answer he always got, and it only happened on a few occasions, was “Yes, it’s quite alright, Dr Shipman”. So there was no check. I must put in a word in defence of the system of registration. Registrars are administrators, they are doing an administrative job and they are not equipped to scrutinise the medical certificate or cause of death that is issued by an individual doctor. It is not their fault if false causes of death go past them.

Q39 Keith Vaz: Dame Janet, you said something quite profound just now, which is that you do not feel the proposals as outlined yesterday would deal with the kind of issues that were raised in your very important inquiries. This is a very profound statement because I think ministers and Members of Parliament believe that they would deal with those problems. Were you consulted by the Lord Chancellor or ministers before they published these proposals?

Dame Janet Smith: Very recently. In fact, soon after my report was published I had a series of meetings with the then Home Secretary Mr Blunkett and a Minister of State in the Home Office called Mr Goggins and I was quite extensively consulted at the time of the Position Paper which was produced by the Home Office in March 2004, it was about nine months after I had produced my report, and the Luce Report came out at more or less the same time and Tom Luce was certainly consulted at that time as well.

Q40 Keith Vaz: But they were all very well aware of your views before these proposals were announced, were they not?

Dame Janet Smith: Yes, but there has been a change of department since then. The change was in May of last year.

Q41 Keith Vaz: Have you not met Harriet Harman or the Lord Chancellor?

Dame Janet Smith: Not until last Thursday. I met them both on that occasion. I have met the Lord Chancellor on other occasions but nothing to do with this. I see him from time to time in the course of other judicial matters, yes.

Q42 Chairman: We need to clarify this because one of the things said yesterday was that the Department of Health would be dealing with issues of registration and ongoing work. Can that be enough or are there aspects within the remit of the Department for Constitutional Affairs which in your view need to be strengthened in their proposals whatever may be achieved by the work the Department of Health is going to do?
Dame Janet Smith: One of the difficulties is having these systems across departments. I do recognise that there is not a department of state that is ideally suited to dealing with all of these issues. I accept that entirely. It is a question of a need for joined-up government. It seems to me that we do need a new system of death certification. I was disappointed, for example, to see that there was no reference at all to cremation certification in the announcement yesterday. I think that cremation certification is unsatisfactory, Mr Luce thinks it is unsatisfactory and the Brodrick Report of 1971 thought it was unsatisfactory. I think if we go back to 1956 we will see there is another report that thought it was unsatisfactory. Here we are and nothing has happened about that. I do think that we need a reform of death certification and that it needs to be completed dovetailed in with the reform of the coronial system. You have to decide how the two are going to be related to one another. In my report I saw there was another report that thought it was unsatisfactory. Here we are and nothing has happened about that. I do think that we need a reform of death certification and that it needs to be completed dovetailed in with the reform of the coronial system. You have to decide how the two are going to be related to one another. In my report I drew attention to how very difficult it is for doctors to know when they ought to report a death to the coroner, that the existing statutory rules are opaque, that those rules have been built upon and there are lists in existence which try to elucidate the statutory rules, that local coroners have their own local rules and it is extremely difficult for doctors to form a view. I myself and my inquiry team tried to draft a list that would be comprehensive and easy to understand and easy to apply. We failed! I notice that the DCA says that they are going to do it and I await their efforts with interest. I wish them luck. They have decided to go down this route. It is important that we have a list of types of deaths that have to be reported to the coroner, but it is not an easy task.

Q43 Chairman: Are you really suggesting that every death should be reported to the coroner? Dame Janet Smith: Yes, but not every death should go for full investigation. I have condensed my proposals into a page or two for ready reading and understanding and if you want I will send something in to you. Essentially what it comes down to is that there should be some information coming from the person who certifies the fact of death. At the moment we do not have any system for certifying a fact of death other than a policeman will not allow you to move the body until it has been done, but nobody writes anything down about it. You do not know who was there or what time it happened, there is no record made at all. I suggested that we should have a very simple form of recording a bit of information about that. I was interested to see that Mr Burgess said it is very important that we collect information. My system was designed to collect information contemporaneously because it is not much good when you look back and try and remember what was happening days and weeks ago. It is much better to make the record contemporaneously. So that would be number one. Form 1 would be something akin to the present cremation Form V, which is the one that is completed by the treating doctor. It would not matter if he had not seen him within 14 days and it would not matter if he was not the one who certified the fact of death. He would provide some information about the medical history and express an opinion, if he felt able to, as to the cause of death. The case would then go into the coroner’s office where a member of the staff would examine the material. If it looked straightforward and there was not any apparent concern about the circumstances of the death that would obviously call for further investigation and if the doctor felt able to express a view about the cause of death then what I proposed is that a member of the coroner’s staff should speak to a member of the family to find out what happened from their point of view and to take that opportunity to explain to them what is happening. I think it is extremely important—and I know the government recognises this—that we have to bring the bereaved into the equation in a way that they have not been brought in in the past. We need direct contact between the coroner’s office and a member of the family, if there is one, there is not always, or a carer if there is not and just cross-checking that there is not a disparity between what they are telling you and what the doctor has told you or the person who has signed Form 1. Then if you find that there is no disparity the death can be certified without further investigation. My estimate was that something like 80% of deaths could be certified in that way without an inquest and without further investigation.

Q44 Chairman: Mrs Morgan is going to ask you some questions about bereaved relatives in a moment but it immediately puts in my mind the question that in a very large number of deaths, where there is nothing very suspicious, doctors reporting then enter into a process which the present coroners system certainly could not handle without delay and a reformed coroners system with a limited number of full-time coroners might not handle without the kind of delays where relatives want to agree with the undertaker the date for a cremation or a funeral, finding slots in what is often a very busy timetable of a crematoria only to be told, “Well, you have missed this week and you have to wait another week or another week” because these processes have to be gone through.

Dame Janet Smith: We have quite a complicated process for cremation at the moment involving three sets of certification. We manage to get that done in about a week in general. I know there are some religious minorities who want, and understandably, to have their certification dealt with very quickly so they can go to the rapid disposal. By and large, people in this country accept a period of about a week between death and disposal. We manage that with a three form cremation certificate in about 75% of all deaths. I do not think there would be any real reason why there should be delays in 80% of the cases that I am talking about. About 20% of cases have got to go to the coroner for proper investigation anyway. The coroner tries to allow disposal as soon as possible, as soon as the medical aspects of the case have been looked at. The rest of the investigation takes place afterwards. One of your
questioners—I am not sure whether it was Mrs Morgan or Ms Morden—was saying that a constituent had complained about a long delay. That does not mean to say that there has been delay in disposal. Yes, I do accept that the resources would have to be there in the coroners office, not requiring a lot of judicial coroners, I wanted to see some medical coroners because most of these decisions are medical decisions and I want to see a well-trained core of coroners' officers because, as Mr Burgess was saying a moment ago, they are the ones that have most of the direct contact with the families. They are the ones that need the bereavement training and they are the ones who would do the bulk of the work that I am talking about. If there are enough of them I do not think it would cause undue delay.

Q45 Julie Morgan: This is about how the bereaved relatives are treated and you have already covered some of those points. You do state in your report that the families of the bereaved are not well-served by the present system. I do not know if you want to expand on that a bit more and what you would like to see in place? You have already covered that a little.

Dame Janet Smith: I have given you some indication. At present, officially, the system ignores them and that is really bad. There are many doctors who are very good and very nice and do explain what is happening in the official system because, as Mr Burgess was saying, most of us do not have much experience, fortunately, of how the system works and an explanation is required. At the moment there is nobody to do it other than the doctor and believe me it does not happen in a lot of cases. I would like to see somebody officially responsible for telling people, the bereaved, what is going to happen, what is required of them and what will be done for them. It seems to me that the person that one could best ask that of is a member of the coroner's staff. I think it was you who was asking about bereavement training, there is very little at the moment. I will go back to the bereaved but, I just want to say a word, if I may, about coroners' officers. I notice that the proposal is that they should still be employed by the police or their local authority, I think that is a real pity. For the police and for local authorities, coroners' officers are not mainstream employees, they are sidelines. Consequently, there is no training for them within their own organisations. The Coroners' Officers Association has tried in the last few years to set up some training and they are making a bit of progress and that is very good but many of the employers, the police and the local authorities, do not want to provide the day release or the cover that would have to be supplied if somebody goes on to release and they will not pay for the expenses either. The result is that there are coroners' officers who have had no training at all. Another problem with them remaining with their old employers is that it is a career backwater, there is no career structure for somebody who wants to become a coroner's officer and do it well, learn the job and rise up the system. That is not possible, it is very much a backwater and I propose, and I think Tom Luce did too, that coroners' officers should be employed by the Coroners Service. I am disappointed to see that is not proposed in the present proposals. You asked me about the bereaved, how should they be handled? How they should be dealt with? The main thing is that they should be consulted and kept informed and really by somebody who knows how to do it. It has been suggested to me, and it was suggested during the inquiry, that the bereaved would find it intrusive to be spoken to by the coroner's office in every case, we should not insist upon that. The advice I was given by Cruse Bereavement Care was their view is that people do not resent it, they welcome it. First of all, they welcome it because very often they want to talk to somebody. Second, they need to know and her advice was that also if there is bad news to be given it is better that it should be given straight rather than in a circuitous way, people should be treated as adults and told what is going to happen and why it has to happen. In general, if you do that in a straightforward way you are not doing any harm, you receive co-operation. The same goes for post mortems. Many people do not want their loved ones to have an autopsy and one can understand why. If you explain to them why it has got to be done in a sensitive way certainly the Cruse Bereavement view, and indeed it was also the view of Professor Brazier's group who did work on retained organs, that if you explain properly to people why you need to do something that they do not want you to do, they will accept it. I think that ought to be the approach.

Q46 Julie Morgan: I am very interested that you mentioned Cruse because I think often voluntary organisations like Cruse have a lot of experience in working directly in this field and have the knowledge and the lack of inhibitions that many of the rest of us may have because of their direct knowledge of dealing with situations like this.

Dame Janet Smith: That is what I want to see incorporated into the coroners service in particular through coroners’ officers because there is a right and a wrong way to talk to bereaved people and the more you do it—witness Cruse—the better in general it is done.

Julie Morgan: My limited experience of constituents, and I accept the fact that they usually only come to us when they feel there is a problem, is the problem is the lack of communication and I think that you have put that case forward very well today. Thank you.

Q47 Chairman: Without challenging the argument you put perhaps I should place on the record, from personal experience, how very good, sensitive and thoughtful many police officers and ex-police officers are in dealing with bereaved people on the basis of the other situations I have to deal with.

Dame Janet Smith: I was going to say they often have to bring very bad news of accidents and matters of that kind and they do have some experience of it, that is true.
Q48 Barbara Keeley: I have a few questions on areas you have already touched on but I think if I still put the questions it will help us be sure that we are clear about what your recommendations are. The first is about jurisdiction. Clearly you recommended in your report that decisions on jurisdiction in reporting deaths would be taken by other medically qualified coroners or coroners’ officers with a medical background.

Dame Janet Smith: I am not sure that I understand the question. To me jurisdiction means have I got power to make a decision on this matter? I was suggesting in my report that many decisions on whether a death should be certified and registered could be made by either a member of the coroner’s staff or the medical examiner, those being decisions on what I would call the straightforward cases that I was describing to Mr Beith, where you have a form from the doctor saying that he believed he understood the cause of death and this was it; and the conversation with the bereaved family or a carer revealed no inconsistencies and then the death could be certified without more. Anything that could not be certified in that way would become a proper coroner’s investigation, a full coroner’s investigation, and it would be up to the coroner, possibly the medical coroner or the medical examiner initially, to decide what form the investigation should take. It would depend on whether the problem was a medical one or a circumstances problem because many inquests do not contain a medical problem, they contain a “what happened?” problem. That is really a matter for a legally qualified coroner, “How are we going to investigate this and what statements are we going to get?” and so on. There is a very important area I ought to mention and that is clinical negligence deaths which do require a combination of medical and circumstantial inquiry. I suggested in my report that it would be a good thing if there was to be a special group, a regional group, of investigators for that particular kind of work. It is not well done on the whole at the moment. It does require special expertise.

Q49 Barbara Keeley: That was my point really, how locally would you see that?

Dame Janet Smith: I see that as a regional function because I felt that it needed a small team that was focusing on that kind of work all of the time.

Q50 Barbara Keeley: In fact, you made some comment about local rules that you seemed to have some concern about.

Dame Janet Smith: My concern about local rules is the rules that the coroner makes, and many coroners make, about the particular types of cases that have to be reported. For example, some coroners will say that if a death has occurred within 24 hours of admission to a hospital, it must be reported. That might be a good idea or might not; it is not a statutory requirement and is not a requirement in all parts of the country, it is a local rule in some places.

Q51 Barbara Keeley: On autopsies and whether or not those are automatically triggered, could you tell us why you believe that autopsies should not be carried out as a matter of course in the case of referrals to coroners?

Dame Janet Smith: Yes, because in quite a number of cases it is not necessary. I can give you as an example a body that was very badly damaged in the course of a road traffic accident or a train accident, you only have to look at it to see that the body is dead and in general terms why. Is there any advantage in detailed dissection of the body parts in order to discover precisely which organs have been damaged in which particular way? The inquest is really about how the train crash happened, how the car accident happened or how the pedestrian was knocked down. It can just be an additional source of distress for the family to think that the body is going to go through an autopsy as well.

Q52 Barbara Keeley: In terms of inquests—and this is something on which we have obviously heard different views—in your report you call for the number of inquests to be substantially reduced, and we heard Mr Burgess’ view on that issue and I think you were here for that.

Dame Janet Smith: Yes, broadly speaking, I agree with what he was saying.

Q53 Barbara Keeley: In terms of what he was saying though, in the light of the increased number of Article 2 inquiries, do you still believe inquests should be limited to the deaths in which there is a real public right to know, or are you really arguing, as he was, for more inquests to be heard outside the public domain?

Dame Janet Smith: I was arguing for fewer inquests taking place orally in public because of the distress that they cause unnecessarily. There are some cases where you have to have it, and rightly so and, of course, anything to do with Article 2 plainly has got to be fully investigated in public either by a coroner’s inquest or some other form of public inquiry; suicides are a good example. I do not mean suicides in prison, I mean suicides at home for private, distressing reasons; child deaths are another example. I am not suggesting that there should not be a decision about the cause and circumstances of death, but I think that unless there is a dispute as to what has happened, in which case you need a judicial decision which may have to be made after the hearing of oral evidence, I cannot see any reason why a written report is not adequate for the purpose of deciding the cause and circumstances of death.

Q54 James Brokenshire: Dame Janet, one of your principal recommendations, and I know you have touched upon it in some of the comments that you have already made this afternoon, was the need to have two different types of coroner, a medical coroner and a judicial coroner. How do you see those two different types of coroner inter-relating or working with each other?
Dame Janet Smith: It was suggested to me that they might quarrel and that one of them would have to be the boss. I did not really see it in that way. It seems to me that if you have two professional people, both officers of the Crown, both responsible in a professional way, there really would not be any reason for one of them to be the boss as opposed to the other. Judges manage to work together without quarrelling, other professional people do: doctors work together in hospitals as part of a team, consultants in a group, general practitioners work together. I did not see any difficulty about that and what I am very keen on, as I mentioned earlier, is professional horses for courses. I do not think it is a good idea to have a legally qualified coroner who has to make a lot of medical decisions. I know Mr Burgess says that he has acquired a good deal of medical knowledge, and I accept that that is so, but that happens over a long period of time. In my view, it is far better if you have doctors taking medical decisions and judges and coroners taking legal ones.

Q55 James Brokenshire: Is it not a question of evidence and medical opinion that could be presented to someone in a quasi-judicial situation as we have at the moment? I notice from the Government’s proposals that they are talking about the creation of a chief medical officer to sit alongside the new head coroner. Could it not be addressed in that way?

Dame Janet Smith: If you had an inquest in which there was a dispute about medical evidence, then plainly it becomes a judicial matter. Most routine decisions that coroners have to make day in, day out in their offices do not entail anything like that. The great majority of decisions that are made in the coroner’s office are medical ones. That was why I suggested we should have a medically qualified coroner taking those everyday decisions and being personally responsible for them and the legally qualified coroners concentrating on the conduct of inquests. The role of the chief coroner we will have to wait and see the small print to know exactly what is proposed about that. I had my own small print and quite a number of suggestions as to what his functions should be, including some appellate functions from decisions of coroners, in particular on questions of whether there should or should not be an inquest, whether they should be held in public or private and also whether or not there should be a post-mortem, because sometimes that can give rise to objection. I want to see the chief coroner having that sort of appellate function as well as his leadership functions. The leadership functions are very important and standard setting can be an issue.

Q56 James Brokenshire: If I could press you on the issue of the dual coroner system. I heard what you said about making a comparison with the judiciary working together but, in many ways, they work as a team, therefore, if a judgment is made it is the decision of the judges sitting in judgment and they reach a joint decision, or maybe they do not in certain circumstances. It was interesting that you said effectively the medical coroner would take certain types of decisions, the judicial coroner would take other sorts of decisions and, therefore, in some ways there was not any inter-relationship between the two. Does that run the risk of some duplication of work?

Dame Janet Smith: No, there would not be any duplication. There would be some cases in which both of them needed to apply their minds to it. Do you remember that case of the man who drowned in the swimming pool? It was a very famous case. There were medical issues and what happened circumstantial issues in that case. In the preparation of that case for inquest I would say both the medical coroner, or medical examiner, and the legally qualified coroner would have an important role, they would work together on a case like that. When the inquest happened it would be the judicial coroner that heard it. The medical coroner might sit by the side of him and listen to the medical aspects so that they could discuss those but, in the end, it would be the judicial coroner who reached the decision or a jury, if you happened to have a jury. I think they both have an important role to play. I do not think that there is, or would be, any duplication of effort. I think it would lead to increased professionalism which is what I think we ought to be aiming for.

Q57 James Brokenshire: In reaching those recommendations in this proposal, did you give any consideration at that time to the likely cost implications and also the practical implications of whether there were sufficient suitably qualified medical experts to be able to fill the post that would obviously arise from the medical coroner position?

Dame Janet Smith: Dealing with that point first, one of the reasons that I disagreed with Tom Luce’s proposals for death certification was that I thought his were very heavy on medical resources. It was he who suggested that there should be double certification by doctors or second certification by a medical examiner in every case. I thought that was going to be very heavy on medical resources and that was one of the main reasons why I went down the route of suggesting that many of these cases could be certified by a coroner’s officer, subject to supervision by a medical examiner. Costings: all very difficult because nobody could tell us what the present system was costing. That is one of the problems with the system being spread over so many different departments. The Coroners Service is costed through local government and in many places it is run on a terribly short shoestring. Death certification is paid for partly through the Department of Health. In fact, doctors are not paid separately for signing an MCCD; they are paid separately for signing cremation certificates and that is paid for by the families. Do you realise that it costs families about £100 for cremation certification? It is a matter of some concern to me that that has not been addressed, because Tom Luce, Broderick, somebody in 1956, and I, all think that the families are not getting value for money out of that. Society is not getting value for that money and that has not
been addressed but, of course, if you take that money out of the system, it is a significant feature of the cost of the existing system.

Q58 James Brokenshire: If judicial coroners were only able to operate essentially from regional offices that would appear to break the more direct local connection to a particular district. Do you see it as important to have that more local connection retained?

Dame Janet Smith: There are two issues arising there, one is the appointment of coroners and the other is the place where they sit. I still think a judicial coroner and more particularly a medical coroner (because there would be more of them and they would have a smaller bailiwick) should have a local connection. I am not in favour of direct local appointment and, in my report, I suggested that the appointment of coroners should be done, probably by the Coroners Service itself, if it were to be set up as an independent organisation as I proposed, with advice and assistance from the DCA, which has a great deal of experience of appointment to judicial offices. It is about to lose some of it to the Judicial Appointments Commission but it has that expertise at the moment and I would like to see that drawn upon. The evidence that I received about local appointments of coroners did not give one confidence. Quite apart from the issues of hereditary coronerships staying within a single firm of solicitors, there was also evidence that many local authorities would only appoint somebody who had already got experience as a deputy or an assistant. As the deputy is appointed by the individual coroner on the individual coroner’s say so, in effect there has been a self-perpetuating oligarchy because coroner appoints deputy, new appointment comes up, local authority says “We will have to appoint somebody with experience, it will have to be the deputy”. You can see examples of that happening all over. If the system is improved, okay. I would prefer to see a central system with some local input.

Q59 James Brokenshire: I was going to say from the announcement that we saw yesterday it certainly seems that the Government wishes to retain that local appointment link. Why do you think they have come to that conclusion?

Dame Janet Smith: I detect a desire not to set up a central structure. There is going to be a chief coroner and he is going to have a chief medical adviser and there is going to be an advisory council but there is not going to be, as I understand it, an executive organisation. I would have liked to see one because, as I mentioned earlier, I would like to see coroners’ officers employed by the Coroners Service to give them a career structure and to ensure that they get the right sort of training instead of the fragmentation that they have at the moment by being employed either by a police service or a local authority.

Q60 Chairman: Mr Brokenshire’s original question about regional coroners does raise the issue of access. The present system, partly because it is distributed around solicitors’ offices in towns all over the place, does give readier access than might be available if there are a small number of coroners at a sub-regional level and certain important coroners’ functions are being exercised at a regional level. How are families going to have ready access to these?

Dame Janet Smith: I suggested there should be around about 60 coroners’ districts, call them what you like, bailiwicks, areas. At the moment we have a lot more than that but some of them are very small, and I notice that the Government’s proposal is 60 to 65. That is England and Wales, not Scotland.

Q61 Chairman: They do not have any coroners in Scotland.

Dame Janet Smith: I think that gives reasonable access. It may be if there was going to be a public inquest the family would have to travel to a regional centre, not necessarily so if there is a court centre in the town where the coroner can come to because mountains can move to Mohammad as well as Mohammad moving to mountains. I see no difficulty about a regional coroner sitting in, say, the North-West, the judicial coroner for the Manchester region, although I think there might have to be two there because it is so big, but there is no reason why he or she should not sit in Bolton Crown Court or Bury Magistrates’ Court, which has quite a bit of spare space, Rochdale has courts; that is not a difficulty. Coroners’ courts do not need to be special. I do not see that as a problem.

Q62 Chairman: Bearing in mind all that you said about the registration system, do you think it would be better if the Bill about coroners that we are going to look at in the spring or summer covers the whole thing, registration as well?

Dame Janet Smith: I do. I think that the two are inextricably linked and ought to be inextricably linked. You may have seen the statistics; there were some appended to the documents on the website yesterday afternoon. They are the 2004 statistics. It looks as though, at the moment, about 40% of deaths are being reported to the coroners’ offices. That has gone up a bit in the last two or three years since I was looking at statistics during the inquiry; it was about a third then. It may have gone up because of the Shipman effect, doctors may be a little more cautious. It may be going up because doctors are worried or confused about whether they ought to be reporting or not. A great number of those are just dealt with by means of a telephone call between the doctor, and either a member of staff or possibly the coroner. Certainly when evidence was given to the inquiry, it suggested that in many cases it was a coroner’s officer who was authorising the doctor to sign and say, “Yes, thank you very much you have reported it, but will you sign the death certificate?”

Q63 Chairman: When you say a coroner’s officer, you mean a clerical officer not a coroner’s officer in the strict sense?
Dame Janet Smith: For example in South Manchester authority was given by clerical officers, administrative officers, yes. I have lost my train of thought.

Q64 Chairman: If it occurs to you later, by all means, drop us a line because you have given us a great deal of help this afternoon. We do not need to take up your time further. Thank you very much.

Dame Janet Smith: Thank you very much.
Tuesday 25 April 2006

Members present:
Mr Alan Beith, in the Chair

Dr Alan Whitehead Jeremy Wright


Q65 Chairman: Mr Luce, welcome. We are very glad to have the benefit of your evidence as things have moved forward a little since you reported comprehensively on this issue. You gave us a helpful written submission, in which you say that the coroners’ system serves multiple purposes, serving the bereaved families need for clarity and contributing to public health and safety. Do you think the reforms that the DCA is now proposing will improve the current system and increase its ability to achieve these objectives? Tom Luce: Sir, I think that the reforms that are now being proposed (that is to say, those that were included in the DCA publication of February this year) will improve the coroners’ system within limits. It seems to me that they are likely to have very little effect, as they have so far been described, on the death certification system, which seems to me to be a very serious lack in the present situation.

Chairman: We will return to that particular issue of death certification in a moment.

Q66 Jeremy Wright: Let me ask you a little more about the position so far as the activity of coroners in this country is concerned and the international comparisons that we can make with other jurisdictions. First of all, coroner activity rates—and to describe them in that way is perhaps a bit too blunt, but you know what I mean—seem to be higher in England and Wales compared with other jurisdictions. Can you help us with why that is? Particularly the increased number of autopsies compared to other jurisdictions.

Tom Luce: I will do my very best to. We thought very carefully about this when we were doing the Review and we were never satisfied that we discovered the causes. In particular, we were not satisfied that we found good reasons for these differences. The two most important figures really are the rate of referral to coroners; that is to say, the rate of referral for specialist investigation. Whether you call them coroners or whether you call them procurators fiscal, as they do on Scotland, or whether you call them something else, as they do in Commonwealth countries, or whether you call them medical examiners, as they do in the USA, the rate of referral for specialist investigation is very much higher in England and Wales than it is elsewhere in the United Kingdom, or, so far as we could find out, elsewhere in the world. It has risen further since we reported. I think at the time we reported 38% of all deaths in England and Wales were referred to coroners and I think the figure went up in the year 2004 to 44%. That in absolute terms is a very high figure and it is a very high rate of increase. It suggests to me that there is basically a serious problem of confidence and self-confidence amongst the doctors doing death certification. In relation to the very high rate of autopsies, which has continued for a long period and seems to have been stable at something like 23% of all deaths in England and Wales—and I am not talking there about deaths referred to the coroner, but all deaths. That is to say, to put it more bluntly, one in every four person who dies will be subjected to an unconsented compulsory autopsy under the coroner’s authority—and, looking around the room, I suppose we have something like 12 or 15 people headed towards the autopsy table in the morgue, if present trends were to continue. The only good reason we could think of for that is, first of all, that it is a kind of inheritance of the coroners’ system, there is a kind of custom and practice flow behind it, and, secondly, it seemed to us that is an indication that the coroners’ system was not adequately provided with medical skills to deal properly with deaths that are probably natural and could, with a reasonable degree of probability, be established as natural if a doctor took the case records, for example, and maybe had a brief word with family or maybe a brief word with the carers of the person concerned. We think it is partly this lack of confidence that has led to this pattern in which there is this routine resort to the compulsory autopsy. Whatever the exact reasons, the fact of the matter is that, so far as we could see and so far as the information we could get hold of was concerned, England and Wales can make the claim—perhaps the rather dubious claim—of being the autopsy capital of the world.

Q67 Chairman: Is that partly because there are more options open to the procurator fiscal in the Scottish system? There are more options, first of all, in whether to go to an inquest, because he can obtain medical reports without getting to that stage, and he also has a procedure he can invoke where the body is viewed with the case notes without carrying out an autopsy. Whatever the exact reasons, the fact of the matter is that, so far as we could see and so far as the information we could get hold of was concerned, England and Wales can make the claim—perhaps the rather dubious claim—of being the autopsy capital of the world.
were certainly impressed by the close relationship between the procurators fiscal and the pathologists and other doctors with whom they work. The second thing, as you very rightly say—and I think it is, with respect, a very important point—they have this system which they call “view and grant” as I recall, and that does mean that the procurator fiscal and the pathologist can together look at the case, with the pathologist looking at the body with the medical case notes in front, and reach a conclusion as to the most likely cause of death without necessarily going as far as an autopsy. I think that is a very important provision. I think part of the provision of extra medical skill to the coroners’ service would be of that kind. I might add that we found an almost exactly similar system, although it did not go by such a declaratory title, in the province of Ontario in Canada, where they have a reformed system that seemed to us to be run by competent expert people who knew their business. It came across to us, in relation to their handling of this sort of situation and their scale of autopsy—which I think was not much different from the Scottish one, maybe a little bit lower—that, if people like that and a service of that standing and quality could manage with a much lower scale autopsy, then so, if we organised ours properly, could ours.

Q68 Jeremy Wright: From what you have already said, there is clearly a lot to comment on the systems used elsewhere in the world, and yet your report does not go quite so far as to say that we ought to start with a clean sheet of paper and not have the coroners’ system any more and start with something else entirely. Is that because in your judgment there is something intrinsically valuable about the coroners’ system that is worth retaining, and, if so, what is that?

Tom Luce: That is a very interesting question. It is partly for the reason you have just given, which is that there is something intrinsically valuable about it. It is also that when we looked at these other systems we found that some of them had good features but they went along with features that were not necessarily so good. In particular, we found that in all the Commonwealth coronial jurisdictions which had gone through major reform, there was a very sharp, indeed a massive reduction in the number of public inquests, so that in most of these jurisdictions there was a kind of common values in the service, but it has not gone quite so far as to say that we ought to start with a clean sheet of paper and not have the coroners’ system any more and start with something else entirely. Is that because in your judgment there is something intrinsically valuable about the coroners’ system that is worth retaining, and, if so, what is that?

Q69 Jeremy Wright: Thank you. Could I move on to the structure of the coroners’ service and the structure that you have recommended in your report and you have suggested that there should be a national coroners’ service, supported and financed by the Department for Constitutional Affairs, and that the number of coroners’ districts should effectively be reduced. First of all, can you tell us about the advantages that a national structure such as that would have? Then I would like to ask you about the disadvantages that there might be—particularly with the reduction of the number of districts meaning that there is, you could argue, less local connection between the corner and the district he represents.

Tom Luce: On the question of a national service, it seemed to us that creating a national service would be the best and surest way of ensuring that the coroners’ service does something that it must do in future but has not done in the past, which is operate to known, open, public standards, both in its process, things like what is the best method of investigation and in what circumstances do you order an autopsy and in what circumstances do you hold a public inquest and so on and so forth. We also thought that going along with that was a very important need to improve the training and professional education and development opportunities of the staff, the coroners themselves and those who work with them, including the pathologists, and, most of all, perhaps, the vitally important 400 or 450 coroners’ officers. We felt the chance of getting good quality training and professional development opportunities would be much higher with a national service. There is a related matter which is that, in order to have consistent standards and consistent practices, there needs to be somebody or some people in charge. There is not anybody in charge at the moment. The Home Office and now the Department of Constitutional Affairs have done not a bad best with very inadequate powers and resources to instil some kind of common values in the service, but it has not been wholly successful, and it was never going to be because they do not have the powers. If one looks at the development of other parts of the judicial system, it has tended to show that they have created
jurisdictions that have people at the top of them who set practice standards and that has had a very good effect. I saw that when I was in the Department of Health dealing with child protection and family law matters. The creation of a family division, with a president of the family division who not only deals with the most complex cases but can set practice standards, is hugely influential. At the moment, in the coroners’ service the only way the more senior parts of the judicial function can get involved in coroner cases is when people go to judicial review and then to appeal and then to the House of Lords—which they have had to do on a very significant scale in recent years because there has been no other way of getting change. We thought that was an important part of a national service as well. As to the local point and the need for a local service, we would completely have accepted that was an important thing to preserve in so far as one could preserve it, but it was not obvious to us that that needed to have 120 or 130 separate coroners’ jurisdictions in order to have a reasonably local service. You can have deputy or assistant coroners who can cover the ground in particular localities if that is the most sensible way to organise things. You need to make sure, in the way that you reorganise the service, that particular issues like rurality and great distance of travel is taken properly into account in the manning of the service. When we came up with the very rough figure of 60-65 coroners’ districts—a figure that the Shipman inquiry subsequently used as well—we built in a substantial reserve, if I might put it like that, for, for example, the south-western region, which is a very long and thin region and has very long travel distances, the north-east and indeed the north-west regions and other areas as well.

Q70 Chairman: Is there any reason why you should not still have part-time coroners serving some of the remote locations if they were part of the national system which standards were being set for?

Tom Luce: I think not, sir. The way we would envisage the structure would be that everywhere would have somewhere or another in the regional area a full-time coroner who was overall responsible for the service but that full-time coroner would be supported by a number of part-time coroners, and, in areas where there is a significant issue about topography and distance and so forth, it might be sensible to have somewhat more part-time coroners than you might have in a denser area where there are not the same problems. No way were we advocating the complete abandonment of part-time coroners. There are part-time high court judges, part-time district judges and part-time circuit judges and there should be part-time coroners as well. But in charge of these services, both nationally and in whatever the main devolved unit is, whether it is a regional area or unit or whatever, there would be a full-time person, first of all to give the service full-time attention and, secondly, to avoid conflicts of interest, which one can perceive in a general way where there are solicitors doing private practice and also acting as a coroner.

Q71 Jeremy Wright: Is there not a problem or a potential problem presented by the fact that the Government have gone part of the way with you? They have said, “We accept that you should reduce the number of coroners to around 60/65 but not that there should be a national and regional structure. Is it possible to do the job that you are describing without the support structure which the Government have said they are not keen on?”

Tom Luce: I think it is preferable to have a national structure. I think it would be preferable if the Government in any rethinking that it does goes back to the proposals that it made itself in March of 2004 which were quite clearly based on the creation of a new national service. I think in particular that that would be helpful in terms of consistent standards and resourcing and consistent training and professional education. That said, I do not think that the structure that the Government has now proposed, which is basically to leave the resourcing, the administrative support of the coroners’ service, with local authorities, is necessarily fatal to the objectives that it wants to achieve. I must say that I think it would be much better to go ahead with those proposals, imperfect as they are, than sit around and wait for another two or three decades until some government, spurred on, no doubt, by some further massive catastrophe and public outcry, eventually gets around to doing a more complete job. There are one or two aspects of the structural proposals which I think do need particularly careful thought. The one about which I feel most strongly is the proposal for the presently divided responsibility for coroners’ officers, whereby some coroners’ officers are provided and employed by the local authority and others are provided and employed by the police authority. I think maintaining that, which the Government appears to be contemplating, would be a very serious error for two reasons. First of all, I think that it is hard enough to get consistent attitude towards the development and employment of a group like coroners’ officers when they are in local Government employment, but it is at least doubly hard when half of them at any given time are in the employment of police authorities. The second thing, which I think is an even more powerful point, is that particularly under the new service, when the Government, rightly, in my opinion, envisages that there will be a greater emphasis on delivering outcomes and delivering certain quality of interaction with families, the coroner’s job is going to become somewhat more managerial than it is at the moment. I do not want to over-emphasise that point, but there will be a shift in that direction, and there should be. If in some of the coroners’ localities, the coroners’ officers (in effect the main support staff for the coroners’ service) are employed not by the local authority which is supporting the coroner but by a completely different public authority altogether, with different reporting standards and all that kind of thing, there is no way that the coroner can take a responsibility for running his or her service. I think that is a very serious matter and I hope very much that the Government will rethink that aspect of it. The other aspect of it which I am
Tom Luce: Indeed.

Q74 Jeremy Wright: I have two final points on the Chief Coroner, if I may. First of all, what judicial rank do you think the Chief Coroner ought to have? Secondly, are there any potential problems with the Chief Coroner being accountable to central government in terms of quasi judicial independence?

Tom Luce: I would hesitate to give a very definite view on the first of those questions, since I do not regard myself as an expert on judicial grading. I think we had in mind that something like a senior circuit court judge might be approximately the right level.

Q75 Jeremy Wright: It would not need to be a high court judge.

Tom Luce: It would not have to be a high court judge. As I understand it, in Northern Ireland, where they are restructuring the service, there is to be a high court judge who is going to be responsible for the judicial practice side of the coroner jurisdiction but I think there will be somebody else who is responsible for what you might call its “management and administration”. As I read the Government’s proposal for England and Wales, it looks as though some of those functions will be held by the same person. I am a little bit uncertain about this: they have not been very explicit about it. It is question of somewhere between circuit court and high court judge. I would guess, but I am not an expert in such delicate matters.

Q76 Jeremy Wright: On the issue of independence from central government?

Tom Luce: I think that is a point, if I may say so, with respect, very fairly raised. My view of the matter would be that the coroners’ service is a rather complex hybrid service. It is partly judicial, in the sense of conducting inquests or other investigations of that kind which need judicial impartiality and skills; it is partly what I would call a regulatory responsibility. It is more like dealing with casework, which requires some management and some experience and background which is not judicial. It has this in common with the probate service, which is a mixture of the two. I do not think there is any harm in the Chief Coroner being responsible to central government for the administration and management of the service and for its performance of the standards of interaction with families that are expected of it, for example, and I do not see why that would necessarily interfere with the judicial independence of coroners themselves or the Chief Coroner in reaching decisions on individual cases. It is quite well known in public administration that people can perform statutory functions in an independent manner and yet still be accountable for their use of resources and for the administration of their service.

Q77 Dr Whitehead: You have already mentioned in your evidence to us this afternoon about the question of the appointment of not just the Chief Coroner but coroners in general through the Judicial

Q72 Jeremy Wright: You mentioned a little earlier on that it is important to have somebody in charge and of course your report recommends the appointment of a Chief Coroner, as well as an advisory Coronial Council, which is something that the Government has taken on board. In your view, is it going to be di the appointment of a Chief Coroner, as well as an advisory Coronial Council, which is something that was adopted. I do not actually see that adopting that approach would be inconsistent with leaving local authorities with a role in the support of the coroners’ service.

Q73 Chairman: And increasing the size of police authorities as well, to which originally you thought you could hook the coroners’ jurisdiction.

Q77 Chairman: I think we had in mind that something like a senior circuit court judge might be approximately the right level.

Q78 Chairman: The Government proposals that we have are not set out in very much detail, so it is di way. The Government proposals that we have are of achieving consistency of standards and independence of coroners themselves or the Chief Coroner in reaching decisions on individual cases. It is partly judicial, in the sense of conducting inquests or other investigations of that kind which need judicial impartiality and skills; it is partly what I would call a regulatory responsibility. It is more like dealing with casework, which requires some management and some experience and background which is not judicial. It has this in common with the probate service, which is a mixture of the two. I do not think there is any harm in the Chief Coroner being responsible to central government for the administration and management of the service and for its performance of the standards of interaction with families that are expected of it, for example, and I do not see why that would necessarily interfere with the judicial independence of coroners themselves or the Chief Coroner in reaching decisions on individual cases. It is quite well known in public administration that people can perform statutory functions in an independent manner and yet still be accountable for their use of resources and for the administration of their service.

Q79 Dr Whitehead: You have already mentioned in your evidence to us this afternoon about the question of the appointment of not just the Chief Coroner but coroners in general through the Judicial
Appointments Commission—with which of course the DCA have not agreed, but they have said that “procedures for appointments will be more robust and . . . in line with national guidance.” Do you think that a similar sort of standard that you had envisaged, perhaps through the appointment of coroners through the Judicial Appointments Commission, could be achieved through a combination of local appointments and national guidance?

**Tom Luce:** Possibly it could. I should have thought the most certain way of achieving it was to put the appointment responsibility into the hands of the Judicial Appointments Commission. I suppose one could conceive of arrangements under which the appointments made by local authorities under guidelines that the Judicial Appointments Commission or some other equivalent body has set out, and with perhaps some representation of the Chief Coroner on the Appointments Committee. I recall from my days in the Department of Health that there used to be regulations on the appointment of hospital consultants which required that certain interests should be represented on the Appointments Committee. I do not see why, if one wants to go down the route of local authority appointments, there should not be something of that kind in this field. Of course, the more you consolidate the coroners’ jurisdictions into large jurisdictions, the greater will be the number of individual local authorities that would claim a stake in each appointment. If you are going to provide, under regulations or in some other way, that the Chief Coroner or the Judicial Appointments Commission should have one or more people on the Appointments Committee, then you risk getting into larger numbers than would be convenient. But those issues have to be faced and I think it is very important that there should be a mechanism through which national appointment standards can be clearly and beyond question brought to bear in the appointment, whichever type of authority at the end of the day is responsible for signing the appointment decision.

Q78 **Dr Whitehead:** You also made recommendations about additional training for coroners. The Government have suggested that substantial parts of that training are already being implemented, are in train, and that training, which is not I think compulsory, is provided by DCA currently. Do you think the Government is right, that in many ways they are implementing what you have suggested?

**Tom Luce:** I can only speak for what I observed when we were doing the Review which was completed three years ago. I am therefore not a competent witness on anything that might have happened since. It was certainly not the case that three years ago there was adequate training of coroners. First of all, there was no requirement that any coroner, either at first appointment or subsequently, should attend any form of training whatsoever. Secondly, the training that was available did not seem to me really to be training. I would regard it as a fairly modest example of continuing professional education. It seemed to me quite inadequate really to the task that needed to be addressed. I think there needs to be systematic training in the approach to bereaved families, human rights issues, and some diversity issues. There also needs to be training perhaps in some managerial aspects of the emerging service, of which there has been very little so far. I would not accept that as of three years ago there was anything approaching adequate training for coroners and there was no requirement for them to undergo any kind of training or orientation at the time of the appointment. The position of the coroners’ officers is even worse. There was very little training indeed. It was absolutely down to the local authority or the police authority as to whether they provided any or if they paid for their coroners’ officers to go on any and most of them, so far as I can make out, did not. I think most of them, particularly, frankly, the police authorities, could not be relied upon to do so for the future because it is so low down their list of priorities.

Q79 **Dr Whitehead:** I take it as a reasonable inference from what you are saying that you would favour a mandatory scheme of training.

**Tom Luce:** Yes.

Q80 **Dr Whitehead:** To be implemented, perhaps, rather than with just an instruction or a suggestion to local authorities to get on with some training, on the basis of a national framework.

**Tom Luce:** I would have thought that most of it had to be provided through a central framework. That is not impossible to do with the sort of structure the Government has in mind, provided they are willing to finance it, because I do not think that local authorities or police authorities are going to pay significant amounts of money to send their coroners’ officers or their coroners off on training courses or that they are going to pay anything towards the cost of their absences, that is to say, providing cover and so forth. I think that it has to be provided centrally. I think it would be quite a good idea if the Judicial Studies Board were involved in some of it but otherwise the Department for Constitutional Affairs could either provide it or could put some other organisation in funds to provide it if that seemed the best thing to do but I feel that it will have to be centrally financed.

Q81 **Dr Whitehead:** There two areas in relation to families where the DCA did accept your recommendations. First, the recommendation for a Family Charter to govern the coroner’s interaction with bereaved families, and also the recommendation that families should have additional rights of appeal. Could you outline how you think a charter—and obviously that would depend on what was to be in the charter—would improve the treatment of bereaved families?

**Tom Luce:** The Home Office did produce a model charter for coroners. I think it actually stemmed from the Citizens’ Charter Initiative that was taken
by the then Government in 1995–96. I think that probably did have some effect on the climate of opinion in which coroners’ services were being provided. It covered issues like being sensitive, so far as was reasonable in a particular situation, in relation to diversity issues, and, in particular, the objections that some religious groups or members of religious groups have to delay in burial and to autopsies. It covered issues about providing information to bereaved families about what was going to happen in the process of a coronial investigation. It did suggest that coroners should give bereaved families help towards getting bereavement counselling if that is what they needed.

The problem is, at the end of the day, that it is a piece of paper, and if a particular coroner does not want to do it or his or her local authority does not want to pay for it then there is nothing that anybody can do about it. The recommendation that we made was that the new coroner legislation should give somebody, the Chief Coroner or the responsible Government department, a statutory power to issue guidance which would have some kind of statutory force. It would, in particular, mean that if a particular coroner departed from the guidance they would be under a legal obligation to show good cause for doing so. It would not necessarily tie everything up, it would be a kind of bureaucratic centralisation. It would permit variation but it would mean that the coroner could be under an obligation to say why he or she had departed from some provision of the charter. In a particular situation, there could be good reasons for doing that. That is what we had in mind. The references to something of that kind in the Government’s proposals of February look to me to be reasonably encouraging, although in that respect, as in all others, the devil lies in the detail, and when the Bill comes forward it will need to be carefully scrutinised. Also, if and when the legislation gets into Parliament and goes through Committees, I take the liberty of suggesting that there should be close scrutiny of the way in which the Government intends that the various order-making and regulation-making powers should be used and what they will cover, and perhaps going back to what I was always taught when I was a young civil servant was good practice which was producing draft regulations and draft codes of practice so that the Legislation Committee can see what the Government has in mind to do.

Q82 Dr Whitehead: Perhaps that could be something we could adopt on a wider basis than coroners’ courts. Thinking about the question of the treatment of bereaved families and the Family Charter, and, indeed, the recommendation that has been adopted that families should have additional rights of appeal, do you think that tips the balance perhaps unwisely towards the role of families in the process of coroners’ courts? For example at the expense of other benefits of the system to public health and safety, or perhaps in terms of the additional appeal rights—appeal rights, but at the expense of tying up resources and causing additional delays and generally encouraging circumstances under which there might be, for example, unfounded vexatious complaints?

Tom Luce: There is always that danger with any kind of appeal or review process. We were very struck by the fact that as things stand the only way in which a family that is dissatisfied with the coroner’s administration of a case can challenge that is by judicial review. That is in practical circumstances more or less impossible to do on a short-term decision, not to mention the expense and the very high threshold that litigants have to get over in judicial review proceedings. We thought, so far as we could see, that it was one of the very few areas of public administration without any kind of review process. We thought that was quite wrong and did need to be put right. I very strongly believe that to be so. It is important, in my opinion, not just in relation to a family’s rights of appeal or to obtain a review of the decision but much more widely in terms of the role of bereaved families in death investigations. It is important to bear in mind the concern there has been over this in recent years, though undoubtedly justified and undoubtedly correct, is a bit of a shift of emphasis from the traditional way of looking at these things, where the possibility of misconduct or neglect or even abuse or homicide within the family was always something that had to be borne in mind. The last decade or so has seen a lot of concern and rightly so about abuse or worse by insiders to healthcare systems, but we should not lose sight of the fact that there is always a risk of abuse or neglect or worse within families. I think that the coroner has a difficult job, in that he or she has to keep these two things in the balance, but I do not see that simply the creation of an avenue of local challenge of administrative avenue of local challenge means that the whole system is going to be too much skewed towards the rights of bereaved families. The most important perspective—in some ways the most important way of seeing this service—is that it is a posthumous service to the deceased. In a way that is not much different, and often not different at all, from it being a service to the bereaved family, but it can be different from a service to the bereaved family. I think that is an important perspective on matters, and it does include things like the preventability of deaths, the public health issues that are very important to the coroners’ service.

Q83 Dr Whitehead: Do you think there should be a backstop, with the new Chief Coroner having the ability to dismiss frivolous vexatious complaints?

Tom Luce: If a complaint is thought to be frivolous or vexatious, it will not be successful.

Q84 Dr Whitehead: But it could be pursued at considerable length.

Tom Luce: There is always that danger. They can be pursued even if there is not a proper complaints’ avenue, and sometimes they are. You do not necessarily stop that by declining to create a proper complaints’ avenue—indeed, I think in some ways you provide a better and clearer way of dealing with this.
Q85 Dr Whitehead: In your report you suggest what might be seen as an alternative avenue, which is the question of consulting and keeping families informed as he process is undertaken and you recommend that maybe some additional training in that respect might be required for coroners and their staff. Who would you envisage providing this training?

Tom Luce: I think there is a variety of people who could have a helpful contribution to make. I should say that all these things are easier said than done, and conducting a fruitful and fair relationship with deeply distressed people is something easier to write about than to do. But there are psychologists who are very experienced and helpful in these matters and there are support groups whose members have been through these experiences on the receiving end and have helpful things to say. They had helpful things to say to us and I know that they are active in the training of coroners and the training of police and so forth. There are one or two people behind me in this room who have been very active and dedicated in that sort of way, so there are skills and perspectives that can be drawn on.

Q86 Dr Whitehead: Should bereaved families, do you think, have access to better legal representation if they are perhaps to better participate in the way that we have been discussing?

Tom Luce: Our recommendation was that the legal aid rules governing the representation of families at inquests should be reviewed, so that it should be easier for bereaved families to get legal aid support when they met the income test for legal aid support in cases where other participants in the inquest had their legal costs publicly funded. For example, if a police authority or a health authority is involved in an inquest, its legal costs will be met by its budget, which is a publicly tax-financed budget. We thought that it was unfair for private individuals facing an inquest in those circumstances to be without legal representation if they could not afford it. That said, we did not think that if there was going to be an issue about financial priorities for the reform of the service this should necessarily be the top priority. In fact, we felt that it should not.

Q87 Dr Whitehead: As far as the resources in the system are concerned, you do recognise in the report that there was a general lack of resources in the current system. Do you think, taking that into account, the current DCA proposals will relieve the pressure on resources or do you think they will increase that pressure?

Tom Luce: There is no doubt in our minds that in parts of the country the coroners’ service has been running on a shoestring and it has not had the same attention to its resourcing that all other significant public or judicial services have had in recent decades. We did try to do some costings of our own recommendations. We found it very difficult because all the money that is spent on the coroners’ service is dissipated in a whole lot of different budgets and nobody had at that time ever brought them together. We did try to bring them together and we thought that you could probably meet the extra costs of what we were proposing—which went significantly further than what the Government is now proposing—if you increased the resourcing available to the service by something of the order of 10% to 15% and if you made some efficiency savings in the service, particularly perhaps by containing the number of autopsies. The other thing we thought was necessary was to reflect in the public financing of the new service the savings that would come to private families from not having to pay cremation certification costs, which amount in England and Wales to something like £30 million a year. That is private expenditure. We thought, if you were going to have a death certification system that dealt adequately with all types of death, whether the body is to be buried or cremated, you would have to compensate for that saving in the public financing of the service. It is not clear what the Government intends to do about death certification.

Q88 Chairman: We will come to that in a moment.

Mr Luce: There is a gigantic hole in that. We do not know enough about the detail of what they are proposing on the reform of the Coroners Service to know exactly how far the £4 million or £5 million of extra money that they are proposing would go but my guess is that there would obviously be some new central costs around the creation of a Chief Coroner’s Office. There would be some costs, a Chief Medical Adviser, they say some extra money will be available for getting local medical advice to coroners and maybe they envisage that some of that money would go on central training. Without knowing the details, it is impossible to know how adequate that is. In fairness, it does not strike me in a ballpark sense as necessarily being completely out of scale with what might be needed.

Q89 Dr Whitehead: Again, doing very simple arithmetic, you would suggest that a figure of perhaps up to £7 million to £12 million might be appropriate and yet the Government is suggesting £5 million. Is that a fairly wide ballpark?

Mr Luce: Yes, but theirs is structurally a less ambitious reform.

Q90 Dr Whitehead: On the question of the fact that the structural reform is not so ambitious and they have essentially kept a service at local level, albeit with some lack of clarity about how the reduction in numbers of coroners might be achieved in terms of who pays for the coroners at the moment, do you think the, what you might say, confusion at local level in terms of who funds, whether it is police or local authorities, who has what priority where, may undermine the integrity of any additional funding and, indeed, the destination of additional funding that might be proposed?

Mr Luce: It is very hard to know through what channels they would be intending to spend this £4 million or £5 million, whether it would be some central finance or some of it might simply be put into the general local government finance settlement which would, in my opinion, mean that probably
none of it would reach the Coroners Service or maybe they are thinking of some kind of earmarking. I do not know. I think there is a serious risk that the implication of your question is correct, that if it is not tied down very carefully it might never reach the destinations it is intended for.

Q91 Dr Whitehead: A police authority, for example, could receive some of this money and then decide that it does not want to fund the Coroners Service in this particular area. What would happen then?

Mr Luce: If it is given out in the general block grants to local authorities and police authorities, they might decide that it was not consistent with their priorities to improve coroner officer training.

Q92 Dr Whitehead: It could be a good way of raising additional money for other local services.

Mr Luce: Yes.

Q93 Chairman: Let us turn to death certification because ministers in the Department for Constitutional Affairs seem to have gone against the Home Office proposition which was already on the table, against the Shipman Inquiry and against your Review in not having reform of death certification as part of the reform of coroners. Does this concern you or do you accept their implicit view that the whole thing would be disproportionate, that the two stage certification process is just an expensive luxury?

Mr Luce: It concerns me very deeply and I find it difficult to know how exactly to read such references as there are to death certification in the February document. There is a brief reference to the fact that the Government is already taking initiatives to improve patient safety and so forth which might lead one to suggest, or lead one to think that they intend that some of the initiatives they have taken since 1997 in that sort of area—quality control of health service provision, and of general practice and of patient safety generally—are directly relevant to the very serious issues there are around death certification. If that is what they think, they will no doubt have an opportunity to explain in evidence why that is correct.

Q94 Chairman: They should say if that is their intent.

Mr Luce: Yes. There are all sorts of environments in which people can die and they can be certified as having died natural deaths when they might have been subject to abuse or neglect, for example in nursing homes or residential homes which have got very little to do with health service provision anyway. Then there is this reference to, as they put it, “the possibility of wide-ranging change is not excluded in the long-term” which led me to think that was written by Sir Humphrey Appleby. I find it extremely disturbing that there appears to be this hole in the Government’s thinking. Maybe there is some intention to come forward with fuller and more satisfactory proposals, but nothing of that kind can be gleaned from what they have said so far. It is a very significant retreat from the proposals they made in 2004 which though not absolutely consistent with either the Shipman Inquiry or our own proposals seem to me to be sensible proposals which should be supported. It is not clear whether they intend to clarify these matters at the same time as they are proposing Parliament should legislate on coroner reform. It seems to me absolutely essential that at the very minimum Parliament should be enabled to consider the whole area of death certification and coroner reform and should not be asked simply to deal with coroner reform with some vague possibility that the issue of death certification might in due course be recovered from the long grass. I feel this is the most serious issue to come up around their proposals. One of the reasons why this is so is that it seems to me that an absolutely essential part of the reform of the Coroners Service is to make sure that the critical link in the chain, which is the process of the cases being referred to the Coroners Service, is working properly. If you continue to have death certification which is conducted outside the Coroners Service, as they are planning to do, there has to be some mechanism for ensuring that those cases which ought to be referred to the coroner are being referred to the coroner. If that is not done, I think that there will be a very serious issue about the integrity of the whole process and the degree to which the public can have confidence in it.

Q95 Chairman: In structural matters, obviously you have been prepared to take the view that half a loaf is better than no bread and that the reform is worth proceeding with even though it lacks any structural element, which you think is desirable. In this instance, do you think it might be pretty dangerous to go ahead with the proposal without death certification being involved because it could give a false sense of assurance? As Dame Janet has said, she sees no basis on which the proposals, as presently drafted, would prevent another Shipman case from occurring and, therefore, it would be a pretty deplorable failure to address what was seen as a serious problem.

Mr Luce: I think it would be a deplorable failure. At the time of the publication of the Shipman Inquiry Report, and indeed of our own report, the Government gave commitments that the issues raised in these two reports would be very seriously considered. So far as I can see, in 2004 it looked as though they were fulfilling that commitment but it looks to me as though they are not fulfilling it in terms of death certification. I would rather not give a direct answer to the half a loaf is better than any bread. I would respectfully like to offer the view that Parliament would not tolerate the Government getting very far with legislation that had this gigantic hole in the middle of the road.

Q96 Chairman: On autopsies, we talked a little about this matter earlier, there is one situation which has been drawn to our attention which is when family members disagree about whether an autopsy should take place. Do you have any view about how that can be resolved by the coroner or by the courts?
Mr Luce: It can certainly happen. There can be a whole set of issues on which families disagree around the administration of a death investigation. They are very difficult for the coroners. I must say that we formed a good impression of the common sense and sensitivity with which such disputes were often dealt with in the Coroner’s Service and, to be candid about it, we did not think that we had anything to offer them which they did not already possess.

Q97 Chairman: What about the information that is gathered from medical examinations? Is there some way in which this could be brought together, perhaps through a national Chief Medical Adviser or in some other way? It is argued by some that a lot of information is generated in these cases but it is all in separate coroners’ jurisdictions.

Mr Luce: That is absolutely correct. I think that there is a very big public health and public safety gain to be made by bringing together the product of a lot of these death certifications by re-angling some aspects of the death investigation towards preventability and, in particular, in terms of conduct of inquests getting rid of the rather unhelpful framework of these verdicts which have been inherited, accidental death, unlawful killing and so on and so forth, which are not very helpful in terms of preventability. I think it should be part of the function of the Chief Coroner without producing gigantic bureaucratic analyses to bring out the public safety and preventability aspects of their work from time to time. I think that would be a great gain.

Q98 Dr Whitehead: In your report you have recommended that inquests should only be public in form where that is required in the public interest. I think the Government have also accepted that some public inquests should be limited, for example, in the case of suicide or child death. Other organisations suggest that child deaths should always be in public. Do you think the question of public interest should be an individual coroner’s discretion or should there perhaps be an attempt to provide a statutory definition of what “public interest” might consist of in terms of how those decisions might be reached?

Mr Luce: I would hesitate to suggest that it should be done on the face of the primary statute because my experience is if you try and do that it would not quite serve the purpose after the first few months. I think there ought to be some kind of practice direction from the Chief Coroner about the use of public inquests. I am not suggesting that he or she should necessarily do it in the first week after appointment but it is something that I think should be done after there has been a certain opportunity to look at emerging patterns in the new service. We certainly thought that it was unnecessary to publicly inquest what some people call domestic suicides. It is relevant that the Government made proposals for the reform of the registration service which would increase the privacy attending information on the cause of death, which at the moment if anybody dies it is possible to pay a fee to the registration service, and find out whether the death certificate mentions AIDS or alcoholism or whatever. The Government made what seemed to me to be very good proposals for changing that in the registration system. I am not sure whether its proposals now stand. I think in some ways the same principle should apply in the inquest. If there are good reasons for keeping information of that kind private, I see no reason why it should be made public unless there is an overriding public reason to find out the cause and circumstances of death. For example, quite a lot of suicides have, in the background, issues of mental ill health and I can see no particular reason why they should be necessarily ventilated in public unless there is some particular reason for doing so.

Q99 Chairman: What is the point of making a family wait nine months only to have a pathologist come along and say “There was a diagnosis for this, I have done an autopsy and the asbestos related cancer was present”. We were also doubtful as to whether the automatic inquesting of all traffic related deaths was necessary. I know this is something that does divide opinion. Quite a lot of people, although not all people, concerned with the position of families bereaved by traffic related deaths felt that if you have an inquest it does bring home to the public the risk of dangerous driving and it might increase the chances of pinning something on the perpetrator. We never saw much evidence that was true, unfortunately. I think that is an area which needs to be carefully looked at. We found it impossible to say how much the inquest rate would be reduced but we did feel that it was a very important part of the reform to reposition the public inquest away from deaths where there was no significant likelihood of finding anything of extra value from the public process towards those deaths which, at the moment, it is not necessarily very good at dealing with because the inquest has narrow bounds and because it is not adequately resourced. Hence you get in certain types of situations, like after multiple deaths in a railway fatality, automatic demands for public inquiries because it is thought that the boundaries of the inquest are not going to be adequate to go into the causation. We thought it was important to reposition the inquest further in the direction of looking at contentious, complex and multiple fatalities and move somewhat away from looking at
individual deaths where the circumstances were pretty clearly known, but not to the extent of depriving a bereaved family of an opportunity for a proper process when there is some grounded anxiety about the circumstances of death.

Q99 Dr Whitehead: I want to touch on the question of inquests in multiple deaths in a moment. If the consideration of public interest is left to an individual coroner’s discretion as we have discussed and, as you have recommended in your report, that management decisions themselves might be subject to appeal, would that perhaps not risk some lengthy delays as a result of appeals on the fact that there is not to be a public inquest and perhaps media appeals being pursued at great length resulting from those management decisions?

Mr Luce: There can be such appeals now and there have been such appeals. Maybe if you had tighter processes and a set of criteria there might initially be some challenges to those, but I would guess that would die down fairly quickly and that overall there would be a benefit from the improved clarity.

Q100 Chairman: We are now having a division in the Commons. There are a couple more things we want to ask you, but I do not think it is fair to hold you back for a quarter of an hour and then resume. If we might write to you about a couple of specific points which may arise, we will do so. May we thank you for what has been quite a marathon session and for all the help you have given and express the hope that a lot more of your report gets attention as the legislation is prepared and considered in draft. 

Mr Luce: Thank you very much, Sir.

Chairman: Thank you.
Tuesday 13 June 2006

Members present:

Mr Alan Beith, in the Chair

James Brokenshire

David Howarth

Keith Vaz

Dr Alan Whitehead


Q101 Chairman: A warm welcome to you, Mr Round. I am sorry that it is quite literally so, but our air conditioning system is not that impressive on a day like today. This is not an apology from me, but somebody should give you an apology for the fact that you are being asked to give evidence in front of this Committee when the Bill was only published yesterday, and although we were able to make a certain amount of information available to you following our own protests to the Department, the Committee is not happy that the parliamentary process should be impaired by Bills not being produced when they were promised and when the Committee is carrying out an investigation. So we produced when they were promised and when the process should be impaired by Bills not being produced when they were promised and when the Committee is carrying out an investigation. So we quite understand any difficulties you might have of not having got round the detailed wording of the clauses.

Victor Round: I am grateful for that, sir. I think it would be disingenuous of me if I did not admit that I have had a day or two, at least with the outline.

Q102 Chairman: Let me provoke you with just an opening question. Why do we have to have coroners at all? Scotland manages without them, has fatal accident inquiries in very few cases—nothing like the number of inquests we have—and leaves the Procurator Fiscal to carry out any investigations that may be necessary if it is a criminal matter and to assist the family if they wish to have, for example, medical reports. There is not the perception there that you need to have an open judicial-style process for most instances of initially unexplained death. Why do we need it in England?

Victor Round: I am not 100% sure, sir, if one were writing a system from the ground up, that I would recommend a judicial-style inquiry into every unnatural death. It is rather a more a question, now that we have it, that people would be bitterly resentful and suspicious if we removed it. That is a terribly pragmatic answer, I know, but one of my own deputy coroners had to fight for years to get an inquiry into the death of her husband in Scotland, and it was a campaign by a lawyer which took several years to get the inquiry even to start, and we are by no means impressed, I regret to say, in Scotland they inquire into quite as much as they should. Had it not been that that particular widow was a deputy coroner, I very much doubt whether the discoveries would ever have been made. So I think, frankly, they are too selective. I notice Mr Luce said that before you on the last occasion as well.

Q103 David Howarth: I have a couple of questions about the draft Bill, in so far as you have been able to work out what it is saying. First of all, under the draft Bill the coronial system essentially has to remain local in terms of appointments and resources, but built on top of that there is going to be a new national government system headed by a Chief Coroner. Do you think that will be an effective system, particularly in terms of accountability?

Victor Round: No. We have doubts that a national Chief Coroner, he or she—can I just get that out of the way and say “he” from now on—whom we welcome completely; it is a splendid idea, but we have doubts whether they are going to be any better at winning an even supply of resources than we have been. There really is a postcode lottery about resources. Well over 30 coroners now struggle to get a court in which to sit for an inquest at all, and the number is rising steadily. That is to do with local authorities’ ability to supply. So unless in some strange way the Chief Coroner is able to even out that supply of staff—two of my own officers have no office. They stand in the mortuary and literally, they have nowhere to sit and type or anything else, and this is not unusual. I do not have an office. I work from home. I have no office at all or office staff. These things outside the cities are quite common, yet my local authority is really rather good to me compared with many. I do not see how the Chief Coroner is going to solve that problem.

Q104 David Howarth: So your preference would be for a national system?

Victor Round: We did rather hope to see a national system. We had almost got to the stage of assuming it would happen, and so we are a bit shaken to find that we still have the old battles to fight.

Q105 David Howarth: The draft Bill also introduces new provisions on the commencement and the discontinuance of coroners’ investigations and the duty to hold an inquest. Could you just give us your view on comparing the new regime with the existing regime in terms of the bureaucracy that a coroner would have to negotiate during an investigation, and a number of investigations.

Victor Round: It is one of the good things in the Bill, I think, sir, that they really have simplified the legal support for the work that has got to be done and removed a lot of the stupid anomalies. That is some of the really welcome material. This important distinction there used to be between is this an inquest inquiry or is it not an inquest inquiry, which made
vast differences to our ability to fund and investigate and everything else has all been removed, and I am sure that is to the good. It is one of the very good things in the Bill that logical approach to the job that they have built in there. I am sure it is a bit hard for them, but it always has been possible, with a sympathetic approach, to somehow survive the absurd legal technicalities and lighten the load for them while trudging through them themselves. So it is nice for us to have them removed. Whether it will actually feel very different to families I rather doubt.

Q106 David Howarth: Will it increase the number of inquests?

Victor Round: They stay the same, as I understand it, sir. It was noticeable in the February briefing note that there was a proposal that certain inquests, and they mentioned specifically domestic suicides and matters of that nature, might not receive a public hearing. It is very noticeable that that has been dropped from the Bill, and I confess, like my predecessor Secretary of the Society, I was rather keen on removing some of those inquests, and publicly so, and I know Mr Luce was before you previously, but I think I have changed my mind. There is this issue of transparency and an awful feeling of cover-up. It is such a wonderful way to defeat conspiracy theories and fears of cover-up to say “It is a public hearing. You do not have to come along. I will read your statement instead if you like, and even you as a family do not have to come. I am still going to do it in public, and you can change your mind and drop in at the last minute if you want to.”

On reflection, we rely on that very heavily, and it may be that it is much better that you can see what we are up to, to put it simply, so I have actually changed my mind.

Q107 David Howarth: In the light of that, the government is estimating that there will be about 60-65 full-time coroners under the new system. Do you think that number will be sufficient to cope with the number of inquests?

Victor Round: I am sure it will not, sir, because inquests are getting longer and longer, and I am not complaining about that but the burdens of making the necessary inquiries dictated by Article 2 of the European Convention of Human Rights has made, for instance, an inquest into a death in prison that might have taken three days now be quite likely to take three weeks, and that has put tremendous pressure on to court accommodation, on staff, and on back-logs; some of us are reeling under them now, and really quite frightened about the future. We did think this new national service would solve this problem, and it has done nothing for it at all. I am quite certain 65 will not be enough, but of course, they have provided a fallback that we could use part-time assistant coroners, and if we use enough, one could still also maintain a rural service.

I am sorry if I am jumping on a hobby horse, but I am a shire coroner, and it is a very different viewpoint. I think I saw the Minister saying in your House “We will have coroners travelling rather than families.” So coroners can travel out, even though there will only be 41 jurisdictions or whatever. There are two problems with that, with respect. The first is that the coroner is then sitting on a car seat instead of sitting on an inquest, and the second is that all those courts we used to travel out to have been shut. It is like cottage hospitals. It is the same situation. It may be a good thing but it does not provide us with anywhere to go. So 65 coroners, 41 jurisdictions, is really the death knell of any kind of local service. We may just survive in some of the rural areas by having part-time coroners helping out from their local practices. It is really quite hard to get across. Some coroners in Wales actually have to drive the night before to a bed and breakfast in order to be in court in time in the morning to start the inquest, and it is a bit hard to envisage until one actually sees it happening.

Q108 Chairman: Who is going to take the jobs of full-time coroners, bearing in mind that there is only a limited number of full-time coroners at present and a large number of part-time coroners, most of whom are in private practice as solicitors and might very well take the option of returning wholly to private practice, since the cross-subsidy, if I can call it that, of having the coroner’s business in their offices would disappear, unless they are appointed as one of these part-time coroners? Presumably the authorities are going to have to look elsewhere for their full-time coroners than from the existing pool of part-timers.

Victor Round: That must be so, must it not, especially when you consider that the DCA are aiming to reduce the structure to 40 or 41 jurisdictions, some of which will have two full-time coroners and some one? A lot of the people with present expertise will simply not want to move hundreds of miles, not be able to abandon a practice, and I am very concerned that a number of them who currently sit on tribunals of various sorts will simply increase their tribunal work, and leave the coronership completely. I think there could be a great big ability gap and I quite accept that appointments must be open to all ultimately, of course, like any judicial appointment, but somehow—and I do not see that any provision has been made for it—the experienced people have got to be kept on board long enough in the interim to keep the system going, and I do not see any provision or discussion even of that at the moment.

Q109 Dr Whitehead: I would like to ask you a question about the dog that did not bark in the Bill, as it were, and that is the apparent silence on the face of the Bill about any change in the relationship with the coroner and the local authority, and indeed, no change in as much as what one might call the fudge of the relationship continues, but with a Chief Coroner who is clearly not related to the local authority system. Do you see the silence in the Bill as
a merit for the future or do you see particular problems with the continuance of that unclear relationship?

Victor Round: I do think there are going to be problems. There are going to be the existing problems with that unclear relationship. I saw a briefing paper from the Local Government Association saying it ought to be all with the local authority and they will control and monitor it direct on the one hand, or all with the DCA on the other hand, and they seem to be uncomfortable with this fudge. That is very alarming for us, when you think that they are our suppliers of money and people, that in a sense they do not really want us on these terms, and we feel unwanted on these terms, very much so, even though the odd personal relationship is sometimes quite good. I have to be a bit discreet about particular cases but I know of three examples where local authorities—and in one of those cases, the local authority’s—own operation in relation to looking after somebody who has died is under question by their coroner—and they have fallen out with the coroner about the money spent on that inquiry, and so I find the idea of us being totally responsible to the point of being monitored by local authorities quite unacceptable, because we would not be remotely independent, and although this “HM Coroner” phrase sounds terribly old-fashioned and the idea of an office to which one has some sort of freehold title is obviously out-dated, that appointment as HM Coroner is what we present to the families as “We are not in the pocket of the local authority, and don’t worry, they can’t dismiss us if they don’t like what we’re doing,” and if it is ever removed—and of course, it is in the Bill at the moment, the bald provision that the office will be removed, and nothing is said about what will replace it—then we will be less independent, and that does worry me. Simply working for a local authority who do not want one and until you shout about resources do not even really notice that you exist is very bad for morale.

Q110 Dr Whitehead: Would you say there is an even greater potential than hitherto of local authorities and perhaps police authorities, where they are providing some or all of the funds, saying in the future “We provide the money. We are not satisfied with the degree of accountability there is. Therefore we won’t provide the money” or “We will try and attach strings to the money” in a way that would de facto place accountability for your work in the hands of local authorities?

Victor Round: I have never come across specific strings being placed, I must admit, but it takes an awfully strong personality to go for a particular local authority department and then at the same time go cap in hand to another department in the local authority saying “I need this much extra money to do this inquest in which the local authority is involved” and indeed, the High Court have on at least one occasion had critical things to say about a local authority that literally did that. They have a duty to indemnify us for what we spend and in some cases, we have even been in the bizarre situation of lending money to a coroner because of the financial difficulties he was in because his local authority would not pay up. We literally lent the money, which is a bizarre situation.

Q111 Chairman: You had a whip-round of other coroners, did you?

Victor Round: We lent the money out of the Society.

Q112 Keith Vaz: The new Chief Coroner is going to be something of a superman or superwoman, having to deal with a huge amount of responsibilities, looking after all the coroners, dealing with training, dealing with complaints, trying to sort out appeals and, apart from all that, he or she is going to have to report on a regular basis to the Lord Chancellor, and maybe even having to give evidence to our Committee. Do you think this is a reasonable workload for one individual?

Victor Round: I am sure it is not, sir, but I understood it differently. I thought that that Chief Coroner was going to have a number of assistant Chief Coroners to do, if I can call it crudely, the leg work, dealing with a lot of the appeals and that sort of thing. I thank you for that list. I think there is another item that the Chief Coroner will have to do that just has not been envisaged yet. At the moment, unlike all the other judicial officers, we supply our own information, case law, case support, updating system and all that, again voluntarily. It is done by the coroners’ Society, and we do it out of our own subscriptions to the Society, which are repaid by the local authorities, but we do it ourselves. The Chief Coroner, who is the one who will be setting standards and keynotes and giving information, will surely be the one to do that. Nobody is really the boss of coroners at the moment. It is a mixture of me and the President today and various other secretaries in the Society. We use the website that way, but we would have no place doing that; the Chief Coroner would have to run it all. So he would have to take that on as well.
Q114 Keith Vaz: The draft Bill also contains a new and much wider definition of interested person. How do you think that these interested people will affect the way in which the investigations will be progressed, especially if they disagree as to how the process should pan out?

Victor Round: They do it now from time to time, sir, so we are used to handling disagreements between interested people, and we console ourselves with the thought that these people are all obviously properly interested. Who would want to exclude them? But at the moment we have the assistance of two things. We have the natural emotional hierarchy in a family, which tends to elect a boss, a leader, a family spokesman, and if it is a split family maybe two of them, but we cope with that regularly, and also then the legal hierarchy provided by the Administration of Estates Act and so on. That would appear to be removed by the Bill, as far as I can see, and one of the additions really alarms me, and that is the friend of long standing. How a friend of long standing can be equated as a properly interested person with members of the family mystifies me completely. A friend of long standing to look after the deceased’s interests because the family do not care would be a splendid thing and of course, we would welcome it, but the Human Tissue Act has, if you will forgive the phrase, a pecking order, a hierarchy, and that is recent legislation on the subject. I would have thought one could almost adopt the pecking order in the Human Tissue Act, otherwise you do, I am afraid, particularly with mental patients, have friends of long standing popping up all over the place, and nowadays we say to them, “Look, the friend of long standing, etc.”

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Q115 Keith Vaz: Do you think that the volume of appeals are going to increase as a result of the regime set out in the draft Bill?

Victor Round: I think “increase” is putting it very mildly, sir. The range of things that can be appealed, which witness one might call, what questions you could put to that witness, whether that witness will have the right to refuse to answer questions as self-incriminating, that whole range of things, because of the way it is currently set up and not restricted in regulations, would be able to stop inquest after inquest in mid flight. That does not happen in other courts. What happens in other courts is that you say to your clients—or I did when I was in practice—“Wait to the end. You may still get the result you want, so this won’t matter then.” PMs I accept are quite a different business; whether or not you have a PM needs a quick response, but so often the things that are vitally important or feel vitally important to people on day one or day two of an inquest diminish into nothing when you get to the verdict, and at the moment it seems to me the Chief Coroner system could get flooded with appeals very quickly indeed.

Q116 Keith Vaz: One of the bizarre descriptions of what happens at the DCA, which is a pretty bizarre department, as far as I can see, is the way in which coroners are currently trained, which seems to be

Q117 James Brokenshire: Just following on on that issue on training, obviously, you have talked about the pressure that would be put upon the Chief Coroner in terms of time and also the time that would need to be freed up from existing coroners. How would you see that actually working in practice? It is all very well for the Chief Coroner to set out standards and to set out perhaps the issues that a coroner should be trained on, and if you do not literally have the time in the day to do the work that you need to do, how do you find the time to do the training?

Victor Round: Again, I think it must come back to delegation. Having seen the job as it was written, I had envisaged that there would be a number of Assistant Chief Coroners, one of them would be Assistant Chief Coroner, Training, another might be Assistant Chief Coroner, Appeals, and so on. Unless it is divided up that way—and I think it was envisaged it would be a High Court Judge as Chief Coroner—I cannot imagine us having the benefit of enough High Court Judges’ time to cover it all.

Q118 Chairman: You do not need a High Court Judge to organise training though, do you? You would have a Director of Training.
Victor Round: I do not see a problem, sir, unless I have misheard your question, with the High Court Judge directing what the training should be and coming and making keynote speeches and so on, but I am quite sure he or she would not have time to get down to the detail. But if he or she could turn to an Assistant Chief Coroner and say, “Now, you sort this out with the Judicial Studies Board”, make attendance at training courses compulsory, introduce something like continuing professional development with points or whatever it is, and introduce massively more training than we have at the moment. But we cannot do it any more. We really do not have the time.

Q119 James Brokenshire: Is there also another resource issue here? To actually find the individual coroners at the local level, their time, they would need presumably to take time away from their general duties, you would therefore need to have assistant coroners deputising for them, and there is a cost implication in that which will presumably need to be borne by the local authorities in that circumstance, given that the existing system is to be retained. What sort of impact do you see that as having in terms of actually implementing proper training on the ground?

Victor Round: It is a problem already, which is why virtually all our training is done at weekends, because we cannot get away from work, or rather, we cannot get coroners to attend during the working week, and the only way we can get them away from their jobs is to say it is at the weekend, and then they come. In fact, we are just experimenting for the first time with trying to train coroners during the week, and we are wondering whether they will leave their desks to come and do it. It is a very new thing for us. Otherwise it has always been arrive Friday night, leave Sunday afternoon, and then straight back into inquests on Monday morning—unpaid of course and without a break, and you will find, sir, I think that the same problem applies to coroners’ officers, because police forces do not like to release coroners’ officers for training courses because they then have to put somebody else in place. It is exactly the same problem. There it is not so much the money as the actual able man- or woman-power to put in place. Some local authorities are very good about letting us pay deputies while we go off on courses and things, because other courses we have to go to are not at weekends, but our own specific training courses are nearly always in our own time, for that reason.

Q120 James Brokenshire: From what you have said, obviously, with new people likely to come into the service in terms of fulfilling the full-time coroner’s role, training is going to be quite an important issue.

Victor Round: It is, sir. What happens at the moment is sometimes quite bizarre. There is nothing like new blood, and it really does improve the strain; there is no question about that. But one or two appointments from outside the coronial service have been made by the local authority and then they say, “Where do I go for my training now?” “Oh, well you might get a place on a training course for four days in six months’ time. Meanwhile, you start your inquests in a few weeks.”

Q121 James Brokenshire: Let us move on to another issue, and perhaps the glaring omission from the Bill, which is in connection with death certification. You will be well aware of the Luce Review, and its recommendations that there should be a direct link between death certification and the coroners service. You will no doubt be aware that Dame Janet Smith has also been quite trenchant in her comments on the fact that there should be this inextricable link between death certification and the coroners service.

The Home Office originally seemed to take that on board but clearly these provisions contained in the Bill make no reference to that whatsoever. What do you think will be the consequences of this decision?

Victor Round: If I could start by saying I also notice, sir, that Mr Luce on the last occasion referred to that absence as a great hole in the road. I think we have to mention Dr Shipman at some stage. These reforms, with respect, have just nothing to do with the Dr Shipman problem at all. They do not impinge upon it at any point. One reason why they cannot is that nothing has been done about modernising the death certification system. It is dropped behind us. I remember one of you asking on the last occasion something like “Is it worth going on with this bit?” given that death certification is not being modernised and tied up at the same time? I think the answer is since we are reviewed or re-analysed every 30 years cyclically, and it really has in the last century been that, and nothing happens, we had better just take what reform we can get, even though we know that the death certification system does render us much less able to do the job. There is no statutory definition of what doctors or registrars must report to a coroner. That is a headline lack. With respect to things that have been said about improving matters by training coroners, it really is no help at all to be brilliantly trained if you do not know the particular patient lived or died because nobody has reported the matter to you so you cannot apply your skills to the case anyway, and we are still in that situation.

Q122 James Brokenshire: I was quite struck by what you said in terms of the impact of this Bill being the death knell of a local coroners service. Do you think that that therefore increases the risk of a Shipman-type incident, because coroners are more taken away from the local level and therefore are not likely to be plugged into those local networks and therefore will not detect even a hint of whether there may be a problem?

Victor Round: It would be so tempting as part of my campaign to latch on to that, sir, but I do not think it is quite fair, because the real eyes and ears of coroners are actually their officers, their all-important coroners’ officers. As long as their strength is kept up and their morale is kept up and they are trained and improved, those are our eyes and ears, and so as long as they are locally available to families, I think it would be unfair to pretend that,
just because the coroner is miles away, families will not be able to communicate with them. We had this plan—we were so excited about it—that we would create a one-stop shop where the family could come in with their paperwork and if it suddenly turned into a coroner’s case, it would be all right; behind that door is a coroner’s officer, maybe not working for the registration service, maybe working for a totally different unit, but as long as the family see it as all in the same building, and they can get rapid access, maybe that does not matter too much. One could get there eventually alongside this legislation and I think that would solve the communication problem to some extent. As long as there is good local access to groups of coroners’ officers who are themselves in close touch with the coroner, families should be able to communicate their concerns about a particular death.

Q123 James Brokenshire: Your response is heavily caveated on, in essence, the retention of good coroners’ officers at a local level. Do you think that there is any risk as a consequence of the changes that have been put forward in this Bill that that might change in some way?

Victor Round: Yes, sir, oddly enough, not so much because of the changes in the Bill as because of the lack of changes in the Bill. Who can blame the Local Government Association for saying, “Look, are we providing this service or are we not? We are sort of half in, half out.” Then they have exactly the same situation vis-à-vis the police, where some police forces take the view “We will provide coroners’ officers. It helps our CID side enormously. It means we have our ear to the ground. We can pick up on all sorts of drugs deaths and drugs information.” The new untoward incidents in hospitals inquiries that they conduct and so on are much better done with police-employed and involved coroners’ officers, to my mind, but there are a few areas where coroners’ officers are supplied in whole or in part by local authorities. Very few local authorities are willing to take that on and I know coroners are now faced with the two most important people to us of all, the local authority and police, arguing about who is going to provide and finance the people we rely on to work with. We are in this strange situation of directing their day by day work, they are our eyes and ears, but we do not pay them or supervise them. We have no controls over them. We are entirely on our own. The lack of change in the Bill—it does not even name coroners’ officers, as far as I can see. So it is not the changes introduced; it is the failure to introduce changes that will, I think, really endanger the continuance of the bit of pride they have built since they have formed a Coroners’ Officers Association on their own and so on; a bit of self-worth will be bled away again.

Q124 James Brokenshire: So it is almost like an indirect impact that might highlight the lack of changes on the death certification side, and whilst it is indirect, it might actually exacerbate the need to have stronger provisions in death certification to avoid something like a Shipman type case.

Victor Round: Yes. There is another avenue, of course, which does not get mentioned very much but one of the plans—and I think it was implicit in the Fundamental Review, and it certainly would have been in Dame Janet’s Shipman plans—was that there would be one body release system, whether burial or cremation, which we for historical reasons do not now have. If that system were enormously strengthened and trained, then one could see the beginnings of some part in the medical examiner checking system. We wanted that. We wanted to be able to turn to them for help and send families to them and everything else, and if society does not want to spend the money, or cannot recruit the doctors, so be it, but in some way something has got to be done because registrars do not quite know whether to refer cases to us or not, and they do not have the training or the expertise. Crematorium referees do but their staff do not. Doctors themselves at the moment are untrained in death certification, and have been for 30 years, and they do not know what to report. There is just a possibility, I suppose, that in regulations under the Act one might be able to name reportable deaths; I do not know. It is a very big hole at the moment that still doctors do not know what to report. If this were passed tomorrow, they would know no better than now what to report to us.

Q125 James Brokenshire: Therefore, if the doctors do not know what to report, other people do not know what they should be reporting and therefore there is still a big gap out there about people who might manipulate and use the system.

Victor Round: Mr Luce’s hole in the road is still there, yes.

Chairman: Mr Round, thank you very much indeed. In only 40 minutes I think you have demonstrated the value of pre-legislative scrutiny by Select Committees, with their witnesses giving them such good help.
withdrawal of their questions, making sure that no vital aspect is missed.

Chair: It is a bit of a steamroller cracking a nut sometimes, in that it involves a whole series of procedures which may be absolutely essential in some sorts of cases and entirely appropriate, but cumbersome and perhaps even distressing in a lot of cases where a more limited and informal inquiry might be sufficient.

Witness: A service to the public is a what local government would see as being the starting point. If you say “Do we need this service?” well, maybe not that service but we need a service, and you are right to say “How does it have to feel for everybody?” Not everybody needs the really intense end of investigation. Everybody needs a service, and we in local government would certainly see the customer care end of that as being one of the most important aspects for us, to make sure that it is seen to be done properly but that it does it in a way that people feel comfortable with.

Chair: From a coroner’s officer’s point of view, we are the interface with the families, with the bereaved, and I think the bereaved actually do get a lot of reassurance when we are involved. We can then explain to them what the procedures are going to be and what inquiries we are going to make, and I think it is the appropriate questioning, the questioning that the coroner’s officer gives to the family, and the appropriate investigation or inquiries that we make for them that gives them the reassurance.

Chair: No. You have heard some of the concerns from Victor Round about the fact that there is a lot of lack of clarity about the roles and responsibilities of various people in the system, and so there is a real need, I think, for a major piece of work to try and clarify those issues. I know coroners’ officers spend a huge amount of time answering queries from doctors themselves as to what they should be saying, as to whether they can issue a certificate. I do not know whether you are aware that doctors can issue a certificate without actually seeing the body. So there is a big problem about all sorts of people involved in the system. The roles and responsibilities are actually unclear. The system only really survives because of the seriousness of it and the fact that on the whole, people will try and do their best in the circumstances, but for instance, the responsibility of people who attend the scene of a death, the responsibilities of the ambulance service, the doctor, the police officers, on the whole are fairly unclear. So in terms of that issue about death certification, what is necessary is a whole-system approach and as many safeguards as possible. That comes from a good system of data capture, data analysis, and opportunities for families and other people to raise concerns. As has been said, the coroners’ officers play a vital role. They are the foot soldiers here. They know who are the doctors they deal with. They know the suspicions and the circumstances in which they need to ask further questions, but it is really about having a number of safeguards within the system, and really, even if there were, for instance, two doctors each time for a death certificate, yet that was still done on the basis of just a paper exercise, clearly, that would not be much of a safeguard. I think a lot more work needs to be done to be absolutely clear about what are the processes and what are the situations in which a doctor can issue a certificate or not. The system has to rely on doctors on trust in the medical system. At the end of the day, you are relying on a doctor to give an opinion one way or the other, unless you are going to do a post mortem and toxicology in each case. So really, where we are disappointed is that there is still a need for much more detailed piece of work to actually clarify the roles and responsibilities. I think also, to deal with that issue the Chairman asked about the steamroller to crack the nut, well, actually in some cases, yes, a lot of the processes probably could be simplified and clarified but we need to do that piece of work because the problem is, as is
outlined in the reports, that there is a huge variation in the way that the coroners service operates across the country.

**Q129 James Brokenshire:** It certainly sounded from the evidence given by our previous witnesses that a lot of the pressure falls on the coroners’ officers and that that will obviously remain post the implementation of this new structure. I do not know, Mrs Hurst, whether you have any comments on what you use in terms of the current practical situation and the implications of what this might mean moving forward, given that in essence nothing is changing here.

**Christine Hurst:** That is basically it. I do not think there would be any move forward at all. The Coroner’s Officers Association believe that all deaths should be reported to the coroners service and we agree with Dame Janet Smith that it would go some way to remedying the defects within the death reporting system, but that would also enable the coroner’s officer to make appropriate inquiries with the doctor, with the bereaved and with all parties concerned, thereby giving them the opportunity to raise any concerns that they have. We also think that if all deaths were reported to the coroners service, that would also eliminate any doubt that doctors have as to what cases should be reported to the service. We also believe that if you have a system where every death is reported to the service, it would alleviate a lot of alarm and distress that some families feel when they find that their loved one’s case has actually been referred to the coroners service. It can be quite alarming for them, and we have to spend quite some time reassuring them why we are involved. I think the reporting of all deaths would also facilitate a programme that could be interrogated, and that then would highlight any anomalies and detect any trends, and maybe the likes of Shipman might be brought to the fore a lot sooner. I know at the present time in my own area we are looking at a number of nursing homes and sooner. I know at the present time in my own area we are looking at a number of nursing homes and we are focusing on that particular nursing home.

**Q130 James Brokenshire:** Obviously you heard some of the comments that Mr Round made in his previous session, and the points I was probing as to whether inadvertently the lack of change and some of the tensions that exist at the moment might exacerbate or make the problems worse in some way. Would you share that view or would you have any other comments?

**Christine Hurst:** The Coroner’s Officers Association really did want some change, and we are very disappointed in the lack of any change really with regard to coroners’ officers. We are now, I think, losing a lot of experienced officers, and there is no formalised training for officers. The COA in partnership with Teesside has formulated some accredited training courses but there is no support for the officers to go on that; there is no resilience in the service for them to be allowed to go on that. There are a lot of problems, and we are getting experienced officers now leaving. There are only about 450 officers in England and Wales dealing with 232,000 deaths, so it is quite a heavy workload that officers have. I can only see that, if we are losing experienced officers because of the poor morale that they have now and the lack of support by some employers for them, with resourcing and training, then it has got to impact. We will have new people coming in, they are not going to be trained, and that has got to have an impact on the bereaved. So yes, I think lack of change.

**Q131 James Brokenshire:** I do not know if your colleagues from the LGA have anything to add in relation to this, whether you have any comments on what you have heard.

**Steve Charteris:** Peter raised a fundamental issue that seems to be avoided in the draft Bill, the issue of the tripartite relationship between the coroner, the local authority and the police. The clarity in the responsibilities is essential for the service to move forward, and this does not seem to assist. It seems to leave everything to local agreement where that can be achieved. We can see nationally that this has always been the case, and some areas have managed to develop local agreements but others have not.

**Q132 James Brokenshire:** I am sure we are going to come on to probe some of the structural arrangements in all of this. One interlinked point relates to the provisions that are contained in the Bill which seem to give the power or the right for a coroner to report a matter to a person who has power to take action in relation to a particular incident, and indeed also to report facts on to the Chief Coroner. You might suggest that that may be a way of trying to raise alarm bells in some way if there is some problem that has been identified. Do you think that that type of approach—I will direct this to you, Mr Fahy—goes far enough to meet ACPO’s concerns about the use of information generated by the coronial system for public health and safety purposes?

**Chief Constable Fahy:** I am not sure there is enough clarity behind that particular proposal to be absolutely sure. What has happened is that really, over the last 10 years the whole world of partnership working at local level has developed enormously, and the point I was trying to make on the evidence really is that the coroner is not connected really to that at all. So at the moment he can issue recommendations and write letters and actually nothing happens. It is a huge opportunity missed. There are all sorts of issues which could be looked into in terms of particularly things like deaths from domestic violence, deaths from drug overdoses, obviously child deaths, where there could be important lessons learned which are not being fed into the system. So I think it needs to be a bit more structured than the way it is termed in the Bill to make sure that there is, as I say, a more robust process, making sure that we are learning those lessons and that there is clarity about how the coroners system feeds into all these different streams, local area agreements, safer and stronger
communities groups and, as I say, this huge network of partnership working which has evolved and which at the moment the coroner is completely outside.

Councillor Rudkin: Directors of public health in the health system where we had health authorities and PCTs would make annual reports that would have exactly those sort of flavours towards them. There might be some particular trends with child deaths that local authorities could pick up on and could certainly do something with and could learn and could actually spread good practice amongst themselves. There are models already in the partnership working that has been described where we do listen to people who would talk to local authorities which might have been avoided and say, you know, these are things we can do collectively, but I do not see how this . . . and coroners could be vital in that. It could be very helpful to everybody but I do not see how that actually fits into this. For health, for example, there is health scrutiny that exists, so local authorities can scrutinise health bodies and learn lessons, and there does not seem to be that kind of accountability. Steve was saying about accountability; we do not feel that that is embedded in this in a way that could be useful and practical to everybody.

Q133 James Brokenshire: Just to follow that through, because in essence, the key word here is “may” it is not “shall”. Certainly, from my understanding of the way that fatal accident inquiries operate in Scotland, at the end of the inquiry what would happen is that the sheriff would actually specifically report on precautions by which the particular accident might have been avoided and any defects in the system that caused or contributed to the death. Would you welcome something actually being physically codified there so that in essence coroners are required to set their minds to that type of approach so that it is actually on the record and therefore the information can be used whether it is reported on or not?

Councillor Rudkin: I think, yes. I would be guarded in so much as it goes back to the questions you were quite rightly asking about training and wanting to make sure that there was some kind of standardised approach so that one did not have a maverick coroner going particularly down one alleyway with one issue. But if there were to be some regularisation of training and approach, I can see that there would be value in highlighting certain trends and actions, and again, that is where good practice comes in, so that if you knew somewhere else somebody had made a recommendation that was of use, you could pass that on, and it would seem to me that that would also be part of training, sharing good practice and improvement. I can see the merit in it, yes.

Chief Constable Fahy: It is hard to underestimate really the huge amount of material that coroners actually gather. For instance for every fatal road accident there will be a huge file and a huge amount of evidence about that particular accident. In a lot of cases it will not go into the criminal court system for various reasons, and I think it is opportunities like that that are sometimes lost because the coroner is perhaps not tied into all the other work the various agencies are carrying out on road safety in general. That is some of the weaknesses. We are just too close to a judicial approach to this. It has got to be very firmly, I think, a lessons-learned approach, where the coroner is able to connect into the different agencies and to try and make sure that lessons are being learned, and could be in a powerful position to knock heads together to make sure that is actually happening.

Q134 James Brokenshire: Obviously, the Chief Coroner has a role in collecting information from the regional coroners under the new system that is proposed here, so there is quite a lot of data, as you have rightly highlighted. How do you think that needs to be used or shared or in some way passed on in order to have some of the wider public health and safety issues that you have rightly alluded to in terms of things happening on the ground?

Chief Constable Fahy: I personally see that happening at a national level as quite difficult. I have to express some confusion about how it links into all the other systems collecting data in things like accident and emergency departments, where clearly they will collect huge amounts of data as to how accidents are caused and injuries and things like that. I think the value of that role is more actually at a local level. There may be some national trends to be picked up but it is probably more about how agencies are working at a local level in terms of perhaps picking up people that may have problems with depression that may lead to suicide, or issues about the agencies not working together well enough on road safety issues, whatever it might be, to the way the agencies are working together to try and prevent deaths in domestic abuse. That is more likely to operate at a local level but really at a high enough local level, shall we say, which again is tied into the partnership working. That is difficult, because obviously everything is changing in terms of local government and police and everything else, but certainly at the moment, at the sort of county level, certainly in shire areas, which at the moment is where most of the key agencies join up.

Councillor Rudkin: We do have models of sharing good practice. I absolutely agree about the local. I can think of a local road safety issue in Suffolk, which is very particular about a road where there had been a spate of accidents, and what we do locally together, fire service and other agencies, together, but actually, local government is getting better about sharing good practice amongst itself. The Local Government Association takes a lead role in that. So whilst there are some things that are local, the local can become of national use in terms of informing on a different area, and we are getting much, much better about being ambassadors for ourselves and helping each other, and I would see that kind of local knowledge being translated into national use elsewhere as being a key to actually getting more added value from a coroners service and collecting all that data that you have referred to.
Q135 James Brokenshire: Obviously, this all comes down to time and resource and also maintaining that local link, but in essence what you are telling me is it should be very much bottom up in terms of the use of the information rather than top down.

Councillor Rudkin: Ultimately, though, it could save lives and therefore it could save money to all sorts of parts of the system. Therefore, although it has a cost, I think we would also want to take on that challenge of eventually turning that round, so that in fact there were fewer deaths in some of those areas we talked about. That has got to be a better and more efficient use, apart from also the human cost, that has to be better for everybody.

Steve Charteris: The coroners are nationally feeding a lot of different information into different agencies. I know in Hertfordshire we are feeding that information into suicide audits. There are lots of different forms of information that we pass to other agencies. It just feels as if there is no national approach to that. I know recently coroners expressed concern that they were being asked to supply data to so many different agencies and the time constraints, etc., were causing problems. There is information being passed, but it is not nationally organised.

Q136 Dr Whitehead: The Government in the Bill is suggesting that there will be additional costs of the new system, particularly with the new responsibilities for maintaining proper accommodation for coroners, for example, and they have suggested, I think, that estimated costs will come to start-up costs of £14.5 million and additional running costs of £5 million per annum. How do you see that from the LGA's point of view, particularly in terms of those costs falling on local authorities, whether or not the Government agrees with the approach because I also think that gives an account that people recognise and understand and is there. But I think you have hit the nail on the head in as much as what we want is something that

Therefore there have been deficits. I have seen evidence of deficits in my own region. We must take responsibility for that but it is actually a part of the system about waiting for change really. We would certainly want to question that. We will look in more detail at those figures, and we would be happy to come back with what our members say, what our constituents say.

Q137 Chairman: Are you going to do serious cost estimates on what the Bill proposes—not your idea of what the perfect system would be but what the Bill is actually proposing—bearing in mind that, as I understand it, quite a lot of the part-time coroners have an administrative support system which is really on the cheap, because it is a part of their practice offices, and if you were to set up an office wholly devoted to a coroner’s duties, new costs would be involved? On the police side not all costs are charged out to coroners. Therefore, there is quite an exercise to do, which your two organisations are probably best placed to do.

Councillor Rudkin: Indeed, and there is an awful lot of—the Chief Constable in Suffolk described it to me as not so much good will but custom and practice in terms of the money that the police in Suffolk have put into it, and at any one time a police authority could turn round and say, “Actually, we are not going to do that any more.” We are all under budget pressures.

Q138 Chairman: Or “You are going to have to pay us for it.”

Councillor Rudkin: Yes, quite, and I have to say that with the amalgamation of forces and the review that is going on, I have no doubt that in looking at the base budgets of different constituent authorities that there will be some questions asked if it is found that a particular authority has a particularly generous kind of arrangement and somebody else is giving not very much. This will be part of the discussion, frankly.

Q139 Dr Whitehead: So bearing in mind that there may be quite a lot of additional expenditure which you are not too clear about the funding of, and indeed, I think ACPO has in its evidence to this Committee suggested there ought to be a clearer form of funding upon local authorities, your evidence to this Committee suggests either that the coroners service should be brought fully into the judiciary or should be integrated as part of a local authority. I presume on the lines that accountability should follow financial responsibility. Which of those do you think is the preferred outcome as far as LGAs are concerned, if you had an ideal clean sheet of paper to write a draft Bill?

Councillor Rudkin: I suppose for the LGA we would have to say that, as we do believe in local delivery of service and this bottom up approach that was used, I would personally want to go for the local authority approach because I also think that gives an accountability that people recognise and understand and is there. But I think you have hit the nail on the head in as much as what we want is something that
is clear and is obvious and in terms of the finance is something that we can be accountable for and we can control. I do not mean that in the control freak sense of the word but in so much that we would have greater powers than we do over the moneys that are spent. My board has not discussed this so that is just my personal view but on the basis that I think we are into local service delivery. Given that it is local authorities with the police with the kind of partnership working models that we now have, which are now complex and sophisticated but actually very good and very good for the public, I think that is what I would welcome.

Q140 Dr Whitehead: Do you think there might be a concern that should coroners’ officers effectively be directly accountable to a local authority system, where the coroners’ office is investigating a death that has occurred perhaps of someone in local authority care . . .

Councillor Rudkin: I think there would be proper checks and balances. At the moment, if there would be a death that would need another social services authority, for example, to investigate, we already have those kinds of checks and balances, as indeed do the police when investigating anything that involves one of their own, and I think with proper recognition of those factors, that is not insurmountable.

Q141 Dr Whitehead: The Government has said in the Bill that local authorities should be represented on the Coronial Advisory Council. Does that impress you much?

Councillor Rudkin: It sounds like I ought to be impressed, does it not? I think we would still want something a little more real than that. We would rather have something directly there. We understand that is an advisory body representing a broad range of interests, and I do not know quite how we would feel that that was enough, frankly.

Q142 Dr Whitehead: The Government has also in Part 4 of the draft Bill, within the new governance system with the Chief Coroner, included investigation of complaints which could result in a referral to the Office for Judicial Complaints. Do you think that perhaps could go part of the way towards meeting some of the concerns that you are expressing?

Councillor Rudkin: I think it is a bit out of touch. If we are wanting people to have the one-stop shop kind of arrangement where everything is dealt with in one place, as was referred to, I think, again, a complaints system that is a different complaints system to others, because actually people’s complaints are usually very complex, are they not? They are not going to relate to just one part of a service. I think we would want to have something that was a better and simpler governance structure and that made more sense to people who are bereaved and therefore need things to be as simple as they can be for them to negotiate.

Q143 Dr Whitehead: On the matter of bereaved people, do you welcome the provisions in the government’s draft Bill about arrangements for involvement of those bereaved in the coronial system and do you think perhaps in terms of what you have already said about the efforts local authorities have made to achieve a greater degree of co-operation between providers in different parts of the system that that perhaps could be something that could be a genuine way forward as far as local authorities are concerned?

Councillor Rudkin: I think we need to make it better. Anything that makes it better for bereaved people . . . As a local councillor, I have been in County Hall when bereaved families have arrived, and I have been ashamed, frankly—not of the way in which they were handled, but, if you like, the system that there was. There was nowhere even for them to have a cigarette because we have a no smoking policy in the building, and just a real lack of understanding of what facilities people require. I think that anything that makes it easier and better for people in what must be the most difficult of circumstances has got to be an improvement. My colleague here from Hertfordshire can tell you that they have done a lot to actually look at that customer care end. There is good practice out there about what people are doing to make sure that people have a better experience—one that nobody would want but that it is a better experience and that their engagement and involvement is meaningful to them. That is a bottom up thing, is it not? It is not just about saying “You have been involved but how meaningful was it for you to have been involved and is it part of your grieving process and helpful to that?"

Q144 Chairman: If you, any of the three bodies represented here, do some work on costings, the Committee would be very interested to see it.

Councillor Rudkin: We are good on cost. We have done the licensing costings and we are very used to gathering information from our body. We would be happy to do it.

Q145 Chairman: Did your estimate on licensing prove near the mark?

Councillor Rudkin: Please, do not ask.

Q146 Chairman: Just a test of your credentials in these matters. I want to turn to a number of matters relating to coroners’ officers. The ACPO position is that you would like to see a national solution involving a transfer of many of the inquiries into sudden deaths carried out presently by operational police officers to coroners’ officers. Does that not have the problem that many cases of sudden death, suspicious circumstances, are only uncovered as a result of proper investigation, and that some police forces regard this investigation of sudden death as a core function, not one to be transferred?

Chief Constable Fahy: We will be very clear. If there is any suspicion about any death, we would want to be told immediately, and whatever happens, we will still have a heavy involvement in sudden deaths, in terms of deaths in the street, all sorts of cases, but
there are lots of other inquiries into cases like suicide which at the moment are passed from the coroner’s officer to operational officers to carry out those inquiries. It is in those sorts of cases that it would be preferable if that could stay within the coroners service. As I say, we would have no problem at all about crossing the gap into criminal activity and absolutely we want to be involved, but I do not actually see a problem with that. It occurs in a number of areas, and this is the difficulty about the differences in the coroners service across the country, but we think overall that if the coroner is directing the inquiries, then he or she should have the staff to carry out those inquiries unless they require that police expertise, but as I say, I would want to be very clear that if there are any suspicious circumstances, we would want to be involved right from the start, and whatever the coroner does, we realise that, as now, out of hours, out of office hours, at weekends, all sorts of cases, police officers will continue to be in many cases the first people on the scene of a sudden death and still have very heavy involvement in those cases.

Q147 Chairman: You normally are the first people on the scene in those circumstances where a body is found. There may be no evidence of anybody else being involved. In the smaller jurisdictions, would I not be right in saying that the coroner might not involve the coroner’s officer at all, because all that would do would be appointing another of your officers to take over the information which the first officer on the scene has obtained and therefore many of the coroners in the smaller jurisdictions would rely on your officer to do the whole thing?

Chief Constable Fahy: Yes. In a lot of cases that will still be the case. A police officer will have attended, will have got the basic information, will have done the identification, will have filled in the forms, and will then pass to the coroner’s officer . . .

Q148 Chairman: The coroner’s officer in a smaller jurisdiction may be another police officer who is actually . . .

Chief Constable Fahy: Even in the bigger jurisdictions it is often another police officer, certainly somebody employed by us. It is distinct roles. Obviously, in the ideal world, we would prefer the coroners service to have a 24-hour service so that they turn out to all these sudden deaths, because we end up having to go to things like death on arrival at hospital. If somebody is brought in dead on arrival at hospital, then often a police officer will have to attend to do the identification, to notify next of kin, to deal with any property, despite the fact that that hospital is full of medical staff who we feel could be doing that job themselves. But we have to do it because there is no doctor there that can issue a death certificate. We have to be realistic about the finances that are available and that there is not going to be a new coroners service that is going to take on that sort of responsibility and that will still lie with the police service.

Q149 Keith Vaz: The draft Bill talks about the improvement of standards in the service, but it makes very little changes to the circumstances of the coroners’ officers themselves. Were you surprised at this lack of tinkering with such a central figure in the relationship between the bereaved and the service?

Christine Hurst: Certainly the Coroner’s Officers Association were very disappointed, and I would go so far as to say dismayed really at the lack of recognition of the role of the coroner’s officer, which is quite an important role with the families—a very important role with the families. We are the interface with the families, as I mentioned before. The lack of any comment with regard to coroners’ officers has taken us somewhat by surprise, to be quite honest, because we had hoped that the system would be reformed and that coroners’ officers would come under a unified national system that would give us the pay and conditions and the appropriate recruitment and resources to do our job and also with sufficient officers to manage the workloads that we have and, most important of all, a standardisation of practice as well.

Q150 Keith Vaz: Chief Constable, do you agree with that?

Chief Constable Fahy: Absolutely. Coroners’ officers play an absolutely vital role. It is not a job for a police officer. It increasingly requires a very high level of medical expertise to understand the medical certificates, to be able to question doctors, to be able to answer questions from doctors. It really is a very, very skilled role. So it is more than just dealing with families; it is a vital role, and the system is extremely ramshackle across the country. It is a mixture of police officers, retired police officers, police staff members that we have been able to employ, but it is incredibly ramshackle and has only really survived because of the fact that we have kept on being told by government that they are going to sort it out. This has been really for the last seven years, and so police authorities have just kept on trying to support the system because we believed that the Government was going to sort it out.

Q151 Keith Vaz: So it is a missed opportunity.

Chief Constable Fahy: Well, I do not think we can afford to miss the opportunity, to be quite honest. I have already had discussions with the Local Government Association and we are going to take this forward in any case, because we cannot afford to miss the opportunity. The coroners’ officers are too important. There are training issues which need to be sorted out, and also this key issue about there is a lot of work that needs to be done on just clarifying the roles and procedures and trying to make sure that we capture the best practice across the country to try and make sure that the system is working as efficiently as it possibly can.

Q152 Keith Vaz: Cllr Rudkin, do you concur?

Councillor Rudkin: Absolutely. I think there is good practice. We do need to share that, and the disparate nature of how it has operated, even within one county, where we now in Suffolk have one coroner
but we used to have four, with different standards, different terms and conditions, and it just is not simple for people to understand and follow. I am meeting the Association of Police Authorities tomorrow and high on the agenda is the discussion about the reform of the police service and how that fits back into it. This is the point at which we have to discuss it because if other things in the jigsaw are going to be altered, then we have to discuss it now otherwise we will lose that opportunity.

**Chief Constable Fahy:** London has seven coroners’ districts. I have just been talking to a colleague from the Metropolitan Police and each one of those works in a slightly different way, so they cannot actually use their staff to move between those coroners’ districts because the practices are different, and that clearly is very unsatisfactory.

**Q153 Keith Vaz:** Now that the Government’s policy is clear, do you foresee any of your various employers providing more resources to help with this system?

**Chief Constable Fahy:** The police authorities’ view would be that we are facing reductions in other areas. On the whole, we have tried to preserve the number of coroners’ officers, under some pressure, and I regularly get calls from coroners asking me to intervene with various chief constables to see if I can persuade one of my colleagues to release more. So I do not think, with all the other pressures that you will be well aware of on the police service, we can say that we would put in more resources. On the other hand, we do think there are a lot of opportunities to try and run the system in a more efficient way.

**Councillor Rudkin:** Local government finance is in the same position. We do try and do things differently and more efficiently and we have taken on best value and all sorts of other agendas as well, and we do try and use the money that we have as creatively as we can, but I think we would be hard pressed to find any more.

**Christine Hurst:** By leaving coroners’ officers as they are, we believe the DCA has lost a real opportunity to modernise, standardise and professionalise death investigation, and one of the comments before with regard to coroners’ officers taking over the role of police officers at the scene of death, yes, I think that is perfectly feasible, but we need more staff to do that, we need appropriate training to do that as well. At the moment officers do not get any formalised training at all. It is on a shadowing basis whereby the new coroner’s officer is taught by the outgoing coroner’s officer, so there may not be any will or commitment there for that coroner’s officer to pass on any good practice. There may be poor practice, and that is promulgated basically down to the new officer. It is a downward spiral, to be quite honest. Unless we get appropriate training and resourcing, I cannot see that the service could cope with that.

**Chief Constable Fahy:** I would also point out that if you are going to have a system which is going to have more appeals and more active encouragement for the public to raise concerns and complaints, clearly that is going to generate more workload, which will inevitably fall either on police forces or on the coroners’ officers themselves.

**Q154 Chairman:** The issue of training, of course, will become the responsibility of the Chief Coroner, will it not?

**Christine Hurst:** The Coroner’s Officers Association are not quite sure about that. I think the Bill does not say anything about it being responsible for training of coroners’ officers. We are in a situation at the moment where we are employed, but we are not owned, if you like by the same employer as the coroner. The DCA at the present time has said that they cannot influence any of our current employers to provide us with more resourcing, to provide us with training, and I cannot see, as we will not come under the Chief Coroner, how he or she will have the power to say to our employers “You must do this” or “You must do that.”

**Q155 Chairman:** He might have the power but not the resources. The power to provide a training programme. That would be a question of releasing people to go on the training programme.

**Christine Hurst:** That is another thing. The fact is that we are in very short supply, our workloads are very heavy, our inquiries are far more complex than they used to be, there is lack of support and officers are now actually feeling stress and leaving the service. That is putting an even bigger burden on the coroners’ officers service.

**Q156 Chairman:** Here we have a situation where everybody agrees that the system needs reform, all the witnesses we have seen today think that the Government’s proposals do not go far enough to meet the various requirements for reform, the existing funding bodies, local authorities and police, do not have any more money to find for it, we all know that the DCA’s budget does not have any more money to find for it, so we are embarking on a very necessary reform inadequately because we cannot afford it. I do not see where we go from there unless we can find offsetting reductions in costs by running some parts of the service in other ways. Is this not a doomed exercise?

**Christine Hurst:** It would appear so to me.

**Councillor Rudkin:** We would try to be more positive. It is like licensing again. The challenge is there to do something better and to do something differently, and I think with more flexibility, and I would say this, if local authorities were to have more power, they would be in a position to look for some of those savings and to make some of those efficiencies. We have done them in other parts of local authority services, because we have had to and because it has been a good thing anyway, but we feel that this does not actually give us those hooks and those controls. We work much more closely with the police these days. Local area agreements mean that all parts of the service, including the hospitals—I was horrified to see the costs that are charged by
hospitals for storing bodies. There have to be better ways of us negotiating some better deals with our health partners.

Q157 Chairman: Some jurisdictions own their own mortuary.

Councillor Rudkin: Why not? We could do things like that if we had more control. This is why I referred to control. Those are the things that we could explore. But we feel that does not actually give us the opportunity to do that, and therefore, to maximise the resources that we have. That is the disappointing thing, because, you are right, we could set up mortuaries. That was exactly the question I asked, “Why aren’t we doing this?” when I was shown the figures in Suffolk, because it seemed to me to be—not a business opportunity but something we could do that would benefit people. If we do not have that power and that control, then we cannot.

Chief Constable Fahy: I would agree. I personally think there are a lot of opportunities for efficiencies in the system. Some of those would be hard decisions to make but I think there are opportunities out there to do things in different ways. It also would be about, in police jargon, a more intelligence-led approach, to work on the basis of better information gathering and analysis to decide what are the cases that you really need to concentrate on. I think that might be that in certain cases, like certain suicides, there would be fewer inquiries, because at the end of the day, you are never going to work out what is in somebody’s head just before they decide to do something. In other cases, you will probably want to do more inquiries. If there was enough resourcing and support and it was a more intelligent approach, I think there is an opportunity to concentrate resources in the right areas, and I think that would involve things like questioning the need for so many inquests and things like that. There are lots of opportunities. Police officers spend a lot of time sitting around waiting for undertakers to turn up to remove bodies. All sorts of things, with a more modern approach, there would be opportunities, but we need really the DCA to encourage that work and to almost invest in some of that work so that we can see what best practise there is.

Steve Charteris: This is reliant upon local agreements and that is really where it seems it falls down nationally. I know I sound like an advert, but in Hertfordshire we have gone a long way under the current system, and so I do believe that there can be things done to improve the service to the local community, even as the draft Bill stands. In Hertfordshire we had a best value review six years ago which identified the fundamental issue which the draft Bill does not seem to address, which is this tripartite relationship, and who is actually responsible for which part, whether it be the police, the coroner or the local authority. On local agreement, we noted that that was the problem, so to bring coroners’ officers first of all to the local authority, the coroners’ admin staff into the local authority to be employees, base the coroner with all their own staff within the centre, provide court facilities on one location. Those are all steps forward, but it required us having agreements and partnership with the police and the trusts, and having a coroner who was forward-thinking and willing and open to be scrutinised by his own local community for the good of the service, and willing to adopt some practices which are not necessarily what other areas want to adopt at the moment. We think it has been a success. We are one of the few services that have actually allowed ourselves to be externally scrutinised both through the ISO process and also from the bereaved. I think you will not find many examples where we have actually surveyed the bereaved who have been dealt with by our services and learned from that. I think there are things that can be done under the current legislation and also what is highlighted in the draft Bill. But it would assist if the draft Bill had incorporated some guidance on this tripartite relationship, who is responsible for which part.

Chairman: Thank you very much. You have given us anything great deal of food for thought and I hope you have given the Government a great deal of food for thought too. Thank you.
Tuesday 20 June 2006

Members present:

Mr Alan Beith, in the Chair

Jessica Morden
Julie Morgan
Dr Alan Whitehead

Witnesses: Dr Michael Wilks, Chairman, Medical Ethics Committee, Dr John Grenville, General Practitioners Committee, Dr Anne Thorpe, Chair, Central Consultants and Specialists Committee Pathology Sub-Committee, and Dr Andrew Davison, Forensic Medicine Committee, British Medical Association, gave evidence.

Q158 Chairman: Dr Grenville, Dr Wilks, Dr Davison and Dr Thorpe, welcome. I am sorry to have kept you waiting for a moment. I also apologise that you appear to outnumber us. The Company Law Reform Bill is sitting at the same time as this Committee and a number of our Members also serve upon that. But we have retained a group of high-quality Members and we look forward to questioning you. You will be aware of the background to this inquiry. It began before the Government produced its draft legislation which you will have had an opportunity to consider. Perhaps I may start by asking you about it in very general terms from your standpoint. I do not know whether any of you have worked in Scotland. In England we have a coroners system that we are setting out to reform, but Scotland manages without any such system; in other words, it has no requirement for a formal inquest other than in the rarest cases where a fatal accident inquiry takes place. The procurator fiscal simply explores whether any criminal proceedings are appropriate or whether the family needs any help in getting information about how the death took place. That is just a prelude to my question as to whether we really need such an extensive system or we can manage without it?

Dr Davison: You will see from my cv that I have experience of working both sides of the Border. I should like to make two brief points on the Scottish system before I answer the final question. First, there is no 14-day rule in Scotland, which I believe impacts on the percentage of cases referred to the procurator fiscal which is lower than the percentage of cases referred to the coroner.

Q159 Chairman: Just explain to Members what the 14-day rule means.

Dr Davison: Essentially, it means that if the doctor treating the patient has not seen the patient alive within 14 days of that death or they haven’t seen the body after death, they really have to refer the death to the coroner because the registrar probably will not accept a certificate on that basis. That does not apply in Scotland and, therefore, perhaps it gives doctors a little more leeway in terms of providing a cause of death and medical certificate of death without referring the matter to the procurator fiscal. Secondly, in Scotland of those cases that are referred a smaller percentage is submitted for post-mortem examination. That is principally because the investigation is much more detailed in terms of the production of a police sudden death report of which I have experience. In Scotland usually a very helpful three or four-page typed report is provided to the pathologist and procurator fiscal prior to a decision being made about whether or not a post-mortem should be performed. I believe that that decreases the number of post-mortems performed. The more information there is available prior to that decision being made the less likely I think there is to be a post-mortem examination. I believe that those two factors account for why fewer cases are referred and why of that number fewer are the subject of a post-mortem examination. In terms of inquests, Scotland perhaps does not have enough of them. It may be we should meet somewhere in the middle. My figures are old and date from the mid-1990s. They indicate that there were about 140 fatal accident inquiries a year. The figure may now be higher.

Q160 Chairman: It is still a very small percentage?

Dr Davison: I believe so. In terms of England and Wales, I believe that inquests are now up to about 28,000 or so. I believe there is a happy medium here. Both systems have got it somewhat wrong in that in England there are too many inquests and in Scotland there are not enough.

Q161 Jessica Morden: Before we get into the detail, what is your broad view of the Government’s draft Bill?

Dr Wilks: Coming from a position where for decades we have argued for reform of the coroner system, particularly in relation to death certification and cremation, we are a little disappointed. We see this as an opportunity half-grabbed. There are a number of general comments to be made. One is that if one looks at the various reports which have led to the draft Bill all of them have had “death certification” in the title but the draft Bill does not. That is a shame. We go further and say that it is also a shame and a huge missed opportunity not to have integrated into the proposals reform of death certification and cremation certification. We are also concerned that, although the position of chief coroner is welcome, that individual will preside over a system which under the proposals is fairly fragmented. Therefore, the chief coroner is appointed, reports centrally and covers coroners who have local jurisdiction, responsibility and appointment. Within that system there is potential
for the kind of non-communication that we have in the present system which has led to situations like Shipman. It remains to be seen whether co-ordination of these various strands will be possible within a service that is a bit fragmented in its proposals. The lack of death certification and cremation certification integration is to be regretted, although we are not necessarily in support of all the recommendations relating to detailed death certification changes. Although they represent a gold standard they may be difficult to achieve unless resources are put into them, but perhaps we will come to that later. Another comment I make concerns a matter that is not in the Bill but obviously is part of this Committee’s remit: the question of medical examiners and advisers. To us this is very important. We have a general concern that that medical advice will be found out of the local coronor budget. We believe that that may lead to a lack of informed advice and this matter ceasing to be a priority in an already stretched budget, which we note from the proposals would not be significantly increased. Finally, we have significant concerns about where people of the right skills, skills mix, training, authority and experience will come from to act as medical examiners. We have some proposals as to where they could come from, because there is an emerging discipline of forensic and legal medicine in this country which we believe needs significant support. At the moment it is quite difficult to see where people of the right experience and background will come from to provide the cadre of medical examiners as envisaged by the Government’s proposals.

Q162 Jessica Morden: The Government has already stated that it will fund a chief medical adviser for advice and guidance with, as you mentioned, medical assistance for coroners at local level, but it makes no provision for a medical examiner system that is fully integrated into the coroners system. Do you believe that this is an improvement in the medical support that we see at the moment? Do you believe that it is sufficient medical input?

Dr Wilks: I believe that in the context of a medical adviser or examiner having more investigative powers, which it is envisaged the new coroners will have, that has to be a good thing, but I just make the point that the type of skills that a medical examiner would need to have in order to provide proper scrutiny of the process of the review of certification would be an awareness of situations that were perhaps not quite right in the experience of forensic medicine, the judicial and criminal processes and obviously experience in suspicious death. Unless resources are put into training those people, identifying them and developing a specialty in that area there may be some difficulty manning this part of the service to produce maximum or any effectiveness. In recent times the Royal College of Physicians has set up a new faculty of forensic and legal medicine, of which I am very proud to be a foundation fellow. The faculty will be developing training programmes for forensic medical practitioners such as myself on the whole aspect of legal medicine. It might help if the faculty were given some responsibility for helping to grow this specialty and provide advice on the core skills.

Q163 Chairman: One of the matters we have looked at is that in Sheffield, for example, there is a situation where the coroner, his officers and staff and the pathologists are all located in the same building. Is that a model that city jurisdiction, at any rate, could usefully follow elsewhere?

Dr Davison: Perhaps I may deal with that question as the forensic pathologist here. That is an ideal. I think you will have to ask the Sheffield coroner and the head of the Sheffield pathology department whether it works efficiently.

Q164 Chairman: We have asked them.

Dr Davison: It should. In theory, communications should be better if the people are in the same building, although that does not always work. The other important group is hospitals. It would be quite useful if the coroners’ offices and officers were closely linked with hospitals, because a significant number of referrals to the coroner come from the hospital system. That is another area where one can look at close communication and the question whether one has coroners’ officers based in hospitals or in medico-legal centres. Probably the two are appropriate. It was regrettable that the Review of Forensic Pathology Services did not take on board some of the recommendations made in submissions that ideally there should be six to eight medico-legal centres around England and Wales providing, if you like, beacons, centres of excellence around which training could be planned. The idea is that there would be full-time autopsy pathologists within those centres of excellence and coroners might well be linked into them as well. They would be responsible for postgraduate training in pathology, revalidation and the continuing professional development of pathologists in that region. I think it is a shame that the resources were not available to provide those centres of excellence because it might have gone a long way to solving this problem.

Q165 Dr Whitehead: Dr Wilks a little while ago said he was concerned and disappointed that the Government had decided not to reform the death certification system. What do you believe will be the consequences of that decision in terms of the new legislation?

Dr Wilks: I should like to ask John Grenville to deal with that, if I may.

Dr Grenville: I think we are clear that the gold standard would be the automatic referral of all cases to a properly constituted coroner service. That would have the effect of reassuring everybody—the public, the profession and politicians—that deaths are being properly certified, recorded and, where necessary, investigated. That would be the gold standard. We realise that it may not be possible due to resources, particularly money and workforce, but
it would not be too difficult to design systems that did not quite reach the gold standard but took into account the various levels of resources that might be available. We are, however, quite clear that the current system is unacceptable. We need a unified system for the certification of deaths for the purposes of burials and cremations, for instance. I do not believe it is reasonable to have a system whereby burials are subjected to less rigorous scrutiny on the grounds that the body can always be exhumed. I do not believe that that is a reasonable stance to take. The reform of the coroners system as suggested in the draft Bill is good as far as it goes, but without proper reform of the certification system it probably will not achieve its aims. Members of the public and bereaved people will probably still be left with the feeling that there is a gap somewhere in the system.

Q166 Dr Whitehead: The Government has said that it is still considering reform in the area of death reporting and certification. Do you think that in terms of the possible progress of the draft Bill, and presumably its passage into legislation, that uncertainty would undermine the reforms in the Bill as proposed, or do you believe it is possible to continue to consider different reforms alongside those other changes?

Dr Grenville: I have considerable concerns. If one reads the Shipman inquiry report one sees that the Government has been saying it intends to undertake reform since the 1925 inquiry. One wonders just how long we would have to wait. But the problem is that a new system will have to try to bed in and start to work and it will develop its ways of working. It would be much easier to reform the whole system at once and find altogether new ways of working than to change little bits of the system, allow them to settle down and develop their own ways of working and then change another bit of the system, which may mean that the first one has to change again.

Q167 Dr Whitehead: Would you include in that the fact that there is no corresponding statutory duty on doctors to refer a death to the coroner and that in the reforms no such duty is proposed?

Dr Grenville: As I have said, the gold standard would be an automatic referral of all cases, so that would not be a question.

Q168 Dr Whitehead: With respect, the gold standard might alternatively be referred to as a utopian standard.

Dr Grenville: Yes, it might.

Q169 Dr Whitehead: I invite you to speculate where a statutory duty to refer deaths to coroners might sit short of the gold standard?

Dr Grenville: I think it is very difficult because death comes in so many forms. If one does not draw up a list in other than the most general terms of those cases that should be referred it is very difficult. I note that Dame Janet said she and her team found it impossible to draw up a list. One of the problems I have as a general practitioner is how certain I have to be of the cause of death. I could give a certificate with an indication of the certainty I felt as to that cause of death. There are some deaths where I am absolutely certain of the cause; there are others where I am absolutely certain that it is a violent and unnatural death and needs to be referred to the coroner. There is a range in between. It may be possible to set up a system which helps doctors to decide, depending on their level of certainty or uncertainty and with someone to talk to, whether or not a particular case needs to be referred to the system.

Q170 Dr Whitehead: You say that there should be a positive statutory duty to refer particular deaths to the coroner?

Dr Grenville: Certainly, if we become aware that there has been a violent or unnatural death there is absolutely no reason for us not to have a statutory duty. Although we do not have a duty, in theory we could complete an MCCD which says that this is a violent or unnatural death and the registrar will refer the matter to the coroner. It does not happen in practice but it is the theory. We could tidy up that practice.

Q171 Dr Whitehead: Is the idea that perhaps that is a useful public safeguard something that might be seen as approaching gold-plating, inasmuch as it could be argued there are rather few circumstances in which a doctor, provided he is reasonably competent, will fail to refer to the coroner a death that ought to be referred?

Dr Grenville: I think that for many doctors the difficulty with the current system is: what level of certainty is required? There is also the difficulty that under the current system referral to the coroner is very likely to lead to a post-mortem examination which the relatives may be keen to avoid. A doctor may certify at a lower level of confidence as to cause of death if the family suggests that it really does not want a post-mortem. If the doctor can say to the family, “There is a degree of uncertainty here and I will refer it to the coroners service and it will be able to make a full investigation, including discussions with you, and decide whether or not a post-mortem needs to be held”, the family will understand that, but at the moment he says, “I will refer it to the coroner.” In many areas that means uniformed police officers and, almost invariably, a post-mortem. That is not a good way to help bereaved relatives.

Q172 Chairman: I was going to ask whether you thought doctors were influenced by the fear of bringing all this upon the bereaved unnecessarily, simply because a certain kind of certification would prompt that?

Dr Grenville: I think many doctors do feel that way, and certainly many families, particularly those who have had experience—it is surprising how many families in the current system have had experience of the coroner system—have views when another death occurs.
Q173 Chairman: Dr Davison, would the existence of something like the Scottish view and grant procedure make that situation easier, because it means there are many cases where although it is referred they do not have to go to the full post-mortem?

Dr Davison: I believe that the English and Welsh systems could take advantage of that in limited cases. When I worked in Glasgow in approximately 10% of referrals the procurator fiscal would put in a note in the letter to us saying, “Would you consider a view and grant in this case?” We would perform an external examination of the body. If we found signs that perhaps were not consistent with the story or slightly suspicious we would phone the procurator fiscal and ask if we could do a full post-mortem. He would say yes. If we found nothing suspicious we would do a view and grant and write out a medical certificate of death. The ability of the pathologist, if you like, to write a certificate of death was helpful in such cases and avoided the need for a post-mortem in, say, 10% of cases in Glasgow. It differed in other jurisdictions in Scotland. Some people used it less and some more.

Q174 Julie Morgan: I want to return to the question of training. Is the current training of doctors in death certification and reporting adequate?

Dr Wilks: Anything sub-gold standard might have seven layers in it. One of our disappointments about not including death certification in the proposals is that it is a missed opportunity to improve the quality of death certification because it is crucial for a whole variety of tasks, including epidemiological patterns of morbidity and mortality. The opportunity is there to improve the quality of death certification, and one aspect is the training of doctors in how to do that. I ask my colleague Dr Thorpe to comment on that.

Dr Thorpe: I work in a district general hospital and am aware of death certification by junior doctors. I believe that about half of all deaths are certified by hospital doctors, mostly junior doctors. When they start their first job they do not feel they have been properly trained in how to complete a medical cause of death certificate. They are often advised by people who themselves are not trained but have more experience, such as older people in the team or the patient affairs officer. I am sure this is a big gap that needs to be filled.

Q175 Julie Morgan: Do you think that lack of training is a contributory factor in the relatively high level of reporting to coroners in this country in comparison with others?

Dr Thorpe: It is certainly the case that if juniors are uncertain, as they often are because of lack of training, they will feel the need for a comfort blanket by speaking to the coroner’s officer. I am sure that a lot of things come into the coroner’s office which, with better training on how to certify death, would not do so.

Q176 Julie Morgan: How do you believe training should be delivered?

Dr Thorpe: Ideally, it would be part of the undergraduate curriculum and reinforced by further training during early postgraduate years. A lot of things are required by death certification. I suppose that in the normal hospital situation where one is not trying to pick up criminal conduct, the main purpose is to obtain accurate statistics from an epidemiological standpoint that can be used in health planning and so on. That is where it is very useful to have accuracy. But a good deal of the discussions on the draft Bill and the reports which have led up to it are in terms of picking up wrongdoing, which is a completely different function of death certification. That requires thinking along different paths.

Q177 Chairman: There are also medical errors?

Dr Thorpe: Indeed.

Q178 Julie Morgan: How important is the advice of coroners’ officers to doctors in filling out death certificates and making a decision about whether or not to refer the matter to the coroner?

Dr Thorpe: It is very influential, because coroners’ officers do this all day every day and become very practised at knowing how their particular coroner likes things managed. They advise junior doctors a good deal.

Q179 Julie Morgan: Therefore, that is a major part of the process?

Dr Thorpe: Yes, it is.

Dr Wilks: Under the new system there could be an extremely crucial central figure in collating information, reporting to the coroner and linking with the medical examiner and, crucially, the family. We see a very strong role for the coroner’s officer, but it has not been one that has developed into a particular career structure with particular set skills. We would like to see that developed.

Dr Davison: There need to be more coroners’ officers. The Bill suggests that there would be the same number of coroners’ officers. We do not see that working if we want them to collate all the available information prior to an informed decision being made about the necessity to perform further investigations, such as an autopsy. I would probably expand the role of coroners’ officers. They could eventually develop into the American model of scene examiners; they could go to the scene of death and examine it. A lot of these people would probably be ex-nurses or ex-police officers with experience of talking to bereaved people and getting information from them, looking at scenes, looking for suicide notes, pills and so on, and taking that information back to the coroner and/or medical adviser and then an informed decision can be made about the best means of disposal of that body, shall we say, in legal terms.

Q180 Julie Morgan: Turning to the autopsy rate in England and Wales, this is also very high compared with other jurisdictions. Why do you believe that is so?
Dr Davison: I would refer to my answer to the first question. I referred to the 14-day rule and the amount of information that is gathered prior to that decision being made. This is crucial. The Royal College of Pathologists has said many times that one of the main problems is the lack of information provided to the coroner and so to the pathologist before the decision to perform a post-mortem is taken. For instance, there is nothing like a typed sudden death report in England and Wales. Sometimes in non-suspicious deaths we will receive, if we are lucky, a typed history from the coroner. Usually, it is a handwritten scrawl. I have experience of cases such as road traffic collisions where all the history I get prior to the post-mortem is: “Deceased involved in road traffic accident. Taken to hospital. Died.” That is almost useless and it does not serve the family well to have a post-mortem done for that reason. Neither the coroner nor the pathologist is served by that lack of information. Part of the problem is that coroners’ officers do not on the whole get out of their office. Some do but not many; a lot of them are deskbound. They do not get out and chat to the relatives; usually, the relatives have to go to them.

Q181 Chairman: The problem with the 14-day rule will become worse because of the number of doctors who will not have seen the patient either because it involves a doctor with an increasingly large practice or it is outside the nine-to-five contract, or whatever it is—if you forgive me for saying so—and an agency doctor is involved?

Dr Davison: That is another minor factor. I suppose that another problem is that doctors are, post-Shipman, slightly worried that relatives might accuse them of doing something improper. That encourages them to refer more cases to the coroner so as to be seen not to be doing anything improper.

Dr Grenville: I am not convinced that it is the changes in the GP contract but the way that we look after patients. There is much more teamwork and there is a much wider team nowadays. While the doctor may be co-ordinating things he may not be seeing the patient on a day-to-day basis. The district nurse and the community matron may be the ones who go in and see the dying patient. This is particularly so in cases where patients have long-term illnesses that are in the terminal phase. The doctor will try to get there, but he may be on holiday. However, the care will continue. The doctor will be the central point and have the record. He may be the person who is best able to synthesise what has gone on and come up with a reasoned opinion as to the cause of death. In this sort of situation it should be fairly obvious anyway, but he may well not have seen the patient in the past 14 days.

Dr Grenville: Under the present rules, yes. We need to be able to get round that and say that information is important, not sticking to the rules. If we believe that we have gathered high-quality information in a reasonable way then we can make high-quality decisions. Just having stuck to the rules does not necessarily mean that the decisions will be of high quality.

Q183 Julie Morgan: Is there a lack of trained pathologists in England and Wales?

Dr Thorpe: Perhaps not everyone here knows what a histopathologist is. Autopsies in this country are done by histopathologists who do two things. They are concerned with the diagnostic reporting of biopsies and surgical specimens and they are also trained how to carry out autopsies and interpret the findings. There are about 1,600 histopathologists in the UK. According to figures provided by the Royal College of Pathologists, this year there are about 200 vacant posts, which is approximately 14%. That in itself indicates there is a shortage. Another factor to consider is the age distribution. About 40% of histopathologists are 50 or older. You may wonder what the implication of that is. Since Bristol and Alder Hey the number of hospital-consented post-mortems has dropped dramatically. My hospital is probably typical, in that we used to do about 200 a year and now we do about 20. The training opportunities have dropped. The College put a figure on how many post-mortems a trainee should do per year, which is currently about 20. When I and my colleagues trained it would have been very unusual for someone to do less than, say, 60 or so a year. Obviously, there was no need for any guidance about numbers. Therefore, younger pathologists and ones coming through training get their first consultant post with a good deal less experience in carrying out autopsies than we did. I suspect that fewer of them will be willing to put themselves in the medico-legal position of carrying out coroners’ autopsies, attending inquests and possibly being questioned by barristers as to their findings when they are not really very experienced. I believe that the age distribution is an indication that a shortage of pathologists to carry out post-mortem examinations for the coroner will be a problem in the future. Within the Royal College of Pathologists there is an active discussion about the concept of “autopsy-light training” in which trainees could self-select themselves into groups that want to become confident in autopsies and those who really do not want to go down that route but stick to diagnostic surgical pathology. Clearly, that would further reduce the pool of pathologists who would be willing to undertake this role. There is a problem of manpower, which I believe will get worse.

Q184 Julie Morgan: Is this having an effect on the death investigation system?

Dr Thorpe: I do not believe that it has started to have an effect on what might be called run-of-the-mill coroners’ post-mortems. There is certainly an effect on specialist types of coroners’ post-mortems, particularly paediatric post-mortems and ones
requiring skills in neuropathology and complex trauma cases. I am sure that Dr Davison can think of more examples. I am sure that there will be a much bigger problem than we are aware of now.

Q185 Julie Morgan: The BMA has accepted the concerns expressed in the Luce Review about the quality of some coroners’ post-mortem examinations. Would the new provisions in the draft Bill allowing bodies to be moved to areas where there is appropriate expertise address the concerns about quality?

Dr Thorpe: From my point of view, that is a good development. Maybe others want to speak about quality. One thing that struck me about the proposed role of the medical examiner or medical assessor proposed by Tom Luce and Dame Janet was that that was an opportunity for somebody to audit the work done for the coroner by the pathologist and make sure that the standards set by the Royal College of Pathologists were broadly adhered to. My sadness about the local medical advice now being on a rather ad hoc basis is that it is not specified that a person would be responsible for assuring the quality of post-mortems in a coroner’s jurisdiction.

Dr Davison: To comment on the issue of quality, it would certainly help if bodies could be moved to certain specialists areas but I would not like to see it as a wholesale option. Part of the problem is that it can be difficult to identify exactly the problem until one has started the post-mortem. I can accept that certain cases can be identified. Paediatric cases are an obvious example, but there are other cases where one does not really know which expertise is required until one starts the examination. For the vast majority of cases I do not believe that the bereaved families want bodies moved a great distance away to a specialist in a big centre. I believe that is of limited value. Anecdotally, there are concerns among pathologists about the quality of a significant minority of post-mortem examinations. The scale of that significant minority we cannot judge. NCEPOD, which used to be the National Confidential Enquiry Into Peri-Operative Death but is now the National Confidential Enquiry Into Patient Outcome and Death, started in 1989. As the title suggests, it looked at peri-operative deaths and found that in about one quarter of cases the pathology was regarded as poor or unacceptable. The outcome of those reports over the years improved that figure somewhat but not much. The Royal College of Pathologists proposed to NCEPOD two years ago that they would do an audit of coroners’ autopsy reports. That is the first time it has ever been done. That report will be published on 18 October of this year. I was an adviser to that study but I cannot speak about any of the findings because it is embargoed until then. I have seen a first draft. I believe many of the recommendations may be of very great interest to this Committee. It may be that you can approach NCEPOD for perhaps sight of a draft or an earlier release in confidence.

Dr Grenville: As to quality, we should remember that that does not end with the post-mortem examination. A report is generated. I think the quality of the whole system could be improved considerably if the coroner’s post-mortem report was routinely made available to the patient’s registered GP. Clearly, most cases are reported to the coroner because the cause of death is uncertain. The GP is one person who needs to learn what cause of death has finally been decided upon and why, so he can use that information to learn from it or change practice where necessary in future. It is part of “an organisation with a memory” and the continuous learning process.

Q186 Julie Morgan: What about helping relatives to understand the implications of a report? Do you think that is the role of the GP?

Dr Grenville: I believe that it is vitally important. The contention is that the new coroners service will be able to do that and that the new service will be a point of contact with the relatives. I think that very many relatives will still want to come to their doctor and be able to discuss it. I find it so much easier to discuss with relatives what exactly has happened if I know all the information. I sometimes find myself in the position of saying that this or that may have happened because I have not seen the post-mortem report and the relatives say that, no, that did or did not happen because they have been told it by the coroner’s officer. It puts everybody in a very difficult position.

Q187 Jessica Morden: I want to ask about the appeals process in the draft Bill which makes provision for the bereaved and others to appeal about anything at any stage in the process. Do you think that this will work? What difficulties can you see? What is your view on it generally?

Dr Wilks: In general, we believe that proposals to improve the understanding and knowledge that relatives have and their involvement in this very painful process can only be a good thing. We have lived through the backlash of Alder Hey and Bristol where, obviously, things were done by doctors which were thought to be in everybody’s best interests but turned out to be perceived as extremely damaging simply because there was not enough communication. That was a dreadful event that was a very important learning process for the profession. We believe that to think of it as an appeal tends in a sense to bring in a rather confrontational element. While obviously an appeal process is important, we hope that if the main provisions of the draft Bill are designed to improve the involvement of families with better communication—we have talked about the GP and the coroner’s officer—to help relatives understand exactly what has happened and has been done it will reduce the level of antagonism and misunderstanding that may take place so that appeals will be less common. What would be more common would be good communication and understanding. But at the end of the day if there is a serious concern on the part of relatives that something has not been properly investigated that
We welcome Dr Radford of the Department of Health. We are very glad to have your help.

Q188 Dr Whitehead: When the evidence of the Department of Health was received by the Committee it was not entirely clear how the Department was involved in the death certification and investigation systems. Can you explain how the Department is involved?

Dr Radford: I will do my best. The Department of Health is not responsible for everything around death certification by any means. As the Committee will know already, the legislation by which doctors complete medical certificates is the Registration of Births and Deaths Act. That is owned by the General Register Office which is part of the Office for National Statistics. That Department owns the legislation dealing with death certificates and the legislation under which doctors complete them. Doctors complete medical certificates of the cause of death as a personal statutory duty. That is a personal role that they play under the Act of 1953. Therefore, issues to do with their conduct in respect of this are subject to regulation by the General Medical Council. First, we have the ONS with responsibility for death certification itself and the legislation concerned with that. The GMC is concerned with ensuring that the conduct of those doctors in completing certificates is satisfactory. Finally, in terms of the Cremations Act, which accounts for up to 70% of disposals, that is legislation for which DCA is responsible. As for the majority of the statutory responsibility, it sits outwith the Department of Health.

Q189 Dr Whitehead: But the Government has apparently changed its view since it put forward its 2004 position paper. Is it fair to say that the Department of Health and the DCA work together on death certification and how to move it forward?

Dr Radford: We have always worked together. When it was under the auspices of the Home Office we worked very closely with that Department in terms of producing the position paper which was then published. Since the responsibility for coroners was taken over by DCA we have also worked closely with DCA officials.

Q190 Chairman: Is that why the view has changed?

Dr Radford: That the responsibility should change to that of DCA? I cannot say. Clearly, the content of the proposed Bill is subject to ministerial views, so that is not something on which I can comment.

Q191 Dr Whitehead: But any change in death certification was not included in the reforms put forward in the draft Bill?

Dr Radford: Absolutely.

Q192 Dr Whitehead: Do you think that may have something to do with the fact that nobody appears to have, as it were, clear responsibility for what goes on?

Dr Radford: There are a number of processes that contribute to the satisfactory completion of a death certificate and a body being able to be released to be either cremated or buried. We sit within the current regulatory framework. At the moment there are different regulatory responsibilities depending on the element that we are talking about, whether it be the Cremation Act or regulation in terms of satisfactorily completing the necessary paperwork so that bodies can be released or the required detail on a death certificate and the processing of that certificate.

Q193 Dr Whitehead: But, as you set out very succinctly, there are what might be called a number of different poles of responsibility, none of which trumps any other one. Is that a fair assessment of the process that you describe?

Dr Radford: Yes. There are different elements of the process.

Q194 Dr Whitehead: Can the fact that there are no reforms in the draft Bill be construed as perhaps a requirement for the resolution of those particular poles? Indeed, the DCA has said hat it is doing further work on the question of death certification and, therefore, reforms may be in the “too hard” tray, as it were, for the time being?

Dr Radford: We are certainly working with DCA to look at what other aspects, particularly around death certification, may be necessary to strengthen death certification in the light of the recommendations of both Shipman and Luce and...
the comments that clearly we have received and the context within which we are now operating. I can say that most definitely there is other work in progress.

Q195 Chairman: Dame Janet said to this Committee that she did not think the Government’s proposals as they then were—they have not changed in this particular respect—went any way to stop another Shipman. You were given the task of working on the Government’s response to Shipman. Surely, the Department would say that it had a major stake in making sure this is put right. Is not the Department involved in the policy lead here with the health aspects and the registration process? From the way you describe the process everyone can conclude that nobody is responsible.

Dr Radford: Certainly, the whole process of death certification needs to be seen in the context of a much broader reform agenda that Shipman and Dame Janet highlighted in terms of issues to do with improving overall quality—quality of care and health care—and clearly death certification is an element of those. We have been working across the broad front of health care reform for a considerable time, as you will know, and quite significant changes have been made in terms of quality and patient safety improvements that have been made in the health care sector. Clearly, as to death certification we are working on issues with DCA in terms of what else can be done outwith the draft Bill to take account of some of the concerns raised by Dame Janet and others.

Q196 Dr Whitehead: In your view, would that involve further legislation or simply a reshuffling of how things are done?

Dr Radford: One of the issues on which we are in discussion with DCA is whether this will require further legislation or we have satisfactory legislation in place which will allow us to improve the system in a way we would wish to.

Q197 Chairman: I find myself quite uneasy. This is a fairly serious matter which involves a major initiative on the part of the Department for Constitutional Affairs but it seems just to pass the buck to you by saying that death certification is for health, not DCA, and so it is not doing too much to incorporate it. Am I misinterpreting what is happening here?

Dr Radford: That is perhaps an unfair summation of its position. Clearly, its draft Bill does not cover death certification as it is set out at the moment, but that does not mean there is not work ongoing in terms of what else can be done to improve the process of death certification to address some of those issues. But at the moment that is not, as you rightly point out, within the draft Bill that is before you.

Q198 Chairman: One matter for which the Department is responsible is the training of doctors. Earlier this afternoon we had quite a good deal of discussion about that. This is looking at it from the other angle, not Shipman; that is, all the other problems which arise for those who have to go through the coroner and inquest systems. Do you think that training may develop in a way which means, as indicated earlier, that we could have fewer reports to coroners because doctors are more confident about what they are doing?

Dr Radford: We are very much aware that to make sure people are appropriately trained is and has been for some time an issue, but we need to realise that training comes at different stages of a medical career. First, there is the undergraduate training which goes on in medical schools to make sure that before they qualify as doctors people have an understanding of death certification. The content of that training is the responsibility of the medical schools. A recent survey by the Council of Heads of Medical Schools showed that at all the medical schools which replied to that survey medical students are being trained in death certification, so medical students are receiving training in terms of how to fill in a death certificates, what the statistics are used for, the reason we need to have accurate death certificates and so on at that stage. But clearly that is not sufficient of itself. We then talk about postgraduate medical education. That is under the control of the Postgraduate Medical and Education Training Board set up in September of last year. Training for doctors in issuing death certificates is now a requirement of postgraduate training. There is a requirement in postgraduate training to ensure that doctors are competent because the training is based on competence, not just “tick box” ability, to issue death certificates. Finally, there is continuing professional development which is lifelong in terms of making sure that practitioners throughout their medical careers are competent and up to date in terms of things like death certificates. As you may be aware, last year ONS published some renewed guidance to all doctors, which also accompanied the CMO’s newsletter, reminding them how to fill in death certificates, setting it in the context of how the information from death certificates is used. But you are absolutely right that there is an ongoing need to ensure that people who fill in death certificates are competent to do so. Clearly, one of the issues is that some doctors do not fill in death certificates necessarily very often. Some do and some do not. To keep that competence up to date and fresh is important. Clearly, that is an ongoing issue, not a new one. How does one keep competence in a task that perhaps is not performed on a daily, weekly or monthly basis up to date and to an appropriate standard?

Q199 Chairman: Post-Shipman did the Department consider a random check of death certificates to see from the results whether competence was being maintained generally? I am not talking of an individual doctor but across the system.

Dr Radford: Yes. You will remember from the Home Office position paper that one of the issues was to do with scrutinising all death certificates, because we are aware of the importance of devising systems that will encourage good practice, rather than just leave it to individuals, and looking at what
I would hope that we would be able to agree some consistent ways of working around reporting concerns in terms of preventable issues or issues that need to be further pursued. It is very important that there is consistency so we are quite clear about what that actually means in practice and also that there is consistency so we are quite clear about what issue we are trying to address and what skills or knowledge we are trying to give them or strengthen before we embark on medical training that may not be appropriate or properly targeted.

Chairman: Do you recognise that not many people outside the system, not even everybody within it, realise the range of activities of a coroner's officer, varying as it does between different jurisdictions?

Radford: Absolutely.

Chairman: As a department have you given any thought to the implication of that part of the Bill which is about providing medical advice to coroners? It is quite understandable that the chief medical adviser should advise the chief coroner, but lower down the system it is not clear at this stage where the medical advice to local coroners purchased on an ad hoc basis will come from. Presumably, the Department would have to be involved in discussions about that, and at the very least it would draw on its resources within the hospital and general practice services. The Department must have views on whether this advice can be provided and how it can be made consistent.

Radford: I think we need to be very clear with the DCA what sort of functionality it is expecting the local medical support to provide. We need to be very clear, therefore, about the sorts of skills required to support that function. Those discussions are ongoing.

Chairman: The Department is involved in trying to develop that?

Radford: Yes, because it will be important. From previous conversations with the BMA and so on, we need to be clear about the skills required and, therefore, the manpower, and also that whatever medical presence is provided can feed into the health and healthcare system.

Chairman: The coroner’s officer is the interface between the coroner and reporting doctor and therefore in a good position to identify any wrongdoing on the part of the reporting doctor. Would the Department look at or offer medical training for them as a group?

Radford: I think we need to be clear about what we see as the role of the coroner’s officer and how that sits with the new medical advice that is proposed at a local level. At this stage we are not thinking of significant medical training for the coroner’s officers, but that is something about which we would be happy to have further discussions. I think it would need to be very clear as to what the purpose of that medical training or input might be and what it might look like, because we need to be clear that coroners’ officers have certain functions. What particular skills or knowledge do we believe they may be missing that would need to be augmented? We need to be very clear about what issue we are trying to address and what skills or knowledge we are trying to give them or strengthen before we embark on medical training that may not be appropriate or properly targeted.

Chairman: There has been criticism about the high autopsy rates in England and Wales. Some have said that unnecessary autopsies are held, with

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Chairman: There has been criticism about the high autopsy rates in England and Wales. Some have said that unnecessary autopsies are held, with
consequential distress to relatives. Is this caused by the precision required by the medical certificate of cause of death?

Dr Radford: I think you have just heard some very good and valuable opinions as to why that may be. The honest truth is that we have only opinions, not necessarily hard factual evidence as to why that may be. As to why that may be, my opinion would be no better than anyone else's. That may well be a contributory factor, but I cannot give you a better answer than my previous colleagues.

Q208 Julie Morgan: Given the concerns expressed about the quality of some post-mortem examinations, is the Department taking any steps to address this? In particular, how does it plan to address the shortage of pathologists?

Dr Radford: We have been aware for some time of the shortage of pathologists and share the concern expressed earlier. We have invested several million pounds in increasing the number of training posts of pathology and recruited quite a considerable number of people into new training posts to increase the sheer numbers and capacity within pathology, but clearly that will take a short time to work through the system so we have people who are then qualified to operate at consultant level. At the moment those people are going through the system. There has been significant investment to improve the numbers in training, because this was not a popular specialty some years ago and we ran into a shortage to which previous colleagues have alluded.

Q209 Julie Morgan: Therefore, you believe that in future there will be enough?

Dr Radford: We are certainly trying to address the shortfall as we see it.

Chairman: Thank you very much. We are very grateful for your help this afternoon.
Tuesday 27 June 2006

Members present:

Mr Alan Beith, in the Chair
Barbara Keeley
Mr Andrew Tyrie
Keith Vaz
Dr Alan Whitehead
Jeremy Wright

Witnesses: Phillip Noyes, Director of Public Policy, Lucy Thorpe, Policy Manager, NSPCC, and Pip Finucane, Trustee, Victim’s Voice, gave evidence.

Q210 Chairman: Mrs Finucane from Victim’s Voice and Mr Noyes and Ms Thorpe from the NSPCC, welcome to the Committee. We are very glad to have the benefit of your evidence this afternoon, which I am sure will be very helpful to us. I should explain and apologise that I have to leave the Committee for another meeting at five o’clock, at which point Mr Vaz will take over the Chair. So please feel comfortable and make use of the water and everything. We are anxious to get the benefit of your knowledge and experience. Perhaps I could start by asking—and this may be something that the NSPCC could answer, although possibly not, given the structure, because there is a separate organisation in Scotland, is there not?

Mr Noyes: Yes.

Q211 Chairman: We have been asking some of our witnesses whether England and Wales really need the elaborate system of inquests and coroners that we have, bearing in mind that just up the road in Scotland they have a system which does not involve anything like the number of inquests and does not involve a coroner at all; it is a much more limited system. Looking at it from the victim’s point of view, are you anxious to keep something on the lines of what we have, or do you think that we could have a much simpler system?

Mr Noyes: The NSPCC does not work in Scotland. Our view of the process and progress on reform is that it is much welcomed. We think there should be a system which is thorough, and from our point of view can establish as well as possible the cause of death of children. We also think that the system needs new introductions made by the DJECS, which is to introduce a pilot child death overview panel to try to bring together the benefit of all the health and education and social care professionals, to add the social context to the forensic evidence that relates to the death so that we can work much more closely at looking to prevent child death in the future. So the broad answer is yes.

Q212 Chairman: I will ask you some specific questions about how child deaths are dealt with in the course of the proceedings. Do you have anything to say at this stage, Mrs Finucane?

Mrs Finucane: I do not see what you can replace it with. Although we do have members in Scotland, from my earlier contact with Road Deaths in Scotland certainly they felt that there were not enough inquiries.

Q213 Jeremy Wright: I want to ask you about your experiences connected with those who have been bereaved. You will have seen in connection with this Bill that there is a draft Charter for Bereaved People attached to the back of the Act. Can I ask you this first of all? You will obviously be aware of the particular concerns that those who have been bereaved have about the way in which the coroners’ system is currently constructed meets or does not meet their needs and their expectations. Do you think that this draft Charter will improve the position? Does it address the problems that you have perceived?

Mrs Finucane: I would say no. The present situation is that the bereaved are left very much without help and information and the draft Bill as it stands—there is a lot in it which is very good which we would welcome—there is certainly one fundamental thing missing, which is we are not going to a national coroners’ service and I do not see that the present situation will be improved to provide the services, although the improvements you are suggesting would obviously be very welcome. I think there are too many ifs and buts about the shortages across the coroners’ system, not only with coroners’ facilities but particularly the situation with coroners’ officers and also mortuary staff. Unless you are going to address those problems you are not going to improve the situation of the bereaved.

Q214 Jeremy Wright: I think we will come on to those specifically, but just on the issue of the draft Charter, is there anything that is not in that document that you think ought to be there?

Mrs Finucane: One specific point in item 2, bulletin point 3—this is just an issue of leaving out—it says, “Inform bereaved people of their rights and responsibilities if an investigation or inquest is conducted in relation to the death.” It does not mention the post-mortem.

Q215 Chairman: Ms Thorpe, you wanted to mention something about the Charter?

Ms Thorpe: A general point, we felt that it might be helpful if it also included a paragraph addressed to bereaved parents—parents of a deceased child—explaining the processes that the coroner will need to follow, and also that there are processes that the Local Safeguarding Children Board—which have just been established in April—would also be following to investigate and to review child deaths, it might be helpful for them to be informed about these
processes. We find that people often find it helpful if they know that these processes are contributing to benefit society knowledge for the greater good. So we feel that this would be helpful. There is something I wanted to raise, which is point 23 here, but it does not necessarily actually relate directly to the Charter, which is the issue of tissue retention, though it does relate back to your point about Scotland. This may be evidence that you have heard from other people, but we have concerns around the fact that in England and Wales it is not possible any longer for the coroner to order the prolonged retention of tissue from a post-mortem without the consent of a parent, and very particularly in relation to infant deaths, where there have been a lot of representations that this is a step backwards because retaining the tissue could help in the future, both in terms of medical research, when new research comes to light, to help explain the causes of death, and also if there are deaths of future siblings, and they can then return to that case. It is something that we have argued. In Scotland it is possible to retain tissue for a prolonged period without parental consent but in England and Wales it no longer is, so we are concerned about that. Clearly parents can give consent and that is fine, but we would argue that it is the cases where perhaps where it is most warranted might be the cases where it is least likely to be granted.

Chairman: I can see that as an issue which would probably generate a lively debate on the floor of the House of Commons if it were to be seen within the Bill.

Q216 Jeremy Wright: Looking at this from a slightly different angle we have talked about the services that coroners can give to the relatives of the deceased. What about in connection with the draft Charter? What can be done to encourage relatives of the deceased to act as a source of information for the coroner? Do you think that there is enough in the Charter to assist in that process?

Ms Finucane: I think the answer to your question from my point of view would be no. Having something in good English that sets out for ordinary users of services what they can expect does feel like a good development. It would be also good to ensure that adjacent to the Charter are set out very clear routes for getting more information because one could not obviously embrace within this everything that somebody would need to know if they were worried and upset, especially at that kind of time.

Q217 Jeremy Wright: Mrs Finucane, do you have anything to add either on the issue of whether or not the Charter does enough to encourage people to contribute to the process or indeed on the issue of whether or not the appeal structure is going to delay proceedings or cause other problems?

Mrs Finucane: I think it depends on what you mean by helping in the process because bereaved people are essentially lacking information in many areas, particularly with respect to the results of post-mortems, for example. So particularly in the early days it would be very difficult to know how they could contribute because for one thing the family is profoundly shocked and they are not necessarily thinking about contributing in that sense. I think the appeals process, the Bill seems to be extending the opportunity to appeal and I think that is a good thing in that you are giving families the opportunity to go, say, to the Chief Coroner with concerns; but, again, might that be extended too far by too many people? I do not know.

Chairman: Dr Whitehead.

Q218 Dr Whitehead: We have mentioned briefly the question of investigation of child deaths and I would like to ask you some questions on that issue. How do you think the investigation of the death of children should differ from that of the investigations of deaths of adults, and do you think that the reforms that are proposed actually meet the challenges of what we would all agree are very difficult circumstances?

Mr Noyes: We are not expert on best practice in investigating deaths of adults. From the point of view of how deaths of children should be investigated, I think it is important to recognise that everyone operates in a specific legal framework for children, where there are very clear duties to ensure that the welfare and protection of the siblings of the deceased child are paramount, and, able to assess the risk to future children. We think it is really very good that the case built up over a decade has now been accepted by the DfES and the process put in place to bring together not only the clinical information, the forensic information, but also in a timely way social information, without which many instances of maltreatment would not be identifiable. What we recognise though is that in the new Working Together, which is the guidance that the DfES published for multi-agencies' safeguarding practice, there is clear reference to the coroner's process in the sense that the multi-agency system will give information to the coroner. But in the Coroners' Bill there is no sense of what the coroners' obligations might be to receive it and take it into account in considering cause of death. We would like to see a join made on that side of the process to the safeguarding process. We also recognise that much has been left to local arrangements between coroners and doctors and we would like to see something rather more centrally led and consistent in the kind of protocol that should be developed between the coroner and the multi-agency process. Thirdly, although we are not quite sure what this will look like in the Bill, we think there should be a requirement of the coroner to give information about learning from child deaths to the Local Safeguarding Board process, so that the very best
data collection can be put in place for learning about what might prevent deaths in future. So we think that huge steps have been made in the last few years and there is further to go to be sure that we have one process and not two.

Q219 Dr Whitehead: In terms of investigations the Committee has been informed previously that there is a shortage of paediatric pathologists working within the coronial system. Do you agree that that is the case and what effect might that shortage have on the investigation of child deaths?

Ms Thorpe: That is a longstanding concern and we published a report in 2001 called Out of Sight, which was about child deaths from abuse and neglect and one of the recommendations in there was that post-mortems on children should be carried out by a paediatric pathologist working with a forensic pathologist where necessary to an agreed protocol, and for a long time there have not been enough paediatric pathologists, so we have obviously had concerns that this has had an impact on the quality of an investigation. We do understand that there are six vacancies for paediatric pathologists at the moment, but there are also the same number in training, so at some point it looks as though perhaps that may be resolved; but in the meantime there is a need to ensure that this happens because there are particular tests that paediatric pathologists will carry out which make it more likely that cause of death can be established than if it is a general pathologist who is carrying out the post mortem, and we are aware of some cases where that has made a difference. One thing we welcome in the Bill is the fact that coroners are now able to move bodies beyond their jurisdictions if that is necessary for post-mortem examination. So that is a benefit. So if paediatric pathologist is quite a long way away, it is possible to do that.

Q220 Chairman: Mrs Finucane, did you want to add something to that?

Mrs Finucane: Yes. We are looking at death investigations—and you specifically asked about child death investigations—we are very concerned, and many organisations are expressing a concern in the standard of investigations across the board. With the shortage of paediatric pathologists, and the shortage of forensic pathologists in some cases, the question of how adequate a post-mortem is is really a question that should be raised. And looking at the situation I cannot find any suggestion that any quality assurance with respect to post-mortems is available. The Royal College of Pathologists set the guidelines for practice but who actually checks that the post-mortems are done to a particular standard?

Q221 Dr Whitehead: Perhaps if we could remain with the question of child deaths for the moment. Ms Thorpe, you mentioned the possible change in the new legislation which would enable, as it were, bodies to be moved, which may therefore make a difference in terms of the availability of paediatric pathologists, and that presumably would need to be undertaken under the authority of the coroner, and therefore the understanding of the coroner that there were significant differences in what investigations might consist of?

Ms Thorpe: Yes. I think coroners clearly need a full understanding of the benefits.

Q222 Dr Whitehead: Is it your view that it is a general understanding that there are very difficult circumstances in investigations, but that paediatric pathologists are not available; or is it the case that there is a wider view that actually forensic pathologists are perfectly able to undertake all the relevant areas of investigation?

Ms Thorpe: I cannot really comment on all of the coroners and what their practice is, I am afraid, but I do understand that there are some coroners who have maybe greater specialisation in child deaths, responding to child deaths than others. So, yes, we would want clearly all coroners to have the same standard of approach and the same understanding about these issues to ensure that there was an appropriate response in every case.

Q223 Dr Whitehead: It has been suggested to us that there are a number of instances therefore of registration of inaccurate causes of death in children and infants. What do you think might be the primary reasons for that, particularly in the light of what you have just said?

Ms Thorpe: That could be one factor, that the post-mortems are not carried out to a proper paediatric protocol. There are other factors in terms of ascribing cause of child death because, for example, maltreatment may be a factor, but without proper and full investigation you are not necessarily going to uncover that. So it can be very difficult at the very beginning to make that kind of judgment and it is the process of investigation itself which will help you to arrive at that judgment. So that needs to be as thorough as possible. I think it is also fair to say that clearly these are very distressing circumstances that the families face—and that professionals face as well. There was some research done by the NSPCC that looked at attribution of cause of death within hospitals, which highlighted the difficulties of dealing with these circumstances: the emotions of the professionals themselves and the emotions of the parents and the sheer difficulties sometimes of facing these questions and maintaining an open mind, because while obviously it is very necessary to support parents and be very sensitive, in a tiny minority of cases they may have contributed to the death of the child; so there is a need to maintain that open mindedness. Hierarchies within hospitals, different views of professionals can also contribute to reaching different decisions on cause of death.

Q224 Dr Whitehead: Is there information that is available how might that be collated about these issues to ensure that there was an appropriate response in every case?
Ms Thorpe: One of the things that has happened, as my colleague Phillip has said, is that there is now a new system being introduced—or will be from April 2008—that local Safeguarding Children Boards will be following an agreed multi-agency protocol to investigate every unexpected child death, and as well as that there is another layer of scrutiny, if you like, in that there will be child death overview panels convened by the Local Safeguarding Children Boards, who will review all child deaths. So that is a very helpful development structurally, and also in terms of the work of the coroner because it will no longer only be them who will be formally having a view of these things. So we do feel that it will be very helpful for these two processes to be linked together and for there to be some sort of formal relationship outlined in the Bill between those processes. What is happening at the moment is that those new processes are being piloted by the DfES in the next two years and we would hope that that would therefore include looking at how the relationship with the coroner works in those areas, and developing protocols for sharing information.

Mr Noyes: On a very specific issue data provided by coroners on deaths reported to them in England and Wales are not broken down by age, and it would be very helpful indeed if they were to be broken down by age under 1, 1 to 4, 5 to 15 and 16 and over—because that would enable a much better understanding of the cause of death of people under 17.

Q225 Dr Whitehead: Would that in any event not be a necessary pre-condition for the idea that the process that you have described of the DfES and the coronial system might better inter-relate?

Mr Noyes: Yes. We think it would be good if the two processes came together into a common data set that should include common language about the cause of death, and also an analysis of whether the death could have been prevented, in common language, and, if so, what would have prevented it. I think that does apply in some American States. The aggregate of that would be very powerful in describing through England and Wales what young people die from, the extent to which coroners thought that deaths could have been prevented, and then obviously what steps could have been taken to prevent the deaths. This is most obvious, I guess, in relation to bad bits of road, relating to road traffic accidents, but actually there is a very important learning that could be shared nationally about how we might prevent not only accidents but also suicides and deaths from maltreatment. So the data collection aggregatable to a national level feels very important.

Q226 Chairman: I am sure that I misheard you, but are you suggesting that in every case the coroner would record if the death could have been prevented by something? You could get into quite a difficult area of saying that the death of an 80-year old could perhaps have been prevented if they had not smoked in their youth, or whatever it might be.

Mr Noyes: We were reflecting on deaths of children.

Q227 Chairman: Specifically deaths of children.

Mr Noyes: We were reflecting on the deaths of children and referring, I think, to clause 12 in the Bill that talked about the preventive role of the coroner, which we greatly welcome.

Q228 Keith Vaz: The Committee has received evidence of both good and bad practice as far as contact with the bereaved is concerned. What are your views on the current quality of service for the bereaved, and do you think that the proposals of the government will make that experience better?

Mrs Finucane: The major causes of complaint in the nine years I have been involved has been lack of information and lack of sustained communication during the whole process. At the moment there are improving and did improve tremendously in criminal cases where FLOs—police family liaison officers—started to be appointed, and of course since about 2000 the training of FLOs has got well underway and now it is well-established. On the other hand I hear recently, of course, that they are cutting back on FLO training courses. I think the other problem is that there seems to be a gap in perception of what the coroners are dealing with because when a murder or road death occurs and FLO is assigned, but when a death occurs in hospital or in the community an FLO is not assigned and these people are left very much high and dry. Recently we have been trying to involve people in our liaison forum meetings, which you are aware of, by bringing in bereaved representatives, who come from deaths in the community circumstances, like epilepsy deaths or cardiac death in young adults—sudden death in young adults—but also deaths in hospital where there may be suspected clinical negligence, and who is to help these people? In hospital you have the immediate help of the hospital staff and the Department of Health, of course, has been pushing for the appointment of bereavement officers in hospital, and this is happening, and we know this because we are now getting requests for our booklets from A&E departments, bereavement departments, mortuary departments and recently ambulance services, which is helping to provide immediate information, which is so urgently needed. I think the other problem is that people do not realise just how urgently that information is needed, and sometimes you ask the question, “Why was information not provided to the family?” and the answer you get is that it is left, in the case of police, to the officer’s discretion at the time. Then you talk to the police and they say, “We have to decide when to provide the information.” We would say that there is no question; you must provide information immediately, not only oral information but written information as well. It is no use feeling that the family may not take it in or the relatives may not read it, but very urgently the information is needed—information about post-mortems particularly because they happen very quickly and families do not know what is happening and they are
not told necessarily that there will even be a post-mortem always. So they are left high and dry. But the problem of communicating the information is who is going to do it in the hospital and who should do it in the community, outside of the criminal justice cases.

Q229 Keith Vaz: Do you think that the experience that people have had—and this is also to the NSPCC—varies according to location? We have had evidence submitted to us which shows that there are inconsistencies because of where somebody happens to have died. So do you think that these reforms will go any way towards dealing with the issue of location problems?

Ms Thorpe: I would like to comment on this in the context of training, which would be across the board for coroners’ officers, and how to respond to the bereaved is a very important element of that. Having looked at other evidence we understand that there are questions about the amount of resources that are going to be made available for training and whether indeed coroners’ officers and others are released to attend training and whether there is cover for their role. I think those kinds of issues are very important in the context of this because currently our understanding is that training is provided in coroners’ own time and it is more ad hoc and that there is not a definite training programme plus continuous professional development, and we would like to see that in a range of issues, including this but also including child protection issues as well.

Q230 Chairman: In that context what about coroners’ officers? They should also have clear programmes of training.

Ms Thorpe: Absolutely. They should also have clear programmes of training.

Q231 Chairman: Who play an absolutely crucial role in relation to the bereaved, and the government’s proposals so far do not appear to involve any additional resources or indeed any change in the system from which they are employed on an ad hoc basis by individual coroners.

Mrs Finucane: The question of coroners’ officers is one that is very important to us because at the moment, as far as we can see, the central role of the coroner’s officer is being ignored. Apart from the training issue, which I would like to come back to, the actual employment of coroners’ officers by the police is still a question; a large number of coroners’ officers are still employed by the police—some are employed by local authorities. But then I notice in some of the transcripts this question of the local agreement causes a problem because how much time is wasted on having discussions about who is going to agree to what. This is one of the reasons why we feel it is so important to go to a national service, so that coroners’ officers are included in the coroners’ service, but the Bill does not mention them. But they are central to dealing with the bereaved. Who else is going to do it? I have just given you the example that an FLO may be appointed, but in hospitals the coroner’s officer could be a key role. One bereavement officer I spoke to recently was quite upset because the coroner’s officers were removed from the hospital premises back to the police station. This sort of thing is going on across the country. We cannot understand why there is not recognition of the coroner’s officer’s role—it is long overdue. They need to have a recognised status and professional standing and be employed within a coroner service, so that the coroners themselves have responsibility for them directly.

Q232 Chairman: I will just raise a couple of other points with you. One is the fact that under the Bill although inquests will generally be held in public coroners can ban publication of information which would identify the deceased and they can take evidence via live-link from children under 17 in a court room cleared of everyone not essential to the proceedings. There are various ways in which open inquests could be held, for understandable reasons. Do you see those as potentially beneficial for the bereaved or are you worried about any dangers in those provisions?

Mrs Finucane: I think the problem, as I certainly understand it, and I think the people I work with in the victims’ charities and the specialist organisations dealing with the bereaved, feel that . . . I am sorry, I have lost track for the moment.

Q233 Chairman: About open inquests?

Mrs Finucane: Yes, I think the problem is the media attention of course, which is something which is very unwelcome. From the point of view of being open and in the public interest, I do not know; I think this needs a bit more thought, perhaps.

Q234 Chairman: Do the NSPCC have any views from the children’s standpoint on this?

Mr Noyes: We were pleased to see the proposals to let children give evidence on video-link. It was quite surprising that vulnerable adults were not included in those provisions as they are in other settings. We have a view that the process should be as public as possible. But, there are some issues then about the transmission and receipt of information in relation to child protection issues, for example from serious case reviews. Our understanding is that work is needed to establish a protocol as to how information might be given from a serious case review to a coroner. We understand that something is happening on that in Northern Ireland, which may be relevant to the Committee, and we will look into that separately.

Q235 Chairman: Finally and more generally, you have seen the comments that have been made, including by Dame Janet Smith, that taken together these proposals would not be enough to prevent another Shipman. Do you have any general reflection on that?

Mrs Finucane: Clearly the public are very concerned that there should not be another one. A lot of comments were made again in the transcripts about the question of death certification and inaccurate causes of death and so on. I do think the Bill would deal with this—in fact I think it would not. An
interesting point coming out of the 2005 coroners' statistics was that I noticed the number of referrals to coroners where there was no post-mortem and no inquest was 106,000. So who dealt with them? Was the decision made by the coroner, the coroner's officer or a doctor that finally decided that they did not need a post-mortem and they did not need an inquest? This raises a question mark over how they were dealt with. But then we know that coroners' officers are being questioned by doctors, doctors seem very uncertain about death certification anyway and the whole thing does not come together. Whether you should deal with death certification in a Bill for the coroners, I do not think we are competent to judge. But I think there is a lot of concern about inaccurate recording of causes of death, particularly in some of the specialist charities with which we have had contact.

Q236 Chairman: NSPCC?
Ms Thorpe: We would share those concerns. There is the proposal to have the Chief Medical Adviser who would work with the Chief Coroner and that coroners will have some resources to buy in medical expertise. I think, at the local level, but that is very far from the system that was proposed in the Luce Review, where you would have a system of a medical auditor working alongside the coroner as a matter of course, and we believe that this would have provided that extra scrutiny and that assistance with ensuring that death certification is accurate.

Q237 Chairman: So you strongly back that particular Luce proposal, do you?
Ms Thorpe: Yes, with some provisos that we would have said that it is not only the clinical expertise that is required but also looking at the family and social factors where child deaths are concerned, so, yes, if they had that training and also that support available to them.

Chairman: Thank you very much for your evidence; we are very grateful for your help this afternoon. This is the point at which I have to hand over the chair to Mr Vaz and invite the Minister to come and give evidence to us.

In the absence of the Chairman, Keith Vaz was called to the Chair

Witness: Rt Hon Harriet Harman QC, a Member of the House of Commons, Minister of State for Constitutional Affairs, gave evidence.

Q238 Keith Vaz: Minister, can I warmly welcome you to your first session before this Select Committee. Minister, this Committee has been asked to carry out pre-legislative scrutiny of the draft Coroners' Bill, as you know. You subsequently announced what you have termed as “pre-legislative scrutiny” by a panel of recently bereaved people to be held at Westminster. What is the status of your proposed consultation exercise?

Ms Harman: I think that we would all agree, would we not, that we need to get more of a sense of the public involved in the parliamentary process. I think we would all agree that we want to be absolutely sure that any Bills we bring forward actually meet the objectives which we say that we intend to have. Also, that anything that government is doing should, as far as possible, be shared with the legislature, so that there should be as much sharing as possible between the knowledge and information which the Executive has, and that we should share that with the legislature. So what we are planning to do is, having undertaken a general quantitative survey of people with recent experience of the inquest system, we would then get the general spread of views in terms of people's experience being positive, negative or neutral, and we would then have a panel of something like 12 people and they would be able to go through the Bill here in the Palace of Westminster, or possibly at Portcullis House, and the idea would be that Members of this House, and Peers—many of us do not have in our constituency surgery that much direct practical feedback from people with recent experience of the coroners' system—if people wanted to involve themselves in the second reading debate and they wanted to hear from a group of people who had recent experience who were actually going through the Bill saying which bits of them they thought would or would not help, but then the idea was that it was to assist the parliamentary debate so it would be before the second reading.

Q239 Keith Vaz: But as the panel will not meet until after the Bill is in its final form for presentation to Parliament, in what way will it represent pre-legislative scrutiny? Why are you creating a parallel form of scrutiny when the Select Committee is already reviewing the legislation?

Ms Harman: I do not think it is parallel. I would say it is additional. I think that the question about whether or not it is the right time to do it, I think that if you have a Bill, which we have tried to do, translated into plain English it is not wrong at that stage, when the Bill is still in draft, to ask people to look at the actual measures in the Bill rather than to have a general discussion, “Let us see whether that works.”

Q240 Keith Vaz: But should this consultation not have taken place before the draft Bill was produced? Is this not a bit late to be doing this kind of analysis?

Ms Harman: We have had consultation with groups of bereaved relatives and they have been incredibly helpful in shaping the proposal, but I think to bring into the House, so that other parliamentary colleagues can see what otherwise government ministers would tend to do as a matter of course for themselves anyway, they would spend public money on it, but we would be the only people who actually knew what the response was.
Q241 Keith Vaz: But in what way does this represent independent scrutiny when this is actually being done by the Government Department that is presenting the Bill? Surely if you have names of people who you think ought to be involved in this process those names need to be passed on to the Select Committee and we can call them to give evidence. Why are we having yet another form of scrutiny? It is not independent, you must accept that, because it is going to be organised by your Department.

Ms Harman: Yes, but we are going to be asking for the people to be chosen on as random a basis and as methodologically sound basis as we can. This is not rocket science; this is the first time that this has been tried. Everybody might say that this was a bad idea, “Thanks for trying it but do not bother to do it again,” but I think we are seeing whether or not a process which would normally be undertaken by the government and not shared with Parliament, whether or not the legislature would find it useful to see. Because we have the ability to contact coroners, to actually ask them to send out a letter on our behalf, to approach them; that is an ability that ordinary Members do not necessarily have.

Q242 Keith Vaz: But Select Committees do have?

Ms Harman: Indeed.

Q243 Keith Vaz: Because we are also concerned by the fact that the Department has delayed publication of this Bill, which really has prevented this Committee from conducting pre-legislative scrutiny properly. What assurances can you give the Committee that future Bills, emanating from your Department, will arrive in good time for thorough and proper pre-legislative scrutiny?

Ms Harman: I have already apologised to the Chair of this Committee for the lateness of the draft Bill being given to the Committee—it should not have happened and I am very regretful of that. I think that had I realised that the delay was accounted for by the fact that we were trying to do the plain English translation alongside the legalese, I would have said that the Select Committee are perfectly able to read the legalese and therefore you do not need to wait to get the proper version. What we should have done, when we realised there was a delay, immediately give you the legalese version. I do apologise. I am sorry about that.

Q244 Keith Vaz: The reason for the delay was the Bill had to be translated into English?

Ms Harman: That effort to put it in plain English contributed to the amount of time it took to draft and I would like to say what a good job has been done, with the assistance of the Parliamentary drafts people to have it translated into plain English.

Q245 Keith Vaz: Minister, why has the government chosen to reform the coronial system rather than opting for a much more fundamental reform of the system, such as adopting a Medical Examiner system or a scheme similar to that in Scotland?

Ms Harman: I think what we felt was that the current system as it operates needs to be improved. We need to be sure that the bereaved get the answers that they need and also that the public interest is served, and that what we should do with this Bill is make sure that there would be national standards with the Chief Coroner, a Charter for the Bereaved, a better ability to investigate, a more professionalised cadre of coroners to replace the rather archaic system we have at the moment, and I think that these are a very sensible, long overdue set of reforms, but which might be necessary to build on further for the future.

Q246 Dr Whitehead: How important do you think it is that there is consistency of service across the whole of the coronial system?

Ms Harman: I think that there should be minimum standards and good practice across the system as a whole, so I think the answer to that is it is very important.

Q247 Dr Whitehead: We have received evidence and information about the continuation indeed under the proposed legislation of the resourcing of the coronial system at local level, and some of the evidence that we have received seems to suggest that this would indeed promote inconsistencies in service, for example the funding under some circumstances by police authorities and some by local government and some under some circumstances a querying by local government of the fact that they appear to be funding a service on a rather open-ended basis, and the suggestion that maybe that might not be something they would want to do. So do you think that the reform of the system can achieve consistency and service if there remains inconsistency in resources?

Ms Harman: I think that the things that will ensure that there are national standards and consistency of service is the leadership of a Chief Coroner, and I think that it is important not to underestimate the importance of having a national leadership figure for the coroners, who all operate in a very independent but also isolated way. So I think having a Chief Coroner, like the Lord Chief Justice heads the judicial fraternity, that each case is decided on a case by case basis, the decisions are made independently by the judges but the Lord Chief Justice is there batting for the judicial fraternity. And I think that coroners will have that national leadership of a Chief Coroner and a Deputy Chief Coroner with a Chief Medical Adviser and a National Coronial Council and a Charter for the Bereaved and the opportunity to issue guidance, which I think will make a huge difference. At the moment there is nobody who can issue guidance to coroners and say, “Do your cases in chronological order and make sure that if something is more than three years old you try and expedite it.” There is nobody who is able to address the question of minimum standards, and our proposals will address that. So as far as resources are concerned the sense is that there are some areas which are adequately resourced and there are other areas which are inadequately resourced and the
problem is that there is not a proper reporting mechanism so there no visibility of that in the system, and what we would be able to have with our system is an ability to look at what is the level of service in each area and then proceed from there.

Q248 Dr Whitehead: But you have in fact made an estimate, have you not, of the start-up costs and additional running costs that the proposals in the Bill would bring about and I think you have suggested £14.5m for start-up costs and £5.8m for additional running costs. How did you arrive at that particular figure, which sounds fairly precise?

Ms Harman: That is the additional cost for setting up the Chief Coroner and the Department, if you like, of the Chief Coroner for the National Coronial Council; it is for training and it is for the extra medical support to be available to coroners at local as well as national level. So that is what that figure is made up of.

Q249 Dr Whitehead: Have you taken account in those figures of certainly what we have come across of what might be described as substantial hidden subsidies in the system, and indeed different departments at local level, either subsidising or being subsidised for the service that they actually provide, both in real financial terms and in terms of use of facilities, rooms, offices, etcetera? Is that part of that £14.5m and £5.8m or is that additional?

Ms Harman: As I understand it what you are talking about is the level of support that comes from the local authority or the police authority and we do not actually have a clear view because of the fragmentation of the system currently and no national levers of how that system is working as between different areas. So I think that what we need to do at least is to have a system which exposes what the figures are against a template of national standards and see where those standards are being met and where those standards might not be met because of inadequate resources and then at least there will be an ability to look further about what can be done about that situation. But at the moment there is no national standard so the question of whether or not a coroner is being under-resourced, there is no objective measurement at all.

Q250 Dr Whitehead: So you will be asking Parliament for additional funds but will that be a two-stage process or a process whereby you will be asking Parliament for this additional start-up money and then perhaps waiting for a while to see how the fragmentation of the system and its resolution in the way that you have described might then give you a better picture of what the running costs are likely to be?

Ms Harman: I think the Bill is to provide the legal framework for the system. The question of resources is a matter which is hotly discussed between the Department for Constitutional Affairs and the Treasury on, I would say, a daily basis. So we set forth the start-up costs and the additional costs that we see are necessitated by the medical assistance and by the training, but costs is an ongoing issue.

Q251 Dr Whitehead: But those costs that you have mentioned will be, as it were, rolled out very early on?

Ms Harman: Yes. They include the actual £15m for setting up the new system.

Q252 Jeremy Wright: Still on the question of resources, you have told us that the Department has calculated what the likely start-up costs will be and the ongoing annual running costs and you have told us that included within that is the cost of setting up the Chief Coroner’s office. Can you tell us what the figure is specifically for the operation of the Chief Coroner’s office, both in start-up costs and in annual running costs?

Ms Harman: Yes, I can. The Chief Medical Adviser and team is 430 . . . It is £1m overall, which includes the treasurer coroner system, the appeals, inspection, Chief Medical and team, Coronial Council—no, the £6m, which includes £1m for the Chief Coroner and Deputy, £370,000 for the treasure coroner, £1.1m for appeals, 250K for inspection, 430K for the Chief Medical Adviser and team, Coronial Council 120K; medical assistance to go to local coroners £1.3m; more ongoing training 120K. So that is how it is broken down.

Q253 Jeremy Wright: That is the annual running costs rather than the set-up costs?

Ms Harman: Yes.

Q254 Jeremy Wright: Presumably you have similar figures for the set-up costs?

Ms Harman: Yes, we do and they are to be over a period of some three to four years.

Q255 Jeremy Wright: Would it be possible for you to write to the Committee giving us those figures so that we can see how they break down?

Ms Harman: Of course.1

Q256 Jeremy Wright: You mentioned in that list of costs the appeal system and I want to ask you something about that. The Bill provides for a very broad range of decisions made by a coroner to be appealed to the Chief Coroner. Does this give you any concerns about the potential volume of appeals that might reach the Chief Coroner and therefore the ability of the Chief Coroner to deal with that volume of appeals?

Ms Harman: That is a very interesting question. If there is a huge volume of complaints/appeals it will show the gap between what people’s expectations are about what the system should be delivering and what is being delivered. For the most part I would expect coroners, as they do now, where there is a difficult decision to sit down and discuss with the family what they plan to do and why and explain it. It is only in rare cases where something has gone wrong and there is a complaint or where the family cannot accept the view that there would be an appeal. I think that there is no outlet in the system at the moment. If somebody wants to appeal or they

1 Ev 112
just want to complain about something which is important for them, there is nowhere they can go. It is going to be very interesting to see what people do appeal or complain about and that will be helpful for coroners to understand how they should be going about the situation. We do not know is the answer to the question.

Q257 Mr Tyrie: I want to go back to costs. It seems that the package of proposals you are coming forward with depends on your getting the extra cash to make it work. Have you Treasury approval?

Ms Harman: The DCA is planning to provide funds for the additional requirements of the Bill. That is what we have undertaken to do: £6 million per annum in additional running costs, £15 million in one off, transitional costs over three to four years.

Q258 Mr Tyrie: The Treasury have agreed to that additional funding on top of what was in the Red Book for the previous year?

Ms Harman: It depends on what year this is starting.

Q259 Mr Tyrie: Which year is it going to start?

Ms Harman: We have set out the time frame. We published the draft Bill on 12 June. On 8 September the formal consultation period ends. We will then have the additional scrutiny by bereaved people. We then will get the response from your Committee and, when legislative time allows, it will be introduced. There are three things I would like to particularly ask the Committee for your views on. I will leave that until later.

Q260 Mr Tyrie: I want to try and clarify whether this is additional money or whether it is coming out of Department for Constitutional Affairs funds.

Ms Harman: It is coming out of Department for Constitutional Affairs funds.

Q261 Mr Tyrie: So, somewhere in the system there are some cuts going on in the Department for Constitutional Affairs to the tune of £15 million in one off costs and also enough to cover the usual running costs.

Ms Harman: The Department for Constitutional Affairs has responsibility for the budget that is provided by the Treasury and has to provide a range of things across that, including our new responsibilities that we have taken over from the Home Office, as the lead department responsible for coroners. I am not sure I can help you much more on this except to provide you with a letter with a more detailed breakdown.

Q262 Mr Tyrie: The Department has published a budget line for three years out showing what you are going to spend and there are either some cuts in the budget line to make room for this or you have found some extra money. When I looked at this I thought you had found some extra money from the Treasury but you have not. You have told me it is coming from within the existing departmental budget ceiling and therefore there must be some savings going on elsewhere of which we are currently unaware. I think the Committee would like to know what those are.

Ms Harman: It is not the way you put it. We have responsibility across a certain time period. We have extra responsibilities. If we take on extra responsibilities we have within our budget to make sure we discharge those new responsibilities and our existing ones. The Treasury look at the requirements that are placed on us and they look at what we are needing to spend our money on.

Q263 Keith Vaz: Can we take up your offer of the letter you were proposing?

Ms Harman: Yes. I am not meaning to be unhelpful. I am aware that I am being unhelpful, but I will try and see if I can help you more.

Q264 Jeremy Wright: I am sure you would accept that there has been a change of view since the position paper in 2004 about the Chief Medical Adviser and the presence of medical examiners who would sit alongside coroners within the system. The proposal now is for the Chief Medical Adviser to assist the Chief Coroner and for some locally funded medical support for coroners throughout the country. What was the reason for the change of mind from a situation in which every coroner would have a medical examiner with them or to rely on to the system that is now being proposed?

Ms Harman: I was looking back at some of the statements that were made previously about our intentions. There are a lot of common themes: establishing a family charter, creating a national jurisdiction, local coroner areas, the appointment of a Chief Coroner, the creation of a Chief Medical Adviser. I think a lot of the things that we set forth to do in March 2004 we are doing, including the creation of a coronial council and increased powers.

Q265 Jeremy Wright: Granted, but this particular item has changed. I wondered what the reason for the change was.

Ms Harman: Which change in particular?

Q266 Jeremy Wright: As I understand it, the position paper of 2004 was proposing that individual coroners, not just the Chief Coroner, would have access to a medical officer who would be specific to that particular coroner. That is no longer the case. What is in the Bill is a proposition to have a Chief Medical Adviser to assist the Chief Coroner and something which is described as locally funded medical support for coroners. There is clearly a change there and I just wondered what the reason for it was.

Ms Harman: The Bill does not cover that point because it does not require primary legislation. We made it clear that this is an important part of the change that senior coroners, as they will be called, will have dedicated medical local input which is under their control. They will have the resources for that. In order to give them money to enable them to do that under the guidance of the Chief Coroner we do not need primary legislation. That is not
something that we have decided does not need to happen. It just does not need legislation to have that local, medical input, but that is there. It is in the budget and it will be very important to help improve and professionalise the service. It has Treasury approval for all of that funding.

Q267 Jeremy Wright: What do you envison that local, medical support being? Would it be a particular individual or is it simply access to a group of people or to existing health services? How do you envison that operating?

Ms Harman: We are facilitating coroners to decide in their own area what is the best way they want to get that medical help. I do not think it would be necessarily a good idea for us to put primary legislative chalk marks on the ground. It might be something which they would want to work out at local level. It might be that the Chief Coroner supported by the Chief Medical Adviser to the Chief Coroner would want to lay down some guidelines on but I certainly would not want to put it in primary legislation. We want to facilitate them to do a good job at local level and the configuration of different people and different services is different in different local areas.

Q268 Jeremy Wright: On that basis, does the Department make an amount of money available to each coroner to spend in the way that he or she wishes? How does the funding operate?

Ms Harman: The answer to that is yes.

Q269 Jeremy Wright: What is the amount of money?

Ms Harman: £1.3 million a year.

Q270 Jeremy Wright: Per coroner or for the entire service?

Ms Harman: For the entire service.

Q271 Jeremy Wright: Does that come from the figures you have already talked about?

Ms Harman: It does, yes. It does not need to be in the Bill. It has not been dropped. It is a commitment and we have put that in the introduction to the draft Bill. We just do not think we need to legislate for it. We have enough machinery to make sure it happens.

Q272 Barbara Keeley: On the question of reforming the arrangements for death certification, there appears to have been a change of mind. There appears in the Home Office position paper of 2004 to be an acceptance of the need for reforming death certification to strengthen public protection from the actions of people like Dr Shipman. I see the draft Bill containing no measures to reform death certification. Could you tell us why the government has decided not to reform death certification in the Bill?

Ms Harman: We want to make sure—and this has been something that the Department of Health as well has been concerned about—that the certification process is robust, rigorous and subject to proper review and is working the way it was intended to. One of the things that specifically we are doing but which is not in the Bill, because it is in regulations and we wanted to do it without waiting for the Bill, is the question of making the cremation certificate available to the next of kin. Some of the families of people murdered by Shipman have said that if they had been able to see the cremation certificate they might have had suspicions arising which otherwise they did not have. That was something which Ann Alexander and the Shipman group of families had asked for and we are doing it. There is also work being done in the Department of Health. It is not the case that nothing has been done on death certification. Of something like half a million deaths every year 475,000 already have more than one check and the point is to make sure that those checks are robust and that there is proper scrutiny and peer review and a complaints system to make sure that that works properly.

Q273 Barbara Keeley: Dame Janet Smith clearly did express concern about this and it seems to be an area that she feels is important. She thinks that not addressing death certification would go nowhere towards remedying the defects that failed to catch or deter Shipman. She seems to feel quite strongly about this issue. You did say in your statement to the House on 6 February this year that you would be looking further at this and you were not ruling out future reform. You have just referred again to the Department of Health on that. An official from the Department of Health appearing before this Committee said that they did not feel that death certification was their responsibility. Perhaps you could help us by clarifying: is it their responsibility or is it the responsibility of the DCA that the Department of Health share? Also, is future reform still being looked at in line with those concerns that Dame Janet Smith has?

Ms Harman: Obviously there is a very important Department of Health patient safety agenda in terms of recruitment of doctors, training of doctors, scrutiny of doctors, all of that, much of which feeds into the death certification process, whether it is in a primary care setting or whether it is in hospitals. It is something which is done by doctors and therefore obviously the Department of Health has an important involvement in that. They have also taken forward changes on controlled drugs management and there is going to be a forthcoming Chief Medical Officer report on doctor regulation. For our part we are reforming the situation in relation to cremation certification. We are going to have a more professional coroners’ service with coroners whose main job it will be so that they will be liaising with the health trusts and the primary care trusts. Because it will be their main professional occupation rather than something bolted on to their solicitors’ practice, they will be a much more professionalised service. There will be their own medical input which they will not have had hitherto and also they will be in a position—I think this is quite important—to offer to people within their jurisdiction that if anybody has any concern about a death certificate it is not a hostile act to say, “Can the coroner take a second look at it?” We are now used to second
opinions from doctors in the health service. It used to be regarded as a terrible thing to ask for a second opinion. Now it is accepted. What we want to do is have that culture operating in relation to the coroners’ system so that people know if they have any suspicion or unease they can refer the matter for the coroner to look at. Taken together, all of those measures do take the progress forward together with national standards, national leadership and improved investigations.

Q274 Barbara Keeley: It is a Department of Health responsibility? It is in with patient safety?

Ms Harman: It is both. We have our responsibilities and they have theirs. We would not seek to be running the peer review system in primary care and saying you should be qualified in terms of medical qualification for doing a death certification. We are also responsible for the coroners’ system, the coroners themselves and the inquests that they hold, so I think there is a responsibility across different departments. I have had meetings with my ministerial colleagues, both Jane Kennedy and Andy Burnham, who work closely on this. The point is to get a system that works and to have everybody who has a contribution to make to it focused on it.

Q275 Keith Vaz: Coroners’ officers are the main point of contact for the bereaved. I know you came in earlier to hear some of the evidence of the groups concerned. They have complained of heavy workloads, lack of training and lack of resources. How can the Bill improve the experience of the bereaved without dealing with these fundamental problems?

Ms Harman: The Bill will improve the experience of the bereaved. There will be a charter for bereaved people. There will be an appeal system, a complaints system. There will be the additional privacy provided by the reporting restrictions, although I want to raise something about this with the Committee. There will be more provision in relation to the maximum time for the retention of bodies. There will be improved investigations. There will be the ability for coroners to order a minimal post mortem. There will be bereaved relatives’ input onto the Coronial Advisory Council. I think that all of those things will help the experience of the bereaved in the inquest system. As far as coroners’ officers are concerned, they play a very important role. They are often the people that are explaining the situation about how the system is working and what has been happening. They are the people who will have the most contact with the bereaved relatives and their job is very important indeed. That is why we think it is very important that we do not have the situation we have at the moment where somebody can be appointed to be a coroners’ officer and, on their first day, they have to do the job without any induction training or any ongoing professional training. The training for coroners’ officers is very important indeed.

Q276 Mr Tyrie: You have said it is your intention that coroners could travel to families rather than families to coroners. While coroners are doing the travelling they are not sitting in courts hearing cases. Presumably there is going to be a cost. Have you estimated what that cost is?

Ms Harman: There will be coroners partly in their courts and coroners partly going to different parts of their jurisdiction. It will depend on how rural the area is but the point is to have sensibleness and flexibility about this. I certainly do not think that this would be something which we would want to put in the Bill as to how much travelling they should be doing or not doing.

Q277 Mr Tyrie: I am not recommending that. I am just asking if you have made an estimate of how much less time coroners will be in court. Alternatively, if they are going to be in court for the same period, how much extra is it going to cost to pay them while they are travelling?

Ms Harman: If you have a coroner who has a smaller jurisdiction—they are only doing two days—and you instead have a coroner with a bigger jurisdiction who is doing it five days a week, I cannot see how the issue about travelling factors into that. What we are talking about is people for whom this is their main job. Because it is their main job, they will have a bigger area. If it was not their main job, they could not have a bigger area.

Q278 Mr Tyrie: When Victor Round said that the effect of this will be that the coroner will be sitting on a car seat instead of sitting on an inquest, was he mistaken?

Ms Harman: Coroners will have to make the decision about where they sit and whether or not they choose to ask people to come to them or they decide that they are going to go to people. That is one of the things that they will be in a position to decide. That is the best way to do it. We are not telling them where they have to hold their inquests. If they are going around in their car to go to a local place, to hold an inquest in a particular local village, that is a matter for them to decide. If they feel that it should be done locally rather than asking people to come to them, they will no doubt have good reasons for that and for therefore being in a car in order to get there.

Q279 Mr Tyrie: He also said that many of the courts to which they used to travel have now been shut. Are you confident that there will be somewhere for these wandering coroners to hold their inquests?

Ms Harman: Yes, I am satisfied there will be. In addition, if it does not happen, there is provision for the ordering of accommodation to be made available and that is in the Bill, provision of accommodation, clause 33. Some coroners hold their inquests in the local magistrates’ court. Some hold them in council buildings. Interestingly, a number of bereaved relatives have said that they do not like the idea of having their inquest held in a court where there are lots of defendants hanging
about. I think flexibility is the key here. What are the buildings available? How suitable are they? Are they municipal offices or courts?

**Q280 Mr Tyrie:** We thought we were going to have a national service but we still really have the structure, largely, of a local service. I see the fingers of the Treasury all over that decision, which would see the costing out of all these hidden subsidies to which Mr Whitehead was referring earlier, if we did have a national system. The Treasury has no doubt fought tooth and nail about that. We have been looking at the budget and have discovered you have been told to absorb the extra costs within your Department and we are going to discover where these few millions are going to come from. I have now asked you about these peripatetic coroners and the extra cost that would involve. You have not, if I may say so, fully answered the question. It seems to me, if they are going to travel around, there will be extra cost. I am a bit worried that these proposals are likely to be in some trouble on the grounds of lack of funds.

**Ms Harman:** I can see the picture you are painting. My own view, bringing forward these proposals to the House of Commons for the scrutiny of the select committee, is that they are sensible proposals which improve a system which, in many respects, is doing a very good job but, in some respects, is not. It is long overdue for improvement. I think they are sensibly building on the current system.

**Q281 Mr Tyrie:** There is much we can agree on there. It is the funding I am concentrating on.

**Ms Harman:** The implication of what you are saying is that if I was given a tonne of money by the Treasury I would somehow do things completely differently. I can say to you completely honestly that I would not. I think this is a good set of proposals. I know that sometimes people think that taking something which is not working locally and making it national can improve it. Sometimes it can. Sometimes what we want to do is have national standards but a local partnership. You will be able to remember when the local magistrates’ courts were not delivering in getting fathers to pay maintenance to their children with whom they were not resident. We all thought that the CSA, a vast, national organisation, would be a marvellous solution to the problem. It was not. There is a really moot point, a machinery of government point, about what is the right balance between national and local. I think in this Bill we are building on the local strengths but we are having national standards. That is the right way to do it. We want to have national standards for schools, for all secondary pupils, but we do not necessarily want to employ them all nationally in central government. The question is can we build onto a local system national standards and get the right result and I hope that we have the balance right here.

**Q282 Keith Vaz:** In your evidence you said you wanted to raise three issues with the Committee. What are they?

**Ms Harman:** This is prelegislative scrutiny. I very much value the role that the Committee is playing. There are three areas which I would like to offer up to you which I am going to particularly be scrutinising in your report and hoping that you will send some signals to us about. These three areas all come out of Dame Janet’s proposals and Tom Luce’s proposals. We have taken them and we have put them in the Bill but I have question marks about them and I want to flag those questions up to you and ask for your assistance in getting us to the correct answer. One is about deaths abroad and the need no longer to have a duty to investigate deaths abroad. Are we doing the right thing in the right way on that? Secondly, no longer having a requirement to have a jury in deaths at work. Have we got that right? Is it right to dispense with that requirement? Thirdly, the power to have reporting restrictions. Should we have that power at all? If we are having that power, should we draw it more narrowly than is currently in the Bill?

**Keith Vaz:** This is another first, the Minister setting a select committee some homework. We will obviously discuss this amongst ourselves at our next meeting to see how we can look at these issues. Thank you very much for raising them with us and thank you for coming to give evidence today.
Written evidence

Evidence submitted by Tom Luce CB, Chair, Fundamental Review of Death Certification and Investigation in England, Wales and Northern Ireland, 2001–03

INTRODUCTION AND SUMMARY

1. The coroner and death certification services have essential roles. They provide each person who dies with a last, posthumous, service from the state; they serve families and friends by clarifying the causes and circumstances of the death; and they contribute to the health and safety of the public as a whole by providing information on mortality and preventable risks to life.

2. The systems in England and Wales have been for decades a forgotten service. They are staffed in the main by people of competence and integrity, but their structures are obsolete, they have historically received only modest support from Governments and until recently they engaged little public and political attention.

3. After a flurry of political concern about occult homicide in the mid-1960s, the Government established the Brodrick Inquiry which reported in 1971.1 Its main conclusion—“there is no requirement to strengthen the present machinery of death certification simply in order more efficiently to prevent or detect secret homicide”—has been shown by events to be wrong. Most of its recommendations for other improvements were not followed up.

4. The conviction in January 2000 of Harold Shipman for multiple murder of his patients, and some high profile cases during the 1990s in which the effectiveness of the coroner service came under challenge, led to appointment of the Shipman Inquiry under Dame Janet Smith and of the Fundamental Review of Death Certification and Investigation which I chaired.2

5. The resulting reports, both published in summer 2003,3 concluded that the death certification and coroner systems were in important respects unsafe and ineffective:

— The death certification and coroner systems are isolated from each other, from the mainstream healthcare and justice systems, and from other public safeguarding agencies (eg public health, child protection, care home regulation).

— No public authority with effective powers is responsible for regulating all deaths, ensuring that they are properly dealt with and supporting the professionals involved.

— There has been no clear and effective focus of responsibility in central government.

— Death certification procedures in their present form provide unreliable protection, and are particularly vulnerable to abuse by care system insiders.

— As a judicial structure, the coroner system is obsolete and un-modernised. It lacks leadership, and mechanisms to ensure consistency and adaptation to changing circumstances. It resorts excessively to routine autopsies and public inquests, and gives a patchy response to the emotional and practical needs of bereaved families. It lacks the medical skills to deal confidently with deaths from natural disease, and powers to investigate some complex and contentious deaths and mass disasters convincingly.

— The role of coroners’ officers is under-recognised and inadequately supported.

6. The review’s main recommendations for reform were:

— A new national coronial service should be created with responsibility for regulating all deaths—both those certified as natural and those needing special investigation. It should contain both legal and medical skills, and have full-time leadership locally and nationally.

— A single Government Department—the Department for Constitutional Affairs—should be have the main responsibility for supporting the new service; the Department of Health should assume policy responsibility for death certification.

— A statutory Coronial Council should be established to oversee development and effective relations with other safeguarding services.

— Death certification should be reformed to improve its reliability and independence. There should be a common procedure for burials and cremations.

— Coroners should have wider powers to investigate complex and contentious deaths including mass disasters; the present inquest “verdicts” should be replaced by narrative and analytical outcomes with a greater emphasis on preventability; public inquests should be used more sparingly.

— The present high scale of compulsory autopsies should be reviewed, and an evidence-based policy for the role in coroners’ investigations of autopsies and other scientific tests should be evolved.

1 Cm 4810
2 The other members were Elizabeth Holder, Deirdre McAuley, Sir Colin Berry, Anthony Heaton-Armstrong, and Sir Iqbal Sacranie. The review covered England and Wales, and Northern Ireland
3 The Review report was Cm 5831, the Inquiry Report Cm 5854
A “Family Charter” with legal status should set out standards for the service’s interactions with bereaved families, including respect for privacy and religious and cultural feelings about the disposal of the dead as well as the service’s powers and obligations to investigate all deaths as fully as necessary. Families should be given fuller and better presented outcomes of investigations into deaths (the very large majority) which are investigated without a public inquest. The service’s interactions with families should be monitored by a small inspectorate.

7. The rest of this paper summarises the present system and the case for change. It argues that the primary legislation necessary for most of the changes should be enacted as soon as is now possible. The main priorities for reform should be the creation of new structures, the implementation of a more effective and safer death certification system, and improved training and development for coroners’ officers.

PRESENT SYSTEM AND STRUCTURES

8. Every death has to be registered with the Registrar of Births, Deaths and Marriages before the body may be buried or cremated. For registration, there needs to be a certificate of the cause of death either from a doctor or the local coroner. If the body is to be cremated, a family member must make an application and two more doctors are involved—a second certificant and the crematorium medical referee. The second certificant is usually chosen by the first. Cremations account for some 70% of deaths in England and Wales. Families pay fees totalling £100 for doctors’ cremation certification.

9. In 2004, some 44% of the 514,000 deaths in England and Wales were reported for investigation by coroners. These referrals are usually made by doctors, the police, or Registrars. Coroners have no powers to investigate deaths which are not reported to them, and no information on or responsibility for any such deaths in their locality. The most common reason for such referrals is that the doctor looking after the patient at the time of death does not meet the requirement to have seen the patient within a month of the death (for example because he or she is a deputising service doctor with no previous contact with the patient), or is not sure of the cause of death.

10. Of the deaths reported to coroners in 2004, 51% led to autopsies (22.5% of all deaths), and 13% (5% of all deaths) to inquests.4

11. Referrals to coroners have tended to rise over the years (for example from 38% to 44% of all deaths between 2001 and 2004). The proportion of reported deaths in which autopsies are ordered has tended to fall as the proportion of all deaths reported has risen. The proportion of all deaths in which autopsies are ordered has in recent years been stable in the range 22% to 23%.

12. These activity rates are high by international standards. At annex 1 (not printed) is table extracted from the Review report comparing the rates of reporting, autopsy and inquest between England and Wales, Scotland, Northern Ireland, the Republic of Ireland and some Commonwealth jurisdictions on which we obtained information. It shows that at the time in England and Wales, compared to the other jurisdictions

— deaths were reported on a scale between double and 50% higher;
— the autopsy rate was twice or three times as high; and
— the inquest rate was much higher than in most other jurisdictions.

13. Registrars are statutory office-holders appointed and resourced locally by local authorities but working under the guidance of the Registrar General in the Office of National Statistics. Coroners in the roughly 120 local jurisdictions that now exist are independent judicial officers appointed and resourced by local authorities. Most are part-time and the large majority are legally qualified; the others are doctors. The roughly 420 Coroners’ Officers, their investigative support staff, are employed by the police in some localities but by local authorities in others.

14. Within central government, the Home Office was responsible for coroners and death certification until June 2005 when responsibility for coroners was transferred to the Department for Constitutional Affairs.

15. Because the coroner service is fragmented between local and police authorities, who meet its costs, no overall figures for its spending are issued by Government. We estimated that in 2000–01 public spending on the coroner service was £71 million, of which around half went on mortuary, autopsy and other testing costs. Registration cost a further £6 million. Cremation fees paid by families totalled £30 million.

4 The figures in paragraphs 8 and 9 are from the Department for Constitutional Affairs’ Statistical Bulletin “Statistics on Coroners” of September 2005
RECOMMENDED NEW STRUCTURE AND DEATH CERTIFICATION PROCEDURES

16. A new unified coroner and death certification service should be created to oversee the certification and investigation of all deaths. It should be financed by the Department for Constitutional Affairs and have around 60 local offices each led by a full-time legally qualified coroner and including also a new medically qualified statutory officer. The new local districts should be broadly aligned with police authority boundaries, though there should be a flexible and sympathetic approach to rural areas with long travel distances.

17. At the centre there should be a full-time Chief Coroner of Circuit Judge from the higher judiciary to set practice standards for the judicial side of the work, deal with appeals within the jurisdiction, and conduct, or in consultation with the Lord Chief Justice arrange for another judge to conduct, a small number of exceptionally complex or contentious inquests. There should also be a Deputy Chief Coroner to develop consistent approaches and standards throughout the service and run training and other essential central services.

18. Deaths from natural causes would continue to be certified first by the doctor looking after the deceased in his or her last illness. All such deaths, whether to be followed by burial or cremation, would need confirmatory second certification from a second doctor from a panel of doctors selected, appointed and supported by the new medical office-holder in the coroner service. The second certifying doctor would be sent copies of the attending doctor’s recent file notes, specialist reports and prescribing records relevant to the death. The coroner service doctor would systematically monitor and audit the certification of all deaths in the locality, including the certification records of individual doctors.

19. Coroners would be appointed after open advertisement through the same mechanism as judges—ie through the Judicial Appointments Commission. Coroners’ Officers would be employed by the new service. Their training and development would be an early priority, and individuals would be encouraged to develop some specialist areas of expertise—for example in the handling of child deaths, deaths from industrial disease, or workplace deaths.

20. The Shipman Inquiry also recommended a double death certification process, though it would have some different features and be within a somewhat different structure. All deaths would be finally certified not by a second medical certifier in clinical practice but by investigators in the local coroner’s office. Local coroners would be doctors and entitled “Medical Coroner”. There would be legally qualified “Judicial Coroners” to deal with circumstantial investigations at a higher regional tier.

21. In its first response to the Review and Inquiry reports—“Reforming the Coroner and Death Certification Service” (March 2004)—the Government outlined a proposal under which, after the treating doctor has given a cause of death certificate, all deaths would be finally certified in the coroner’s office under the supervision of a medically qualified “medical examiner” who would be working alongside a legally qualified coroner. There would be no regional structure. In my view the Government’s proposal should be supported.

A CORONIAL COUNCIL

22. The Review recommended that a Coronial Council should be established with a strategic, reporting and guidance role. It would, for example, prepare the Family Charter.

23. The new coroner service will have a complex range of professional tasks covering both medicine and law. In character it will be both regulatory and judicial. It will be interacting with families and the public on matters of great sensitivity such as the role of autopsies and other post-mortem procedures, the retention of body parts and tissues, and support for bereaved families. It will serve a variety of objectives—administrative and statistical through the registration system, public health and epidemiological, legal and judicial. The Council would help the service to keep these different perspectives in view and in balance and encourage it to adapt to new challenges. The lack of any mechanism to bring about adaptation in a consistent way lies at the heart of some of the problems encountered in recent years.

COMPLEX AND CONTENTIOUS DEATHS: INQUESTS AND PUBLIC INQUIRIES

24. We recommended that the public inquest should be used only where there is a public interest in a public process, or there are uncertainties or conflicts of evidence best resolved by a public forensic process. If this approach is adopted there will be fewer public inquests into traffic deaths, deaths from occupational disease where the diagnosis is clear, and suicides with no suspicion of third party involvement or negligence. There would continue to be investigations of such deaths accessible to families and other interested parties, but they would no longer be in public.

25. Inquests would continue to be held into deaths in custody (unless it were clear beyond reasonable doubt that they were from natural disease), police shootings, traumatic workplace deaths, deaths attributable to crashes, collisions or sinkings of public service aircraft, vessels or road transport, child deaths of uncertain circumstances, and other deaths judged by the coroner to justify a public forensic process or with significant public interest features.
26. On this basis, inquests would tend to be held into more complex cases, and the overall number of inquests would fall appreciably though to nothing like the extent that they have fallen in some Commonwealth jurisdictions where they are now reserved for investigations on the scale of major public inquiries.

27. We were also concerned to re-establish the coroner’s inquest as a viable and effective procedure for investigating complex and contentious deaths, which would enjoy public confidence and security from challenge in the higher courts. We were struck by the amount of litigation in the higher courts over inquest scopes and outcomes, the scale and instancy of demand for ad hoc public inquiries after contentious or multiple deaths, the development of European Human Rights Convention jurisprudence, and the evidence of a large number of people—lay and professional—who had been through inquests in complex or highly contentious cases and found the process unsatisfactory. All these factors combined to convince us that the inquest in its traditional form and with its traditionally narrow scope was in need of reinforcement before it could meet the needs and expectations of the modern public to the standards increasingly required by modern law.

28. As well as the structure reforms which would enable exceptionally complex cases to be handled by a more senior judicial figure than the first instance coroner (in the same way that exceptionally complex criminal or civil cases are heard in the higher courts) we recommended some broadening of the inquest scope in cases where this is necessary for a convincing inquiry. We also recommended that the traditional inquest “verdicts” should be replaced by narrative and analytical outcomes exploring the causes and circumstances of the death, and the effectiveness or otherwise of the safety regimes designed to reduce the risks of deaths of the kind under scrutiny. It is clear that these “verdicts” (e.g., lawful killing, unlawful killing, accidental death, misadventure etc.) can in complex cases generate more heat than light, and they prevent the coroner from making findings which do justice to the often complex issues around the preventability of deaths.

29. In two recent judgements the House of Lords Judicial Committee has ruled that in cases which engage Article 2 of the European Human Rights Convention (so far interpreted to mean mainly deaths occurring in state custody or at the hands of the police or armed forces) the scope of the inquest should be extended to cover the circumstances as well as the immediate causes of a death.

30. This judgement helpfully improves the capacity of inquests to provide a suitable form of inquiry in the types of case that it covers. However, it does not cover cases where the role of the state is regulatory rather than custodial or involving the use of force. In consequence it appears that deaths, including multiple deaths, which result from train or aircraft crashes or the sinking of public service vessels, for example, will not generate inquests with the wider scope. In such cases, therefore, it seems likely that the inquest will continue to be regarded as too narrow in scope to satisfy families and the pressure for the Government to not generate inquests with the wider scope. In such cases, therefore, it seems likely that the inquest will continue to be regarded as too narrow in scope to satisfy families and the pressure for the Government to set up ad hoc judicial public inquiries will continue.

31. The higher courts may gradually expand the category of case in which they rule the wider inquest to be required by the European Human Rights Convention, but it would be preferable in coroner reform legislation, or in the subordinate Regulations which govern the conduct of inquests, to put beyond doubt the power of the coroner system to conduct inquests which properly address the circumstances and the preventability of deaths as well as their immediate causes.

32. Setting the bounds of inquiry in individual cases within the wider general inquest scope will require careful decisions by coroners and judges in complex and contentious cases. There is often multi-party representation at inquests and representation costs, as well as the inquest court’s own costs, may be high. It may be worth considering whether the new statute should stipulate that the likely cost and length of proceedings and the likelihood of findings of importance to wider public safety should be amongst the factors to be weighed. The aim would be to ensure that inquests are proportionate in scale and cost to the public benefit likely to stem from them in terms of the protection of life.

33. A provision akin to S 39 of the Inquiries Act 2005, which gives a Minister in certain circumstances discretion to withhold funding from a Government-appointed statutory inquiry if it examines matters he has certified to be outside its terms of reference, would be out of place since the Government has and will continue to have no influence over coroners’ decisions on the holding and scope of inquests, and would not be involved in the direct funding of individual inquests.

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5 Regina vs HM Coroner for West Somerset ex parte Middleton 11 March 2004 [2004 UKHL 10] and Regina vs HM Coroner for West Yorkshire ex parte Sackler [2004 UKHL 11]

6 It is relevant that the Government’s announcement recently that it will not set up a public inquiry into the Potters Bar Rail crash was followed by a statement from the coroner to the effect that he does not regard an inquest as an adequate form of inquiry into the issues
Ev 64

REFORM COSTS

34. We estimated that after transitional costs the underlying costs of the coroner service might increase by roughly 10% after some efficiency gains from scrutiny of autopsy rates and currently high referral rates for investigation. There would however need to be some additional public finance to allow for the fact that the new “two layer” certification system applicable to all deaths would replace the “three layer” system now in force for cremations, for which families pay. It does not seem likely that families would be expected to pay for any of the new service.

RELATED REFORMS

35. The Home Office has in hand a programme to improve recruitment and quality assurance in forensic pathology.

36. The Office of National Statistics launched in 2003 a programme of change to Registration procedures to make telephone and digital registration of deaths possible and to improve the privacy protection for some personal and health information used in death registration. An announcement is awaited on implementation.

37. The Human Tissue Act 2004 introduced new safeguards against malpractice in the use of body parts and tissues. It does not apply to coroners.

TIMING OF REFORM

38. There are more than half a million deaths each year in England and Wales. Since Shipman’s conviction in early 2000, when the effectiveness of death certification and coroner investigation as a safeguard became seriously suspect, there have already been more than two and a half million deaths. Since 2003, when the work of the Shipman Inquiry showed incontrovertibly the systems weakness that had allowed him to get away with his crimes for so long, there have been more than a million deaths. The reform agenda is complex and needs careful preparation but it is to be hoped that time for legislation will be found without fail in the Parliamentary session of 2006-07, following the Select Committee’s important and timely Inquiry.

Tom Luce CB
January 2006

Supplementary evidence submitted by Tom Luce CB, Chair, Fundamental Review of Death Certification and Investigation in England, Wales and Northern Ireland, 2001–03

1. In this note I offer comments on the Government’s Draft Coroner Reform Bill, as requested by the Select Committee. After a summary of main points, there is a proposal for overcoming the regulatory and cost issues the Government now associates with its 2004 proposal that all deaths should be reported to the coroner before registration. In the final paragraphs I cover some other points arising from a first study of the Bill

MAIN POINTS

2. It is valuable that the Government has published the Bill in draft for pre-legislative scrutiny.

3. The draft Bill’s scope and coverage is limited to procedural and other reforms within the Coroner Service. In this it is consistent with the Government’s statement of 6 February 2006, which made clear that the Government is no longer willing to proceed with some of the components of its Position Paper of March 2004 which covered death certification as well as coroner reform. In particular the Bill does not carry forward the intention then described to create a centrally—financed coroner service with an overview responsibility for the proper certification and handling of all deaths and which would scrutinise all individual deaths.

4. The Bill is presented as “part of a package of reforms aimed at addressing some of the weaknesses in the present coroner system, identified in the reports of the Fundamental Review of Death Certification and Investigation and the Shipman Inquiry, both published in 2003”. Beyond confirmation that coroners and the new post of Chief Coroner will be provided with medical advice, no other components of the package have so far been described.

5. Within the area of coroner reform, the Bill nevertheless offers the prospect of valuable and urgently necessary changes, which (subject to some clarification and amendment of detail) could pave the way for the most important reform and improvement of the England and Wales coroner system since the reforms in the Coroners (Amendment) Act 1926 or even since the election of coroners was abolished through the Local Government Act 1884.
6. Central to these improvements are the creation of a new unified coroner jurisdiction to replace the 120 independent local coroners, the institution of new national leadership under a chief coroner, the building of a new service around whole-time legally qualified senior coroners newly selected and appointed to fewer, larger coroner areas, new rights and status for bereaved families and other interested people, the creation of a statutory advisory council, the modernisation of coroners' inquiry and investigation powers, a rationalisation of the jury role in inquests, providing the new service centrally and locally with some medical expertise, a sensible new approach to the handling of overseas deaths, and the removal of the "treasure" function from the mainstream coroner service.

7. The Government’s decision to leave the resourcing and administration of the coroner service with local authorities is likely to compromise the prospect of achieving uniform improvements and standards in the new service (though central financing and direction of public services does not of itself provide any guarantee of either adequate funding or the achievement of uniform standards).

8. The most critical defect, however, in the Government’s position as so far disclosed is that it contains little if anything to remedy the structural defect that was a major contributor to the long drawn-out Shipman catastrophe—the absence of any effective supervision or support of death certification by doctors, and of any mechanism to ensure so far as is reasonably possible that deaths which should be reported for investigation by the coroner are so reported. In the absence of such a mechanism, the coroner service will remain reactive, and though the Bill should improve its standards of investigation, the failure to tackle this issue is surprising and extremely serious.

9. In my view the right course in the circumstances is to encourage the Government to proceed without delay with its Bill, amended and improved as necessary on certain key points of detail, but to press the Government very strongly to provide, in addition, better safeguards against such systems failure and its consequences for public safety and public confidence in the regulation of deaths.

10. In the following paragraphs I outline a basis on which the structures could be made more joined up and the safeguards against incompetent or abusive certification improved to a worthwhile extent without adding significantly to costs or to regulatory process for families, and would seem feasible to include in the present Bill without delaying its introduction.

**Amalgamating Death Registration and Investigation; or Bringing the Registration and Coroner Services Closer Together**

11. The objective is to make a public authority with the necessary skills responsible for supporting and auditing the death certification process, and, preferably, checking each death not already identified as requiring further investigation (and therefore reported directly to the coroner) before the death is registered and disposal of the body is authorised.

12. There is at present no public authority tasked to audit and support death certification. The function of registering deaths and authorising disposal of the body without further investigation is the responsibility of local Registrars of Births, Deaths and Marriages to whom after a death which has not been reported to the coroner the bereaved family must take the Medical Certificate of the Cause of Death. However, the Registrar service, in spite of its undoubted skills in registration matters, is not equipped with any medical or investigative skills, and does not have the range of knowledge of local circumstances and facilities in which deaths may occur (hospitals, care homes, prisons etc) that comes to coroners and their staffs from their death investigation work.

13. In its 2004 Position Paper, the Government accepted this line of argument in its proposal that all deaths should be reported to the coroner’s office before registration could occur and authorisation for disposal of the body could be given. This procedure would replace the present certification processes under which a doctor may certify a death without any further medical check or opinion if the body is to be buried but the family must obtain (and pay for) three medical certificates or clearances if it is to be cremated.

14. For reasons apparently connected with cost and the extra regulatory step that would be involved in burial cases by adding a referral to the coroner’s office before the death could be registered, the Government is now unwilling to go forward with its 2004 proposal.

15. It would however be possible to avoid the extra regulatory step for families of referring the death to the coroner’s office before it could be registered by the Registrar, if the registration could be effected in the coroner’s office and there was therefore, from the family’s perspective, no further regulatory step or process through which they needed to go.

16. This could be achieved in a number of different ways:

   (a) responsibility for the local registration of deaths (but not, of course, births or marriages) could be transferred from local registrars to local coroners;

   (b) alternatively, the coroner or members of his or her staff might be appointed Deputy Registrars who would deal only with deaths (not births or marriages) but who would continue to have their normal death investigation functions;
(c) or, a Deputy Registrar could be out-posted from the Registrar’s office to the coroner’s office to deal with death registration there;

(d) or, Registrars’ and Coroners’ offices could be co-located.

17. Under any of these variants the death registration process would continue to be performed under the guidance and powers of the Registrar General.

18. The first two of these variants (and possibly the third) would probably need alteration of registration legislation. This could be included in the present draft Bill, adding somewhat to its scope but probably little to its length.

19. We estimated the recurrent cost of death registration to be £6 million a year. That would in principle need to be transferred from the registration service to the new coroner service under the first two variants (to compensate the coroner service for the new responsibility it would have for covering all deaths). There would be some additional training and process costs in the coroner’s office but they probably would not be great.

20. The simplest and probably from every perspective the best variant would be the second—the appointment of the coroner and/or members of his or her staff as Deputy Registrars of deaths. This would enable the coroner service to have an oversight responsibility for and bring its special skills and knowledge to bear on all deaths without involving any extra process for families, or risking the fragmentation at local or national level of the Registrar General’s important responsibilities for population statistics and for registration.

21. A solution on these lines would pave the way for the abolition of the separate cremation certification—which every informed interest has wanted to abolish for decades and was recommended in the Brodrick report of 1973 as well as both the 2003 reform reports. This would save families the £25 million a year they now have to spend on cremation certification fees.

22. Since local registration is a local authority responsibility it would also capitalise on the Government’s decision to leave the resourcing and administration of the local coroner service at local level with local authorities, and provide wider scope for the kind of constructive local authority engagement about which the Local Government Association spoke in its recent oral evidence to the Select Committee.

23. It would be a timely and logical change now that the coroner service is to be provided with new medical skills, and represent a necessary improvement in “joined up” Government and public administration. The present situation under which the information provided by doctors and families in the certification process is not available for scrutiny by the public service with the skills and experience best suited to safeguard the public interest, when the need to improve the safeguards is now so widely recognised, is indefensible.

24. I understand that present registration legislation may prevent the sharing between registrars and coroners of registration data on any deaths other than those formally reported to the coroner. If this is so, it would prevent the coroner service, or its new medical advisers, undertaking any post-registration audit and scrutiny of death certification. There seems an unanswerable case for ensuring that such sharing is possible.

25. I respectfully invite the Select Committee to consider recommending that the Government should include powers in the legislation version of the Coroners Bill for the new coroner service to bring to bear its skills and knowledge on all deaths along the lines broadly explored in this note, by arranging for death registration to be performed in the coroner’s office.

OTHER MAJOR POLICY POINTS ON THE BILL

Inquests

26. The provisions in Chapter 2 of the Bill appear to require a coroner to hold an inquest into all deaths he investigates, unless he specifically decides not to do so for one or more of the reasons specified in the Bill. The present arrangements implicitly mean that in most cases a coroner holds an inquest after making a specific decision in favour of doing so. It is said in the Explanatory Note on Clause 11 that “It is not anticipated that the number of inquests will increase in the reformed system”. However the way in which the inquest duty is presented in the Bill may in practice mean that whatever the intention the number of inquests may increase, particularly bearing in mind the new rights of appeal the Bill provides for families and other interested people.

27. The two reform reports both argued in favour of using the inquest process more sparingly.

28. An important issue arises on Clause 10, which is concerned with the scope of inquests and investigations. The Government’s statement acknowledged that “Since the mid-1990s questions about the effectiveness of the inquest system have been voiced, particularly following major disasters such as Hillsborough, Zeebrugge, the sinking of the Marchioness and the complexities which arise in investigating
such as deaths occurring in police custody or in prison”. However, the provision in Clause 10 appears to constrain all inquests to a narrow scope except those into deaths which fall under Article 2 of the ECHR. The category of deaths which the courts have so far found to be within the scope of Article 2 are mainly those which occur in custody or as a consequence of police or other law and order operations. Deaths in other settings, including those which occur in mass disasters such as the Marchioness sinking and call into question the adequacy or observance of the relevant safety regulations, have not so far been held to be within the scope of Article 2.

29. The effect of the Clause as it stands appears to be to limit the scope of “disaster” or other complex and contentious inquests to an investigation of “by what means” the deceased died. In case of multiple deaths in the sinking of a public transport vessel, this may mean that the inquest would be limited to finding that the deaths had been caused “by drowning”, without any investigation of the underlying causes or circumstances.

Few would accept this on its own as an adequate or sensible outcome to a serious investigation and such a limitation on the bounds of inquiry would undermine the valuable structural improvements which the Government intends for complex inquests—the use of the permanent judiciary in some cases, and the appointment of “Counsel to the Inquest”, for example

30. If there is a concern that inquests into deaths where the wider scope is not mandated by Article 2 may be disproportionately long and expensive, it could be addressed by allowing senior coroners to conduct “non-Article 2” inquests with the wider Article 2 scope, provided that they have the authority of the Chief Coroner.

POST-MORTEMS/AUTOPSIES

31. The provision in Clause 26 (1) giving a senior coroner power to define the “description” of post-mortem he commissions should be strongly supported.

32. It is to be hoped that the language of the sub-clause is sufficiently broad to enable the coroner to order, for example, that there should be an expert external inspection of the body which should not proceed to an autopsy unless, taken with all available clinical and other information on the death, the external examination shows grounds not previously known to the coroner for a partial or full autopsy.

33. If so, the Clause would seem to provide for the Scottish “View and Grant” system in which the Select Committee has shown a consistent interest and which could with great advantage be introduced to England and Wales.

34. However, Clause 9 can be interpreted as requiring the coroner to commission a “post-mortem” before he can conclude any investigation. This may not be the intention (though the Explanatory Note seems to convey the same idea). The meaning of the provision needs clarification, and perhaps justification. If it means what it seems to, the effect would be significantly to increase the number of “post-mortems”, which, whether the term is given the broader meaning as in paragraph 32 above or the narrower meaning of “autopsy”—its meaning in normal usage—seems to be going in the wrong direction.

PROHIBITIONS ON PUBLICATION

35. Clause 30 gives coroners power to prohibit the publication of the deceased’s identity, even in cases where there has been a public inquest. No doubt the whole set of issues around publicity and privacy will be fully explored in proceedings. The Government’s February statement said “Coroners will have discretion not to hold a public inquest in limited cases, for example some suicides and child deaths, where no public interest would be served by a public hearing”. However, this intention does not seem to be conveyed in the Bill which seems instead to provide for public inquests in such cases, with a power to prohibit publication of the deceased’s name (notwithstanding that the inquest may be attended by the press, other family members, and the public), but not any power to prohibit publication of intimate or domestic details which may be referred to at the inquest but which there is no public interest in broadcasting.

36. This whole area may need further thought. It is one thing to conduct investigations into such cases out of the public eye if there is no public interest in public proceedings, or to hold public inquests and then restrict the broadcasting of intimate material not essential to the outcome. It is another thing altogether to allow the death investigation system to conceal the identity of the deceased, particularly since the statutory registration process requires coroners to provide registration details, including the deceased’s identity, for inclusion in the publicly accessible register of deaths.

Tom Luce CB
July 2006
Evidence submitted by Michael Burgess, HM Coroner for Surrey

INDEX

Submission

Appendix 1: Statistics

Appendix 2: The Role & Function of the Coroner in England & Wales

Appendix 3: Changes to the Coroners Act 1988 to make it more “fit for the purpose”

Appendix 4: Profile of The Coroners’ Society of England and Wales

Initial Note: This submission is being made with the agreement of Mr V F Round, HM Coroner for Worcester, the present Honorary Secretary of the Coroners’ Society of England and Wales.7

SUBMISSION

1. Coroner Service: There is no national coroner service in England and Wales.

2. Instead, there are individual office holders each personally responsible for carrying on the coroner function in his/her own district. Each has exclusive responsibility. Coroners have been described as “independent judicial officers”. The only oversight is by the disciplinary powers of Lord Chancellor,8 the collection of annual statistics by the DCA (formerly by the Home Office) and by the High Court, via proceedings for judicial review by an aggrieved party.

3. The Law: The function of the coroner and limitations are to be found primarily in statute law. Coroners Act 1988 (“the Act”) is a consolidation act and re-consolidates previous Acts. Essentially, the inquest process as presently laid down is an early 19th century legal process. The coroner was expected to carry out his duties locally relying on local resources for everything. Then there were different concerns addressed in a very different way, without any delay. It was very parochial. The way in which the whole system works at a local level is set out in Appendix 2.9

4. There are 112 coroners. They are barristers, solicitors or registered medical practitioners of not less than 5 years standing.10 Eleven are registered medical practitioners—some of whom also are qualified lawyers. Twenty-seven coroners hold “whole-time”11 appointments, with the rest free to carry on their medical or legal practice. The whole-time coroners deal with approximately 50% of all cases referred to coroners.12

5. All coroners are equal: There is no hierarchy or different levels of seniority of appointment. In their individual districts, each coroner has precisely the same power and authority, regardless of the length of their appointment, size of their district or their relative experience.

6. Each coroner—
   (a) has been appointed by their own relevant council;13
   (b) is paid and otherwise resourced by their relevant council and/or local police force;
   (c) is required to interpret the law and apply it in the individual, particular cases that come to his/her jurisdiction; and
   (d) is permitted only to hold inquests in his/her district14.

7. Local Service: It is a local service, totally determined by the position of the body, NOT by the place where the cause of death arose. Therefore, the law requires—
   (a) Local post-mortem examination,16 if there is to be one;
   (b) Local coroner’s inquest, if there is to be one;
   (c) Local registrar will report the death and record the necessary registration details;
   (d) Local police will usually provide coroner’s officers; and
   (e) Local funding will be provided by the relevant council.

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7 See Appendix 4 for a profile of The Coroners’ Society
8 s 3(4) of the Act
9 Appendix 2 was originally prepared for another forum but broadly sets out the different features
10 s 2 (1) of the Act
11 If they hold a whole-time appointment, and are a barrister or solicitor, they may not otherwise engage in any professional business (s.75 & sch 11, Courts and Legal Services Act 1991)
12 Some basic statistics are set out in Appendix 1
13 s.1 of the Act
14 Ss. 27 & 31 of the Act
15 s. 5(2) of the Act
16 s. 22 of the Act allows the coroner to remove the body only so far as an adjoining district for the purposes of a post-mortem examination
8. While coroners and the Coroners’ Society make their own unresourced efforts to share experience and information, there is no national system to facilitate it or legal requirement to do so.

9. Reviews of the System: There were 3 major reviews of the coroner system in the first 71 years of the 20th Century, though none of the reports was implemented in its entirety.

10. Following the conviction of Harold Shipman, on multiple counts of murder, reviews of the coroner and registration systems were ordered. These were eventually undertaken by Dame Janet Smith (as part of the Shipman Inquiry) and Tom Luce chairing the Home Office Fundamental Review.

11. Many of the recommendations seemed broadly sensible and would pave the way for a single national service across England and Wales. Between them Dame Janet and Mr Luce held out solutions which, though different in detail, would both, nevertheless, have created a single national service, funded centrally.

12. Dame Janet’s report recommended the establishment of an extensive network of medical examiners who would scrutinise and then authorise every death certification with a small cadre of legally qualified coroners who would deal with the (rather more limited in number) inquiries/inquests. It is unclear how locally available the service would be.

13. Her proposals for the more limited provision of inquests would also give rise to problems—
   (a) case law has now recognised and imposed upon individual coroners’ inquests a larger function, namely the discharge of the duty of the State to investigate under Art 2 of the European Convention on Human Rights loss of life in which the State is in any way involved; and
   (b) while some reduction in public inquest hearings might well be desirable, a large scale imposed reduction might well be mistrusted and resented by the people most closely affected and by society at large.

14. Mr Luce proposed a system which was evolved and more directly derived from the present coroner system with medical examiners sitting in the coroner structure. There would be a reduced number of coroners, most of not all as whole-time coroners. The service would have a strong local presence.

15. As stated, both would have resulted in a single national system and be part of the national court service. This should result in more resilience and potential flexibility and ready access to the court accommodation (this is frequently a major problem) and a more extensive training capability than the present limited facility.

16. The Home Office received the reports and in March 2004, published their “Position Paper”. Since then, a number of indications, formal and informal have been offered by ministers and officials but nothing material has yet come about and coroners individually still run the “old” system.

17. We have seen how, overseas, coroner systems based upon the English statutory model have successfully developed into an effective inquiry tool. In North America, the different United States and in the “old” Commonwealth (Canada, Australia and New Zealand) have all developed such systems. Dame Janet Smith heard evidence from Australia and elsewhere and Mr Luce and his team visited and examined several foreign systems. I visited Victoria (Australia) with Mr Luce and members of his review team in January 2003.

18. In England and Wales, in the meantime, we wait wondering what, if anything will happen. Will these 2 reports, with all their good sense, go the same way as previous reports? Some coroners feel that they have been left, abandoned.

19. “Reform Blight”: Many coroners feel that they suffer from “reform blight.” In the Government’s position paper of March 2004, it said that they would claw-back the existing cost of running the service from the present resource providers. It is small wonder then that there is real reluctance on the part of many relevant councils and police forces to put further (even extra or “new”) funds into their local coroner service, if the end result is that they are going to lose that as well.

20. There are delays brought about in part by insufficient and inadequate resources. Coroners sometimes feel that there are those who seek to criticise when deficiencies are evident but few who wish to “own” (and resource) the service.

17 Chalmers in 1910, Wright in 1936 and Brodrick in 1971
18 Mr Luce’s report was published in June 2003 and Dame Janet Smith’s Third Report in July 2003
19 2004 House of Lords case R (Middleton) v Coroner for W Somerset
20 Para 84 of the Home Office position paper—“We intend our reforms to be affordable within existing resources. To achieve this, we will need not only to make an accurate assessment of the existing resources but also ensure that existing resources can be captured and re-directed towards the new system. We will need to plan a timed development and phasing as necessary for resourcing”
21. **Consistency:** Daily, coroners are all very conscious of the bereaved families and others touched by the deaths with which they deal. So far as circumstances and resources permit, they are striving for a consistency of approach so that everywhere the standards are raised, that is there is a levelling up of standards. Our 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.

22. **The needs of the coroner service:** In the meantime, coroners have done as much as they can by massaging the system to move the quality of service forward into what should be expected in the 21st century but they are constrained by the limited resources, human, financial and legal, with which we are expected to address a range of very different types of issues—

   (a) Article 2 inquiries, especially into police shooting, prison or custody deaths;
   (b) Detailed and sometimes complex medical inquiries,
   (c) Provide protection to prevent another “Shipman”
   (d) Police the death certification system
   (e) Determine limited factual circumstances in non-natural deaths.

23. **Making the existing Act fit for the purpose:** Some of the legal problems could be relatively easy to resolve. Amendments21 to s. 5(2), s.14 and s.22 would make the existing Act much more “fit for the purpose” and also buy a bit more time. The suggestions detailed in Appendix 3 are neither partisan nor controversial. They were offered to ministers as a non-controversial solution but to date no one has not taken them forward.

24. **Cost of providing Coroner Services:** Together, the total cost of providing coroner services across England and Wales is believed to be in the order of £75 million per year. These are primarily charges on the relevant local councils and police forces. The direct cost to central government is very small.

25. On the premise that it is the expense to central government that dictates the level of government interest, it is understandable why so little time is devoted to resolving these issues. However, on the premise that, at some time or other, 38% or more of the population will have some direct involvement with their local coroner, it may be argued that the coroner system actually touches more people than most other court systems. Thus, it should be got right.

26. **Need for clear understanding as function etc:** It is to be hoped that this Committee will be able to move matters forward so that the national service so long needed becomes a reality. Death is local; we therefore need a local presence. More importantly, though, there must be a clear understanding of the function, purpose and expectations of the coroner and the service.

27. **Resources:** Flowing from that, there is an obvious need for proper resources, legal, human and financial.

   (a) **Legal Resources:** Coroners must be given the right legal powers and authorities to perform whatever function is required of them.
   (b) **Human Resources:** They must have sufficient trained officers and staff; and
   (c) **Financial and Other Resources:** Coroners are entirely dependant upon others for the provision of accommodation and facilities. In particular, as coroners are not part of the mainstream court service, there are frequently very long delays in getting access to courts and court facilities. A number of coroners have complained about having to adjourn jury cases, part heard for several months, because allocated the court time was insufficient.

28. **Further Information:** Should the Committee require any further information or detail I will be happy to provide it. Amongst other material, both the Coroners’ Society and I personally provided detailed information to both Dame Janet and Mr Luce.

29. Finally, on a personal note, I spend a good deal of time as a Society spokesman meeting with government officials and others and discussing the function of the coroner, especially in the context of emergency planning and mass fatalities. The various limitations that statute imposes on coroners causes incredulity among the mainstream emergency services who seem to be able to address their responsibilities in a flexible and effective way that coroners can only dream about. The re-structuring and reform could change all that.

*Michael Burgess*

*January 2006*

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21 An outline of the problems and the suggested remedies are is to be found in Appendix 3
### Appendix 1

#### Statistics

For calendar year 2004

- (a) Number of deaths in E&W (Total) 514,000
- (b) Number of referrals to coroners 225,511
- (c) Number of PMs ordered by coroners 115,773
- (d) Number of Inquests held by coroners 28,274

### Appendix 2

#### The role and function of the coroner in England and Wales

1. The system of death certification is one in which a number of different people have distinct and separate roles. These include the coroner. Let us examine each in turn—

2. The medical practitioner who has been "in attendance on the deceased" during the last illness is required to complete a medical certificate of cause of death—this should be completed to the best of his information knowledge and belief and should have seen the deceased either within the 14 days before death or after death. The duties cannot be delegated, even to a medical practitioner’s partner, though if a death is expected imminently, then it may be possible for a doctor to pass responsibility for the patient over to a partner.

3. This may well cause problems when a doctor’s out-of-hours responsibility are addressed by a specialist referral or locum service where the attending doctor has no personal knowledge (and certainly is not the medical practitioner “in attendance during the last illness”) of the deceased.

4. This medical certificate is then passed via the “informant”, to the Registrar of Deaths and if, on the face of it, the cause of death is one that may require referral to the coroner then the Registrar will take this course of action—the Registrar has a duty to see whether the certificate is properly completed and that the certificating doctor has fulfilled his responsibility in seeing the deceased either within the 14 days before death or after death.

5. To minimise the distress to families, the coroner is frequently approached by the certificating doctor at an early stage, ie, before the Registrar is presented with a certificate, in order to iron out problems before they arise. If the disposal of the deceased’s body is to be by cremation, then the attending medical practitioner has also to complete a cremation form and this has to be referred to a second, independent doctor, before being passed to the Cremation Referee.

6. The coroner becomes involved when the certificate either cannot be completed or is completed incorrectly or demonstrates a cause requiring a referral to the coroner. Coroners are independent judicial officers whose main interest is that of the investigation of deaths. The principal law is Coroners Act 1988 (a consolidation act)—"the Act".

7. A coroner is a lawyer or doctor, is appointed by the “relevant council” but is not an employee, and cannot be dismissed other than by the Lord Chancellor for misconduct etc. Most coroners (about 100 out of 130) are part-time, carrying on their legal or medical practice. Their respective caseloads and coronal experience will vary.

8. A coroner takes jurisdiction from the presence of a body lying in his district regardless of where the incident arose. Once there is such a body, then it is mandatory for the coroner to conduct an inquest. In effect he is solely responsible for investigations into the bodies lying within his district.

9. s. 8(1) of the Act says that "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 . . . .”

10. A coroner is appointed to a specific territorial district and may only work within his district. A coroner may remove a body of the district to an adjoining district for the purposes of a post-mortem examination. Coroners may transfer cases between themselves but only by mutual agreement or if there is a refusal on the part of a transferee coroner, by order of the Secretary of State. Responsibility for paying the expenses incurred follows any change in jurisdiction.

11. There must be a “body”—coroners do not normally have the authority to investigate a death if there is no body. An inquest may be adjourned for a criminal trial or judicial inquiry to take place. However, the coroner remains responsible for registering the death(s) and may also resume the inquest(s) following the trial or judicial inquiry.

*Originally prepared: 9 October 2004*
Appendix 3

AMENDMENTS TO THE CORONERS ACT 1988 OFFERED TO THE LORD CHANCELLOR AND MINISTERS IN JULY 2005

1. What I am proposing is not a departure from the current “norm” — that there is and should be exclusive jurisdiction arising for the coroner in whose district the body is lying. This principle has ensured that there should be an effective safety net, provided the other parts of the net, the certifying doctor and registrar, each play their roles.

2. I have repeatedly had to explain to the many different fora concerning mass fatalities and/or emergency planning that coroners are different, that there is no automatic “mutual aid” and when there is, there are very serious cost implications.

3. The proposals are minimal, are cost-neutral or even cost beneficial.

4. The proposals could allow for some degree of case expertise to develop among coroners. By way of an example if all the amendments were to come about, a coroner could accept a transfer of a particular type of case from another coroner without taking responsibility of the expenses of that case to be transferred. The transfer could be made at any time up to the hearing of the case, and the presiding coroner could sit at whatever location best suited the case and witnesses, without the coroner having either sit in his own district or be appointed a deputy/assistant deputy to the original coroner.

5. In the case of mass fatalities, they could more easily be addressed by (a) coroner(s) at a regional level with a single regional mortuary able to take fatalities not just from the district of the mortuary or from the districts adjoining but from wherever the bodies lie.

6. These problems have been well-known and understood by coroners for some time. However, it was various difficulties that arose during the 7 July 2005 Bombings that brought this once more to the fore. I have had several discussions with Paul Matthews, one of the coroners concerned and he agrees with the suggestions that I am making. What were these difficulties?

(a) Difficulties in transfer the body has to be lying in the district when the transfer is actually made for a s.14 transfer to be made (the section states “in the case of a body lying in his district”) The only way to effect a transfer if the body is outside the coroner’s district, is artificially to take the body back into the original coroner’s district solely for the purpose of effecting a transfer to another coroner.

(b) Each body or body part becomes the subject of a separate transfer — in the case of the 7 bodies at Aldergate (in Matthews’ district—City) this required 20 separate agreements—there should be a change to cover all deaths associated or arising from a single incident

(c) Normally, costs and expenses follow the coroner exchange—this may be inequitable, especially in this sort of case, There should be a change to enable coroners to agree the way that expenses should fall.

(d) It should be possible for Lord Chancellor to intervene and impose a solution (inc expenses) even without a dispute arising and reference to SoS under s.14 arbitration and dispute resolution processes.

(e) Coroners only able to move bodies a single district (ie, to an adjoining district) for PM. In these days of specialist regional hospitals it is not practicable or realistic. In cases of mass fatalities where there is an increasing move to a regional solution, not legally possible. S.22

(f) Coroners may only hold inquests in their own district. In cases where we may expect families to come some distance, to have to visit both the family meeting centre and then the emergency mortuary to expect them to go, possibly some distance to attend the opening of the inquest is unreasonable. In addition to which there is an increasing difficulty for coroners to find suitable accommodation fro running cases whilst there may be relatively close at hand but in the district of another coroner suitable accommodation that is lying unused.—S.5(2)

POSSIBLE AMENDMENTS TO CORONERS ACT 1988

Suggested new text/Amendments are shown in BOLD

s.22 of the Act—Removal of body for post mortem examination

A coroner may only remove a body to an adjoining district for the purposes of a post-mortem. Coroners already have considerable difficulty in transferring bodies to mortuaries having specialist facilities, eg, for child deaths, burns, highly infectious, diving or specialist neurological examinations. There are now fewer of such specialist hospitals and probably not one in the coroner’s district or in an adjoining district.

Removing this limitation enables every coroner to send bodies to the most suitable mortuary, regardless of its location.
In mass fatality situations: It has already become evident that however useful that facility may be it is actually quite insufficient to address the potential; if emergency mortuaries are established at, for example, a regional level (ie, other than at a very local level) and/or if a number of incidents arise so that bodies lie in different coroner’s districts it may be impossible to work out of a single mortuary because the coroners with jurisdiction may be more than one coroner’s district distant from the emergency mortuary location.

Increasingly we are looking at regional solutions for providing dedicated emergency mortuaries. This is only realistic if this amendment follows through.

I suggest that the following amendments should be made—

Section 22 (1) Subject to sub-section (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 or within an adjoining district of another coroner.

(4) Where a coroner—

(a) orders under this section the removal of a body to any place outside his district; and—

(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

s. 14 Transfer out of jurisdiction

Although coroners may transfer jurisdiction, this can only arise if—

(a) they agree; and

(b) the body is lying within the district of the transferor coroner.

Removing this condition precedent would obviate that problem. It would enable coroners to transfer jurisdiction between themselves in the fullness of time, possibly after further information has come to their knowledge including information which, if it had been known at the time, would have enabled a transfer to take place immediately after the death.

Mass fatalities: If bodies are very quickly moved to another district for the purposes of a post-mortem, the coroner is incapable of availing himself of this facility—in effect, once the body has left the district the coroner has to hold the inquest regardless of the logic of transferring and also the willingness of the coroners to transfer.

I suggest that the following amendments could be made to Section 14

14. (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 either a particular body over which he has jurisdiction whether or not it is then lying in his district or a number of bodies arising from a single incident but it is expedient that the Inquest or inquests should be held by some other Coroner, he may request the Coroner to assume jurisdiction to hold the inquest or inquests; and if that Coroner agrees he, and not the Coroner then having jurisdiction 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 Lord Chancellor 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 Lord Chancellor—

(9) The Coroner who assumes jurisdiction to hold the inquest and the Coroner within whose district the body is lying may agree between themselves who shall pay the whole or any part or parts or proportion of any fees or other expenses incurred directly or indirectly in respect of the inquest but unless the coroners otherwise agree, 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.

However, there is a further anomaly in section 14 that needs to be considered.

There may well be instances when a coroner, for any number of reasons (eg, ill-health, work-load, inexperience, or neglect) failed to take cases forward to inquest. This proposal would enable the Lord Chancellor to direct another coroner to take such cases forward to inquest but for the costs and expenses to remain with the original coroner’s relevant council.

Mass fatalities: Coroners may be unwilling to transfer either because of their own desire to retain jurisdiction or because of the liability for the costs and expenses which passes.
I suggest an entirely new Section—

New Section 14A

Notwithstanding the provisions of section 14, the Lord Chancellor may at any time direct a coroner to transfer jurisdiction in respect of either an inquest into a particular body or a number of inquests into particular bodies arising from a single incident in respect of which no inquest has yet been completed to another coroner and in his direction the Lord Chancellor shall also direct which coroner shall pay any fees or other expenses incurred in the course of his duties by both the transferee coroner before he ceased to have jurisdiction and by the transfereree coroner after he assumed jurisdiction and any such fees or other expenses shall be accounted for and repaid accordingly.

Section 5(2)—Jurisdiction of Coroners

Many coroners are already having substantial difficulty in finding suitable accommodation, whether in HM Court Service (DCA) courts or otherwise, and yet possible accommodation may well be available close at hand but denied to them because it is not physically in their district. The effect of this repeal would enable the coroner to sit wherever he could best arrange the inquest, whether inside or outside his district. Mass fatalities: This limitation means that a coroner has to return to his own district and to premises capable and suitable of being used as a coroner’s court both for opening the inquest and for the subsequent full hearing(s). If the coroner is having to spend considerable time at the emergency mortuary which may be far removed from (or even outside) his own district, then he may be put under considerable and unnecessary pressure. When the time comes for resuming the inquests, the probability is that the “usual” premises used as a coroner’s court will be of insufficient size to accommodate the inquest and/or available for a sufficient length of time.

I suggest therefore a repeal of Section 5(2)—

(2) Subject to subsection (3) and section 13 below, a coroner shall hold inquests only within his district.

Appendix 4

Profile of the Coroners’ Society of England and Wales

The Coroners’ Society of England and Wales was founded in 1846. All those holding coronial office in England and Wales are members. The Objects of the Society include—

— the promotion of the usefulness of the office of coroner to the public;
— the ascertainment in questions of difficulty of the duties which devolve upon coroners;
— the advancement of such amendments to the law as seem desirable;
— the establishment and maintenance of contact with HM Government; and
— the protection of the rights and interest of coroners.

The Society numbers amongst its members all the coroners holding appointments in England and Wales and most of their deputies and assistant deputies.

The Society has regular Contact with HM Government.

Under the Rules of the Society it is the Hon Secretary who has the day to day conduct of the affairs of the Society.

Supplementary evidence submitted by Michael Burgess, HM Coroner for Surrey

Many of us, individual coroners and many others with an interest in the coroner system, have spent many thousands of hours contributing to these two inquiries that resulted in the reports. We received the Position Paper 2 years ago and have now studied, albeit briefly the Minister’s Statement and Briefing paper and Hansard, too—I do hope that matters are moving forward. It really would be most unfortunate if this opportunity was lost and significant reform was not taken forward.

However, it does look very much as though the prospect of a single national coroner system being part of and integrated into the Court System has been abandoned by Government and that this opportunity for any significant reform seems to have been lost. As I make clear in paras 1 & 2 of my submission, there is no national coroner service in England and Wales. Instead, there are individual office holders each personally and exclusively responsible for carrying on the coroner function in his/her own district. It is unclear from the Minister’s statement whether her reforms will change this.

During both reviews, we all participated and welcomed the scrutiny that had been given to the work we do and the genuine appreciation and analysis of the function we presently perform. The reports offered clear “road maps” for the future. In paras 11-18, I make some general points about the 2 reports and the reservations which many coroners have about the suggested new coroner service. There is obvious apprehension and the longer the uncertainty continues, the more concern there is. Some coroners feel that they have been left, deserted, abandoned even.
A Body Focused system—The whole coroner system was and is focused on “the body”—the presence of the body determines which coroner if any takes jurisdiction, empowers the coroner to authorize a PM and thence to take the further step to hold an inquest. Without a body there can be no inquest, no inquiry—the coroner has no part to play in any investigation concerning the death (unless the SoS has given his licence [s.15 of the CA] when there must be a connection with proximity to the coroner’s district).

Bereaved—There may well be tensions at times between the wishes of families and the interests of justice. Inquests were intended to view matters objectively—they were not intended to reach conclusions only from the position of the families. Of course we do and will strive to be fair and helpful to relatives and others suffering bereavement but coroners should not be expected to be other than independent.

The prospect of fewer inquests?—At para 13.b, I suggest that while some reduction in public inquest hearings might well be desirable, a large scale imposed reduction might well be mistrusted and resented by the people most closely affected—ie the bereaved—and by society at large. That is not to say that there should be fewer investigations. As I referred to a moment ago, I do feel that if the Minister is going to reduce the number of inquests then this may be no bad thing

Michael Burgess
March 2006

Evidence submitted by the Coroner’s Officers Association (COA)

SUMMARY

The Coroner’s Officers Association (COA) was formed in 1997 because of concern that there was little or no training available for coroner’s officers; no standardisation of practice, and as a result a variable level of service was provided to the bereaved.

The COA gave evidence to the Shipman Inquiry, and the Coroner Service Review. We have representatives on various working parties and committees and we have regular meetings with the Coroner Service Reform team at the Home Office/Department for Constitutional Affairs (DCA). We are currently working, with some funding from the DCA, on a COA national practice and procedure manual, which we believe will go some way to standardising practice.

Although we are a small association, we have made a significant contribution over the past few years by instigating, developing and delivering training for coroner’s officers. However, current employers do not view the Coroners service a priority, so despite the fact that some training is now available, many officers are still not receiving it.

A number of improvements have been made to the Coroner service in the interim period, which has substantially increased workloads and the number of tasks coroners officers have to carry out. With the possibility that coroner’s officers may transfer to another employer, there has been significant reluctance from current employers to invest in coroner’s officers and in, what we believe is, an already an under funded service.

The strain is now telling, due to lack of acknowledgement of their role, insufficient investment in staffing and training, officers are leaving or thinking of leaving the service. This loss of expertise can only have a detrimental impact on both the current and future service to the bereaved.

THE PRESENT

1. Evidence suggests that following the publication and recommendations of a number of reports including the Luce, Shipman and the Isaacs Reports, more deaths are being reported to the coroner. This factor combined with the recent amendments to Coroner’s Rules 9 and 12, along with a significant rise in the numbers of inquests opened and adjourned, and diminishing support from employers, has meant that many coroner’s officers are now experiencing a substantial increase in their work loads, backlogs are building, resulting in delays in cases being heard.

2. Due to the recent uncertainty with regard to the Coroner service and the suggestion that coroner’s officers would be transferred to another employer; there is great reluctance on the part of existing employers to invest in coroner’s officers and in, what we believe is, an already an under funded service.

The strain is now telling, due to lack of acknowledgement of their role, insufficient investment in staffing and training, officers are leaving or thinking of leaving the service. This loss of expertise can only have a detrimental impact on both the current and future service to the bereaved.

3. As a result, the service is losing some of its more experienced officers. The COA believes that this and the factors identified in paragraphs 1 & 2 have the potential for a significant impact on the interim and future provisions of a service to the bereaved.

4. The COA was formed by coroner’s officers in 1997, because of concern that there was little or no training available for coroner’s officers; no standardisation of practice, and as a result a variable level of service was provided to the bereaved.
5. The COA has developed training components which are included in our conferences. We also arrange a one day training symposium once a year. This is done on a voluntary basis, and in the past was funded solely from member’s subscriptions. More recently however, the COA has received some funding support for our conferences and symposia from the Home Office/Department for Constitutional Affairs.

6. Since 2002, the COA has, in partnership with the University of Teesside, been instrumental in developing some training courses, which are the only accredited courses designed and available specifically for coroner’s officers or other staff working in association with the coroner service. Unfortunately most officers are unable to attend the courses, due to the reluctance of employers to provide funding to pay for the courses or lack of available cover to enable them to attend.

7. There is scant acknowledgement of the quality and professionalism of coroner’s officers in post today. It seems incongruous that the practitioners who are dealing with the bereaved on a daily basis are not given adequate resources; training and support to enable them to develop the skills to ensure the bereaved get the quality service they expect and deserve.

8. The COA actively seeks a significant improvement in the professionalism of the Coroners service. We strongly believe that all deaths should be reported to the coroners’ office for scrutiny. As outlined in our response to the Fundamental review (Appendix A)

9. We envisage a service with:
   — Appropriate recruitment and retention of suitably qualified staff.
   — Clearly defined roles for all staff and a progressive career structure.
   — Appropriate education and training on appointment with continuous professional development, in order to ensure that best practice is achieved and the needs of the judicial process and the bereaved are met.
   — A register of practitioners with a “certificate to practice”, following appropriate training and assessment.
   — Clearly defined roles and responsibilities for all coroner service staff.

10. The Coroners’ Office
    — Full-time coroner.
    — Full-time deputy coroner.
    — Full-time medical examiner attached to department for consultation and authorisation of documents in natural deaths.
    — Mandatory training for coroners/deputies/medical examiner (to include management skills training).
    — Trained coroner’s officers (to include management training for senior officers).
    — Trained coroner’s clerks.
    — Trained office staff to carry out administration.

    — Facilitating enquiries from any person regardless of place of death.
    — Facilitating national statistical analysis.
    — Setting appropriate parameters to flag defined trends.
    — Out of England applications linked to original record regardless of where body is laying.

12. Electronic link to Registrar General.
    — Rapid download of “authorised” forms for Registrars to retrieve on to their own system, allowing families to register early and without additional journey to Coroner’s Office.
    — Standardisation of documentation and procedures in England and Wales. The public would benefit from a common standard.
    — All deaths reported to the Coroner’s Office, no need for NOK to collect medical certificate of cause of death from GP or hospital.
    — All documentation relating to a death/registration/disposal emanating from centralised office in a Coroner’s jurisdiction.
    — All information/documentation should be computerised and printed ready for signature.
    — All Inquest documentation to be signed by Coroner.
    — All other documentation signed by two signatories, the Snr Coroner’s Officer and Medical Referee.

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22 The courses are: Fundamental Medicine for the Coroner Service; Bereavement and the Coroner Service and Medico-Legal Death Investigation
— All Burial and Cremation documents issued by Coroner’s Office.
— All other standard letters, statements and witness warnings produced from computer.
— All expenses incurred entered on to computer by office staff.

13. Coroner’s Officers.
— Role to be recognised by Act of Parliament.
— All Coroner’s Officers to be appropriately trained to 1st 2nd and Senior level (Appendix B).
— Entry level (level 1) with entry examination.
— Initial one month training in medical/legal/coronial rules: serve a one year probationary period, gain on the job experience working under supervision.
— On completion of first year, receive a certificate to practice and progress to level 2. After completion of 2 years foundations studies programme, the officer is eligible to be entered on to a professional register.
— Suitable experience and management training to senior level.
— Mandatory continued professional development to remain current with legislation and procedures.
— Salaries commensurate with responsibility of role.
— Minimum of 6 weeks paid leave per year and appropriate support from occupational health at least to the standard presently given to FLOs.
— Empowered on behalf of HMC (within clearly defined protocols) to authorise post-mortem examinations.
— Power of entry, search and seizure: early preservation of evidence relevant to the Coroners’ Inquiry.
— Level 2 and Senior Coroner’s Officer to pronounce life extinct after suitable training and accreditation.
— Office accommodation, resources and equipment appropriate for the role to carry out functions.

14. Training
Minimum training requirement should include:
— Death certification, registration and referral to the coroner, basic coroners’ law and documentation. Requirements for disposal of deceased remains.
— Effective and ethical communication with the bereaved.
— Equality and Diversity issues in the context of sudden death and the coroner service.
— Handling difficult situations such as conflict and identification issues with the bereaved.
— Basic anatomy and physiology, with an understanding of disease, procedures and causes of death.
— Understanding GP/Hospital medical records.
— Understanding the context of co-existent enquiries eg: police, Health and Safety Executive, Judicial public inquiries.
— Statement taking, record keeping.
— Preparation and management of Inquest files.
— Attending a scene and what to look for.
— Personal Health and Safety.

15. Finance
Present
— The COA believes that an injection of finance to support an increase in resources and training is now urgent.

Future
— The COA believes that some of the financial implications of these proposals could be offset by the fees for cremation certificates paid to doctors, which would then be invested in the Coroners Service.
— Introduce fee for other certificates such as the “Out of England” and Burial certificate.

Mrs Christine C Hurst
Chair
Coroner’s Officers Association
February 2006
Appendix A

PROPOSAL FOR THE IDEAL MODEL REPORTS OF DEATH

1. ALL DEATHS IN ENGLAND AND WALES TO BE REPORTED TO THE CORONER’S OFFICE BY DOCTORS, HOSPITALS, POLICE, AMBULANCE, FUNERAL DIRECTORS AND ANY OTHER PERSON.

2. CASE TO BE DISCUSSED WITH A CORONER’S OFFICER (LEVEL ONE OR LEVEL TWO) WHO WILL OBTAIN FULL CIRCUMSTANCES OF THE DEATH, THE MEDICAL HISTORY AND THE IDENTIFICATION OF THE DECEASED.

3. BASED ON CIRCUMSTANCES AND INFORMATION OBTAINED, CASE WILL BE DIRECTED INTO ONE OF THREE CATEGORIES.

4. CATEGORY 1
   CAUSE OF DEATH IS KNOWN BY DECEASED’S DOCTOR AND IS NATURAL WITH NO SUSPICIOUS CIRCUMSTANCES.
   4a. WRITTEN NOTIFICATION OF CAUSE OF DEATH FROM MEDICAL PRACTITIONER.
   4b. ISSUE FORM ‘A’ SIGNED BY SENIOR CORONER’S OFFICER AND COUNTERSIGNED BY MEDICAL REFEREE.
   4c. RELATIVES ATTEND LOCAL REGISTRAR OFFICE TO COLLECT DEATH CERTIFICATE.
   4d. COMPLETE CORONER’S RECORDS, SEND DOCUMENTATION ELECTRONICALLY TO REGISTRAR GENERAL, FILE HARD COPY.

5. CATEGORY 2
   CAUSE OF DEATH UNKNOWN BUT THOUGHT TO BE NATURAL OR UNNATURAL BUT NOT SUSPICIOUS.
   5a. PROCEED TO POST-MORTEM EXAMINATION.
   5b. CAUSE OF DEATH FOUND TO BE NATURAL — ISSUE FORM ‘B’ COUNTERSIGNED BY MEDICAL REFEREE AND LEVEL 2 & SENIOR CORONER’S OFFICER.
   5c. CAUSE OF DEATH FOUND TO BE UNNATURAL OR UNASCERTAINED.

6. CATEGORY 3
   CAUSE OF DEATH SUSPECTED TO BE SUSPICIOUS OR UNNATURAL.
   6a. PROCEED TO SPECIAL SKILLS POST-MORTEM EXAMINATION.
   6b. CAUSE OF DEATH FOUND TO BE SUSPICIOUS.
   6c. CAUSE OF DEATH FOUND TO BE NATURAL — REFER TO 5b.

7. OPEN AND ADJOURN INQUEST.
   7a. ISSUE INTERIM DEATH CERTIFICATES.
   7b. FULL INVESTIGATION OF DEATH BY POLICE SERVICE IN CONJUNCTION WITH CORONER’S OFFICE. SECOND POST MORTEM IF REQUIRED. POLICE AND CORONER AUTHORISE RELEASE OF BODY FOR BURIAL OR CREMATION.
   7c. ISSUE BURIAL OR CREMATION OR OUT OF ENGLAND CERTIFICATES TO FUNERAL DIRECTOR SIGNED BY CORONER AND MEDICAL REFEREE.

8. IF NO SUSPECT CHARGED.
   8a. IF SUSPECT CHARGED CASE TO PROCEED TO CRIMINAL COURT.
   8b. COMMITTAL TO CRIMINAL COURT ISSUE FORM 120 TO REGISTER SO DEATH CAN BE REGISTERED AND CERTIFICATE ISSUED.

9. FOLLOWING FULL INVESTIGATION: THE INQUEST FILE PRODUCED BY A LEVEL 2 CORONER’S OFFICER OR SENIOR INVESTIGATING POLICE OFFICER, SUBMITTED TO SENIOR CORONER’S OFFICER, FORWARDED TO THE CORONER FOR READING AND DIRECTION.

10. THE INQUEST WILL BE HEARD AND THE CORONER WILL ISSUE THE CERTIFICATE AFTER INQUEST FORM TO REGISTER THE DEATH WHO WILL ISSUE A DEATH CERTIFICATE, OR, IN CRIMINAL CASES, AFTER THE TRIAL, ISSUE BLUE FORM TO COMPLETE REGISTRATION DETAILS FOR THE REGISTRAR GENERAL, PROCEED AS 4d.

11. OUTCOME OF TRIAL NOTIFICATION TO HMC — ISSUE FORM 121 TO REGISTRAR, COMPLETE RECORD & FILE HARD COPY.
Appendix B

CAREER STRUCTURE AND TRAINING PROPOSAL FOR FUTURE CORONER SERVICE

RECRUITMENT

Specific employment criteria, specified minimum educational standards, person specification or/and relevant professional experience.

CAREER STRUCTURE

Trainee Coroner Service Officer—train in both medical examiner’s team and coroner’s investigative team. On successful completion of year one—certificate to practice as Coroners Service Officer. On successful completion of the full two year foundation studies programme the coroner’s officer will be eligible to be entered on to a professional register after two years (see also section one below).

Coroner Service Officer (Level One)—may work in medical examiner’s team or coroner’s investigative team, or rotate. Existing coroner’s officers will enter at this level.

Medical Examiner Officer or Coroner’s Investigator (Level Two)—dedicated to the ME team or the CI team with own caseload—may transfer between ME and CI teams may develop specialist skills.

Medical Examiner Officer or Coroner’s Investigator (Level Three)—team management responsibility, mentoring and training responsibility. Will develop specialist skills which will require further CPD.

TRAINING

Section One—Two year foundation studies course, which is core to all coroner service staff whether on the Medical Examiner or the Coroner’s Investigator team. Staff wishing to remain at Level One may opt out after the end of year one with a certificate to practice. Year one therefore covers all areas a basic level. Successful completion of year two allows professional registration.

Section Two—Optional for staff wishing to progress beyond level two and represents specialisation in the Medical Examiner or Coroner’s Investigator teams.

Section one

Year One

Workplace log book and compulsory modules.

One week course—Study skills.

Two week course—Grief, Bereavement—communication and appropriate language, ethical practice, support groups and counselling services, diversity issues.

Coronial Service—referral to the coroner, coroner’s documentation, relevant coroner’s law and the inquest process.

Post mortem and tissue issues.

Two week course—Fundamental Medicine—medical terminology and common abbreviations, basic human anatomy and physiology and common physiology. Medical notes. Common procedures and complications, causation of death and the Medical Certificate of Cause of death.

Two week course—Procedural and Investigative studies (level one)—identification, document analysis, evidence retrieval, statement taking, record keeping, log and note taking, file building, case management, introduction to witness skills, introduction to scene examination, scene and post mortem health and safety issues.

One week course—Other agency deaths (level one)—road deaths, suspicious deaths, work related deaths (Health and Safety), child/infant deaths, firearms, drowning, drug related deaths, rail deaths, prison/custody deaths.

Year Two

Workplace portfolio and compulsory modules.

One week course—Applied Coroner’s Law—considering coroner’s law applied to practice: Jurisdiction, Human Rights Act and legislation, death reporting, disclaiming an investigation, legal aspects of autopsy and organ/tissue retention, criminal investigations, the inquest, documentation, witnesses and the inquest, jury requirements, purpose of inquests, evidence taking, verdicts, rights and requirements post inquest hearing, disposal law, judicial review.
Two week course—Other Agency deaths (level two)—considering issues with regards to specific circumstances of death—road deaths, suspicious deaths, work related deaths (Health and Safety), child/infant deaths, firearms, drowning, drug related deaths, rail deaths, prison/custody deaths.

One week course—Death in Healthcare settings—developing foundation medicine course (year one) considering specifically deaths in healthcare settings.

Two week course—Procedural and Investigative studies (level two)—identification, document analysis, evidence retrieval, statement taking, record keeping, log and note taking, file building, case management, introduction to witness skills, introduction to scene examination.

Two week course—Scene Evidence—considering all aspects of evidence from scenes

One week course—Suspicious deaths/Major Incident (multiple fatalities)—dealing specifically with issues arising from deaths in suspicious circumstances or major incidents.

One week course—Coroner’s service Officer Family Liaison—consolidating the issues raised in year one with regards to the needs of the bereaved in the context of the coroner’s service.

Section two

Following completion of the two year foundation studies a selection of optional specialist modules available for those wishing to progress to Level 3 (Me or CI teams) some modules may be appropriate for both.

Supplementary evidence submitted by the Coroner’s Officers Association (COA)

Comments considering the six key areas of reform mentioned in the Coroners Service Reform Briefing Note February 2006

1. Bereaved people will have a right to contribute to coroners’ investigations. They will be able to bring their concerns to coroners even where a death certificate has been issued. A coroners’ charter will set out the service bereaved people can expect

COA comment

1.1 This is existing good practice in many areas and we welcome an enhancement of this practice through legislation.

2. We will introduce national leadership, guidance and support, with a Chief Coroner, and an advisory Coronial Council. The Chief Coroner will be accountable to Government. Coroners will continue to be appointed and funded by their local councils, and served by coroners’ officers drawn from the local police or local authority

COA comment

2.1 We support the appointment of a chief coroner and a coronial council, however, we are very disappointed that the opportunity to professionalise and standardise working practice and terms and conditions has been missed by continuing with the diversity of existing employers. So long as Coroners are not the employers of Coroner’s Officers there will continue to be a conflict between the Coroners’ demands and those of the employers.

2.2 The independence of Coroner’s Officers will continue to be compromised so the bereaved will not receive the higher standard of service anticipated through the reforms and as suggested by the Charter.

2.3 There will be continued insecurity for Coroner’s Officers and it is anticipated that ACPO will recommence their efforts to divest themselves of the financial responsibility for Coroner’s Officers. Coroners’ Officers will continue to not receive adequate training and support to deliver a higher standard of service.

2.4 We also note that later on in this briefing note it states that the Chief Coroner is to be responsible for training and setting standards for Coroners. Who is to be responsible for training and setting standards for Coroner’s Officers? The existence of a Chief Coroner may influence the practice of Coroners, but we believe this will not filter down to Coroner’s Officers.

2.5 We note other recommendations such as those relating to the type and content of training provided to coroners and their staff are already being implemented and will continue to be taken forward by the Chief Coroner and Coronial Council in the reformed service.
2.6 We have to ask what training is already being supplied to Coroner’s Officers that will continue to be taken forward? To date there is no formalised training for Coroner’s Officers. The COA has, in partnership with the University of Teesside developed three accredited courses for Coroner’s Officers, unfortunately there has been, and still is, reluctance on behalf of our current employers to invest in Coroner’s Officer training.

3. We will create a body of full-time coroners, and will reshape current boundaries to create a smaller number of coroner jurisdictions

COA comment

3.1 We support this principle as we believe this will increase the likelihood of standardisation of working practices and conditions. We foresee that this will involve relocation for some Coroner’s Officers and would suggest that if Coroners’ boundaries are removed, then those for Coroner’s Officers should also be removed.

4. We will modernise investigation and inquest processes, and give coroners new powers to obtain information to help their investigations. Archaic boundary restrictions will go, so as to improve co-ordinated action, for example in incidents with mass fatalities

COA comment

4.1 We support this. We hope that the new powers to Coroners will be delegated to their Coroner’s Officers, eg for entry into premises and enquiries regarding next of kin. We support the removal of boundaries which currently necessitate transfers under section 14 of the Coroner’s Act. This should lead to a better service to families.

4.2 It is not clear to us how the investigation is to be modernised without changes in conditions for the Coroner’s Officers who are performing the investigative role. We look forward to the specific proposals for modernisation.

5. In limited and specific cases, such as some suicides and child deaths, coroners will have a new discretion to complete their investigations and decide on the facts without holding inquests, where no public interest is served by doing so. Such public hearings can intrude unnecessarily into private grief

COA comment

5.1 We find the terminology confusing on this point. Surely there is no suggestion that a Coroner need not have an inquest opening or investigation at all? Perhaps it is meant that there need not be a resumed public inquest hearing in some cases.

5.2 While we acknowledge the further anguish caused to families in some instances by holding a resumed public inquest hearing, we do have some concerns about the lack of standardisation that could ensue if discretion is allowed to Coroners without very precise guidelines. We note that later on in this briefing note this point is expanded as regard criminal cases and we express the same concern about terminology.

6. Coroners will have better medical advice and support at local and national level to help them in their investigations

COA comment

6.1 We support the appropriateness of good medical advice to legally qualified Coroners. We can envisage that some of this “medical advice” could come from Coroner’s Officers who had had appropriate medical training. We hope that Coroners will be granted additional powers which would be able to be delegated to Coroner’s Officers eg to obtain medical information eg notes.

Mrs Christine C Hurst
Chair
Coroner’s Officers Association

March 2006
Further supplementary evidence submitted by the Coroner’s Officers Association (COA)

RESPONSE TO CORONERS REFORM: THE GOVERNMENT’S DRAFT BILL

1. The Coroner’s Officers Association (COA) has serious concerns about the Draft Bill on Coroners Reform.

2. Numerous public inquiries have centred on the actions of NHS doctors (Bristol Royal Infirmary, Alder Hey, Manchester, Isaacs and Shipman). Shipman also included an extensive review of death certification and coroners’ investigation; and both it and Luce’s 2003 Fundamental Review recommended a national service with scrutiny of all deaths. It is therefore ironic that the Government has decided not to proceed with such scrutiny and that the Bill reforming the coroners service is “the best way forward”. It also suggests that the reforms proposed in the Draft Bill on Coroners Reform will be “. . . complemented by initiatives the Government is developing aimed at improving patient safety and promoting quality in the NHS.

3. The Government’s rationale for the Bill, set out in the Regulatory Impact Assessment (RIA) of 12 June 2006 (paragraphs 7 to 10 inclusive on pages 2 and 3) diverts attention from the serious inadequacies in death certification, the primary object of the Shipman Inquiry’s criticisms, onto the weaknesses of the coroners service and wrongly suggests that its proposals for coroners address those weaknesses.

4. The COA believes that the proposed Bill clearly does not address the fundamental weakness of the system namely, that the death certification process has not changed so a Shipman scenario can recur; it does not correct the weaknesses of the coroners system namely, that all deaths are not reported for scrutiny nor does it address the chronic under-funding of the service resulting in lack of resources and sufficient numbers of appropriately trained coroners officers and staff within the service.

5. The key role of the Coroners Service is to protect society. To that end, the COA believes that an effective coroners service to the bereaved and general public requires that all deaths are reported to the service and that if an investigation into a death is needed then:

- The investigation is independent, thorough and meaningful.
- The investigators have the resources, training and expertise to that end.
- The bereaved are kept informed and involved in the process.
- On completion of the investigation, the inquiry is brought to a conclusion as speedily as possible.

6. The COA is dismayed that there is no mention or acknowledgement of the role of coroners officers in the Draft Bill, when it is acknowledged by the Coroner’s Society that coroners officers are the eyes and ears of the coroner, locally available to families and are as such, the frontline day to day contact with the bereaved.

7. The COA, like the Coroners Society, hoped for a national Coroners service; that coroner’s officers would come under one independent employer; and that the service would, at last, be appropriately resourced with mandatory accredited training and national standards.

8. Coroners officers are employed, not by coroners, but by police authorities or local authorities to work to the coroner. This hybrid situation has long been a cause of friction in many areas as to who—the coroner or the employer—has the final say in directing the coroners officer’s work. A continuance of this unsatisfactory arrangement has to be at odds with the independence of the service and can only perpetuate the inconsistencies in the levels of service to the bereaved.

9. Sadly, coroner’s officers are to remain with their current employers who may or may not decide to negotiate a transfer to another employer thereby reinforcing for the foreseeable future the uncertainty which has blighted the service and which has been the motive for further under-investment in resources and training.

10. According to the RIA “the Bill is not expected to change directly or indirectly the total numbers of coroners officers or staff for the new service”. The COA can not see how, without further investment in front line staff and their appropriate accredited training, the new service will be better able to serve the bereaved.

11. The COA has long had concerns about the lack of formal training available for coroners officers and staff which results in a variability of practice. As a result of initiatives by the COA and in partnership with the University of Teesside, three accredited courses for coroners officers and staff have been developed. (See Appendix)

12. The Draft Bill does not include provision for the mandatory accredited training of coroner’s officers and staff. Although we acknowledge the benefits of a Chief Coroner who will, amongst his/her many other functions “prepare and maintain appropriate arrangements for training and guidance” of coroners and any persons assisting them, the COA does not believe that the Chief Coroner will have the power to compel employers to provide sufficient resources and training for coroner’s officers. This was confirmed to us at the first of the DCA’s regional workshops in London on Friday 23 June 2006.

13. In summary, on detailed consideration of both the Draft Bill and the Regulatory Impact Assessment, it seems to the COA that the purpose of the current proposals is not to improve death reporting and investigation and provide a quality service to the bereaved, but rather to divert attention from the deficiencies in the death certification process and the lack of scrutiny. Nothing in this Draft Bill would help detect or prevent another “Dr Shipman”.

Ev 82
14. The under-funding and under-resourcing of the service is to continue; training for coroners officers will be patchy which will perpetuate the variable standards of practice. In view of these factors, it is perhaps fortunate for the Government that due to the conscientiousness, care, compassion and dedication of those working within the service that, in fact, of the 232,000 plus cases referred to the Coroners service in 2005, that relatively few complaints about the service were received.

Mrs Christine C Hurst
Chair
Coroner’s Officers Association
March 2006

Appendix

University Certificate of Professional Development for Coroners’ Officers

As a result of initiatives by the COA and in partnership with the University of Teesside, three accredited courses for coroner’s officers and staff have been developed leading to a University Certificate of Professional Development (UCPD).

The courses:
— Bereavement and the Coroners Service;
— Medico-legal Death Investigation;
— Fundamental Medicine for the Coroner Service,
are part-time requiring at present that the student attends a two week placement at the university where the courses are delivered by academics and practitioners. A variety of teaching techniques are used most of which involve student participation and include lectures, seminars, case studies and project work. Assessment methods include an examination and written case study analysis. On successful completion of each course, students are awarded recognised UCPD credits (40 at level one).

At present these courses are held once a year at the university, however, the frequency of these courses can be increased to suit demand. The delivery of the courses can also be adapted to suit the needs of the students, for example if it is felt that students may have difficulty in leaving their employment for the two weeks, a combination of university based and distance learning could be developed.

There are approximately 450 coroners officers in England and Wales the Coroners Officers Association would like to see a rolling out of this training over the next three years so that all coroners officers currently in the service complete these three courses. We estimate the total course fee cost per coroners officer would be £2,150 and the total cost per annum for the next three years would be £322,500. Thereafter the numbers of officers who would require training would reduce significantly to those coming into the service.

Evidence submitted by the Association of Chief Police Officers (ACPO)

ACPO welcomes this opportunity to provide evidence to your enquiries on the reform of the Coroners Service. The Association and those involved in the Coroners Service have great frustration that the reform process has taken so long. We are aware that previous attempts to reform the Service over many decades has come to very little and we sincerely hope that this will not be repeated this time.

ACPO is made up of all of Chief Officers of Police across England, Wales and Northern Ireland. The work of the Association in forming policy is shared between its members and I have held the portfolio for Coroners for the past seven years. I work with representatives of the Coroners Society and the Coroners Officers Association as well as civil servants tasked with this particular area of responsibility. Progress on day to day issues of improving policy and practice have been seriously affected by the uncertainty of the last five years.

I have already read the oral evidence given by Dame Janet and Tom Luce. ACPO broadly agrees with the evidence that they have given and therefore I do not intend to repeat much of the detail that they have covered. I will however, identify some issues that are important to the Police Service.

In moving forward on reform of the Coroners Service it is crucial that there is clarity on what reform is trying to achieve. The Shipman case was appalling for all involved and demonstrated very serious failings in the system of death certification and oversight which allowed this individual to continue to commit murders undetected for such a long period. There are undoubtedly very important lessons to be learnt from the case but at the same time it needs to be kept in perspective. Where there is an individual who knows intimately the workings of a system and is determined to frustrate the safeguards in that system there will always be a serious risk that the system will indeed be subverted. It is accepted that in moving forward the Government has to balance the need to establish greater safeguards with matters such as the degree of risk and the costs involved.
In the Association’s view there should be four main aims of coroners reform:

(a) greater scrutiny and safeguards;
(b) a greater standardisation in structure and processes;
(c) a stronger role for families and those who may have concerns in particular cases;
(d) a more “lessons learned” approach which may reduce the risk of unexpected death in the future.

At this point we would want to reaffirm that the Corners Service is made up of many dedicated members of staff who deal with families with huge sensitivity and tact in some of the worse moments of their lives. They have to balance the need for scrutiny and safeguards with the understandable wish of many families to see processes expedited as quickly as possible. It has been all the more difficult for these staff that they have worked in such a long period of uncertainty.

The Police Service has considerable involvement in the matter of sudden deaths. When a death occurs in the street or in a public place or when a medical practitioner is not available to issue a certificate of death as to the cause or where there are any suspicious circumstances then police officers have to attend. In much of the country coroners officers are desk bound and so enquiries into sudden deaths are conducted by operational police officers. Most coroners officers only work office hours so deaths that may be coroners cases which occur outside those hours and at weekends again are attended by operational police officers.

Where for instance a death occurs on arrival at hospital police officers will have to attend to arrange identification, to secure any evidence, deal with property, complete sudden death forms and arrange next of kin to be informed.

In many cases such as accidental death suicide or fatalities on the roads there are very considerable enquiries to be undertaken which again falls to operational police officers. The Police Service gets no recognition in the various performance systems it is subjected to for this type of work. The Police Service has found itself increasingly drawn into investigations into patterns of death in hospitals or carrying out more exhaustive investigations into such matters as deaths in prisons.

ACPO has long been in favour of transferring employment and management of coroners officers from the Police Service to the local authorities who appoint and pay for the coroners. It clearly does not make sense that police authorities employ and pay for staff when they have no influence on how these members of staff are deployed. It is perhaps not surprising that police authorities have been reluctant to invest in the training and support given to these staff when there has been such a long period of uncertainty over their future status. In a number of parts of the country the transfer of coroners officers to local authorities has already occurred. ACPO having received the governments paper of February this year has already initiated discussions with the Local Government Association to see if this matter can be moved forward across the country. There are some difficult issues regarding the transfer of finances and clearly it would be better if it was resolved at a national level. There can not be any progress on the matter of increasing the professional status and training of coroners officers unless there is a national solution to their future employment status.

The evidence given by the Coroners Officers Association regarding their training and a number of other issues they have raised seems reasonable. Coroners officers are a very important safeguard in the system and develop a considerable amount of expertise and experience in what to look for. Coroners officers in the future need to be drawn from both investigative but increasingly medical backgrounds. ACPO would like to see a national solution involving the transfer of many of the enquiries into sudden deaths carried out presently by operational police officers to coroners officers. We accept however that it will probably be to expensive to establish coroners officers on a 24-hour, seven day a week basis.

The Select Committee will be aware that the work of the Coroners Service and coroners officers has grown over recent years. Doctors are increasingly reluctant to issue certificates of death and the Human Tissues Act and recent stated cases have added to the burdens on coroners officers and have extended the scope of some of the investigations. Most police authorities have been unable to fund additional coroners officers giving this increasing workload due to the fact that they are making reductions in other areas. The employment of coroners officers is an anomaly which should have been resolved at the time of the enactment of the Police and Magistrates Court Act.

The Police Service is quite clear that where there is any suggestion that a death may be suspicious or the result of criminality that police officers would wish to attend at the earliest instance to secure all necessary evidence. It is accepted that whatever the outcome of reform the Police Service will continue to have a heavy involvement in the matter of death and death investigation.

The Shipman case demonstrated very serious failings in the process of death certification and ACPO agrees that further reform is necessary if adequate safeguards are to be put in place. It is clear that any system ultimately has to rest on the expertise of the medical profession. There is no system that will be able to establish the exact cause of death in all cases. If post mortems and toxicology were to be carried out in all deaths then that would clearly increase the level of safeguard but would be unnecessarily invasive and expensive. What is necessary however, is the capacity for the analysis of data to establish trends and unusual cases. It is also crucial that those members of the medical profession ultimately tasked with making decisions as to cause of death should be furnished with all the possible information particularly background information on the individual and the circumstances surrounding the death. As Tom Luce has identified there are also serious issues concerning the training provided to the medical profession.
ACPO have some concerns about the medical services available to support the system. Recent high profile cases have eroded some of the public trust in the science of pathology particularly where it involves children. There is huge pressure on a small number of Home Office pathologists and it is fair to say that the system of police surgeons in many parts of the country is extremely shaky. The system of death certification very much depends on the expertise and the support given to those who have to make difficult decisions on the basis of the evidence placed in front of them. Given the pressures and problems we have alluded to above, perhaps consideration should be given to establish a state medical service as exists in some other countries.

ACPO believes that further work is required to clearly establish the roles of all those involved in the Coroners and death certification system. There have been difficulties surrounding the responsibilities of those who can pronounce life extinct and the responsibilities of those first attending the scene of the death as to what background evidence needs to be captured. There is certainly scope for streamlining some of the processes and ACPO would support the establishment of a multi disciplinary team to work through all the policies and practices involved to establish clear national guidelines and to exploit for instance the benefits of new technology. Many of the policies and practices of the Coroners service have grown up over time through custom and practice and vary widely across the country.

ACPO supports the appointment of a Chief Coroner to oversee the creation of policy and practice and maintain standards. It is agreed that the rest of the Service should be based on a strong local structure but given the uncertainty in the structures and boundaries of the Health Service the Police Service, the Court Service and local government it is difficult at this point to be clear about what that local structure should be. ACPO was always sceptical that funds were available to establish a truly independent national Coroners Service. The support services which coroners need such as human resource and finance expertise need to be provided by other agencies.

Coroners collect vast amounts of information about sudden deaths and the circumstances leading to them. Coroners are able to summon witnesses and to write to agencies after inquests pointing out failings and calling for action. The powers of Coroners to make sure that this action is actually completed are unclear. Over recent years a whole range of public sector partnerships have been established dealing with matters concerning public health, community safety and general wellbeing. Unfortunately the Coroner is not tied into any of these structures and so local communities do not get the full benefit of their experience in their findings.

In summary ACPO would like to see:
(a) The employment of coroners officers to be transferred to a new Coroners Service based locally but working under a national framework of policy and practice.
(b) Detailed work to be carried out to establish the policies and procedures of the Coroners service of the future so that all involved are clear of their roles and the expectations of them. There should also be a strong emphasis on the collection and analysis of data concerning sudden deaths.
(c) Further work to be carried out leading to reform of the system of death certification to reduce greater safeguards and more informed decisions by those involved.

Peter Fahy
Chief Constable of Cheshire
on behalf of the Association of Chief Police Officers
May 2006

Evidence submitted by The Local Government Association (LGA)

INTRODUCTION

1. The Local Government Association (LGA) speaks for nearly 500 local authorities in England and Wales that spend some £78 billion pounds per annum and represent over 50 million people. The LGA exists to promote better local government. We work with and for our member authorities to realise a shared vision of local government that enables local people to shape a distinctive and better future for their locality and its communities. We aim to put local councils at the heart of the drive to improve public services and to work with government to ensure that the policy, legislative and financial context in which they operate, supports that objective. This submission only looks at the reform of the coroners system.

THE CURRENT SYSTEM

2. Coroners in England and Wales are independent judicial officials who investigate deaths reported to them and find out the cause of the death to allow it to be registered. Although coroners are appointed and funded by consortia of local authorities across 129 coronial districts, the coroner is not a local government officer but holds office under the Crown. Coroners can only be dismissed by the Lord Chancellor and have no retirement age.
3. District coroners are appointed by the ‘relevant council’, ie county or borough council or consortia of councils, in accordance with the Coroners Act 1988. The relevant council gives notice of the vacancy to the Secretary of State, makes the appointment and gives notice of the appointment to the Secretary of State. Appointments in certain districts are subject to approval by the Home Secretary.

4. The relevant council is responsible for payment of the coroner’s expenses and remuneration. A coroner is paid an annual salary at such a rate ‘as may be fixed between the coroner and that council’. The Joint Negotiating Committee for Coroners (JNCC) publishes suggested salary scales for whole and part-time coroners. Whole-time salary levels are set in accordance with the population band of the district and range from £68,409 to £83,529; part-time salaries are set according to the annual referral caseload and start at £8,343.

5. Arrangements to pay an allowance to whole or part-time coroners to cover office expenses, including administrative assistance, are settled locally between the relevant authority and the coroner. The cost of coroner’s administrative staff can be met through the office expenses claimed by the coroner or by the council employing the administrative staff directly.

6. There are also statutory fees, payable by the relevant council, determined by the Secretary of State, for:
   - post mortem examinations—£87.70;
   - professional witness allowance at inquest eg up to 2 hours—£83.50
   - juror and witness expenses (subsistence, travel etc).

7. In addition, the relevant council is responsible for the additional expenses incurred by coroners in the course of their duties; usually this includes the removal of the deceased, mortuary services, specialist examinations and tests, medical reports, courtroom facilities etc.

8. Councils express considerable frustration at the difficulty in controlling the ever increasing costs of inquests. This is because the majority of costs are the result of decisions taken by the coroner, on the basis of professional judgement, and therefore outside council control. These include increased costs of tests, such as toxicology, and increased use of those tests; more elaborate inquests due to Human Rights Act 1998; additional administrative and investigative support required by coroners. We would expect any reform proposals to address the significant costs pressures in the current system.

9. The cost of Coroner’s Officers is usually met by police authorities, although there are locally agreed combinations of funding and employment involving local authorities. Coroner’s officers receive referrals of deaths and sometimes make the initial decision as to whether a post mortem is required. In relevant cases they commence the inquest investigation, take witness statements and present information to the coroner.

CORONERS REFORM

10. Following the Fundamental Review of Death Certification and Investigation (the Luce report) and the third Shipman inquiry report in 2003, the Government issued a position paper in March 2004 proposing a national coroners agency with oversight of all deaths based around full time independent coroners. This would have effectively removed the function from local authorities which the LGA did not oppose as long as appropriate links were maintained with local services. The paper promised a draft Bill and white paper within a year, these did not appear. Responsibility for coroners policy transferred from the Home Office to the Department for Constitutional Affairs (DCA) in June 2005.

THE LATEST REFORM PROPOSALS

11. On 6 February 2006, the DCA announced that a draft Coroners bill would be introduced this spring. The reforms proposed do not go as far as those published in 2004, and it is disappointing that the LGA was not consulted on the change to the Government’s published position in advance of the announcement. We have now had the opportunity to meet with DCA officials and can offer the following view.

12. The current proposal will:
   - leave appointment and funding arrangements with local authorities and the power to confirm or remove appointments with the Lord Chancellor;
   - give coroners new powers to obtain information, including medical advice, to help them with investigations and to dispense with inquests in certain cases;
   - create new rights for the bereaved;
   - establish a Chief Coroner and an advisory Coronial Council with the power to commission inspections, provide guidance and promote good practice;
   - change investigation and inquest processes;
   - bring together small areas into whole-time coronial jurisdictions.
ACCOUNTABILITY AND GOVERNANCE

13. The LGA agrees there is need for a fundamental change in the coroners system to improve public confidence, as there is a widespread view that coroners are not accountable and do not always provide a consistent or effective service. The LGA believes that as long as the ultimate power to ‘hire and fire’ remains with the Lord Chancellor then the coroner will not be truly accountable, as councils will continue to pay the bills but have no control over performance and policy. The recent Teesside case where the 75 year old coroner had a backlog of over 200 cases, yet only received a ‘severe reprimand’ from the Lord Chancellor following a private investigation, shows how far this antiquated system must change to become a modern public service.

14. The LGA believes that an independent legal function, accountable to the head of the judiciary yet funded through local taxation, sitting alongside a local authority’s democratic role is an outdated anomaly in a political environment where council leaders, supported by ODPM ministers, are calling for local people to be given more control of public services through devolution of power to communities.

15. The LGA is calling for the coroners service to:
— either be brought fully into the judiciary as set out in the government’s 2004 position paper, or, 
— become a fully integrated part of the local authority, working alongside other statutory agencies, accountable to the local strategic partnership.

16. The government’s current proposal represents a partial reform falling between the two options in paragraph 15. In order to deliver a modern coroners service we believe this most recent proposal would benefit from robust accountability arrangements such as:
— joint governance arrangements between councils and the Lord Chancellor;
— the Chief Coroner to be jointly appointed by DCA and ODPM, with local authority representation on the advisory council;
— council overview and scrutiny committees to have the power to review local coroners performance, send a report to the Lord Chancellor and request a response within 28 days;
— coroners to be subject to the same terms, conditions and employment policies as other local government officers;
— a ‘trigger’ mechanism for the bereaved that will lead to a review of the coroner’s investigative process by the DCA;
— mechanisms to ensure councils can keep costs under control;
— inspection consistent with public sector regulatory reform ie by self or peer assessment.

FUNDING

17. Uncertainties about the future of the service since 2002 mean that some authorities have been reluctant to invest in service improvements, leading to uneven provision around the country. The government’s latest proposals clearly represent new financial burdens for councils and we would expect them to be fully funded by DCA. That being said, we also want some mechanism to ensure that ongoing costs are under council control to ensure efficiency and effectiveness and minimal burdens on local taxation.

18. The uncertainty has also led to some police forces threatening to remove long standing funding that supports coroners officers which means that the burden would fall on councils. We would not want to see these proposals used as reason for more police forces to withdraw funding without proper compensation.

OTHER MATTERS

19. Any new coronial districts must be co-terminus with councils, police, criminal justice and health services.

The Local Government Association (LGA)

March 2006

Supplementary evidence submitted by The Local Government Association (LGA)

INTRODUCTION

1. The LGA welcomes this opportunity to give further evidence to the Committee on emerging thinking that gives coroners services the potential to become a modern people-centred public service that is properly integrated with local partners.
Ev 88

FIT FOR THE FUTURE

2. On 22 May the LGA launched its vision of the future government of localities “Closer to People and Places”, setting out our ambitions for the people and places we represent. Our objectives, shared with the government, are to:

— secure more fundamental improvements in public services and make better use of public money;
— improve the quality of life and economic performance of cities, towns and villages;
— give people greater power and influence over their lives, their services and the future of the places where they live.

3. At the heart of the new settlement we envision there would be a reinvigorated local government responsible for steering and joining the totality of public services in its area and getting ‘up close and personal’ with local people. There is no reason why coroners services, which deal with people at a most sensitive time and which are financed through local taxation, should not meet the challenge of modernisation and local accountability.

4. We have already seen the success of Local Area Agreements (LAAs). These are three year agreements that set out the priorities for a local area between central Government and a local area, represented by the lead local authority and other key partners through the Local Strategic Partnership (LSP). The LSP is a single body that brings together different parts of the public sector as well as the private, business, community and voluntary sectors at a local level, so that initiatives and services support each other and work together. We want to see the development of a next generation of LAAs that will see the joining together of public services and resources in an area to deliver improved outcomes, better access and efficiency savings. This would involve a contract between the LAA partners around a vision for the area to which the community has contributed, backed with a ‘duty to co-operate’ on Local Area Agreement partners.

PERFORMANCE AND ACCOUNTABILITY

5. People rightly expect high quality public services that are easy to access, provide choice and personalisation, and achieve the highest value for money for the taxpayer. Councils are already redesigning their services around the user; coroners services must not remain outside the ring. Parts of the coroners service are delivered not by local government, but locally by the police, health service or the private sector. Achieving a step change in re-designing coroners services around the user means joining up all service providers with local government, as the current and likely future manager and funder of coroners services, in the driving seat.

6. The LGA believes that the role of the Lord Chancellor as the ultimate power in the coroners system is incompatible with this performance and accountability framework. The LGA is calling for the coroners service to:

— either be brought fully into the judiciary as set out in the Government’s 2004 position paper, or,
— become a fully integrated part of the local authority, working alongside other statutory agencies, accountable to the LSP.

7. Local government’s challenge is to ensure that people always feel they have mechanisms to exercise voice, choice, and influence, should they choose to use them. This is equally relevant to coroners services where citizens have reasonable expectations in terms of choice, quality and efficiency. We argue that the independent judicial nature of coroners’ decision making is not undermined by these proposals as sufficient legal mechanisms exist for those dissatisfied with a coroner’s decision.

8. Responsiveness to local people means giving people the power to drive service improvement and value for money, and hold all local public service leaders to account for their performance. To achieve this we propose:

— a locally-focused performance and accountability framework, backed by sector-led peer support, with zero tolerance of poor performance;
— as part of this framework, more visible elected local leaders accountable not just for council performance but delivery of the Local Area Agreement outcomes; and
— powerful performance challenge through public “select committees” or “juries” drawing on business, voluntary and public sector partners, consumer and user groups, MPs and councillors, building on but significantly wider in scope and power than current scrutiny arrangements.
9. In relation to coroners service we believe the following governance and accountability arrangements will ensure a focus on the service user without compromising the judicial aspects of the process:

- joint governance arrangements between councils and the Lord Chancellor;
- the Chief Coroner to be jointly appointed by DCA and ODPM;
- local authority representation on the national advisory council;
- council scrutiny committees to have the power to review coroner’s performance, send report to the Lord Chancellor and request a response within 28 days;
- coroners to be subject to the same terms, conditions and employment policies as other local government officers;
- a ‘trigger’ mechanism for the bereaved that will lead to a review of the coroner’s investigative process (not the decision) by the DCA;
- mechanisms to ensure councils can keep costs under control.

Local Government Association (LGA)

May 2006

Evidence submitted by the Department of Health (DoH)

INDEX

Introduction (paragraph 1)
Process of death certification/registration (paragraph 2, & Appendix)
The purpose of death certification (paragraphs 3–7)
The Use of information from death certification (paragraphs 8–9)
Suicide prevention (paragraphs 10–14)
Cardiovascular disease (paragraphs 15–19)
Wider issues arising from Shipman Inquiry (paragraphs 20–28)
Appendix (process of certification/registration)

INTRODUCTION

1. In line with the steer from the Committee secretariat, this note focuses on how information about deaths (including information emerging from coroners’ verdicts) is used for health-related purposes, and sets out the activity the Department of Health is carrying out in response to the wider issues raised by the Shipman Inquiry.
Process of certification/registration

2. The Office for National Statistics (ONS) processes the information from all deaths registered in England and Wales, then analyses the data to produce mortality statistics by age, sex, cause of death, area of the country, social class etc. We understand that the Committee is not taking evidence from the General Register Office or the Office for National Statistics, who have relevant expertise in the legislation and processes relating to the certification and registration of deaths. A brief summary of the process is therefore set out in the Appendix as background.

The purpose of death certification

3. Death Certification serves a number of functions. It:
   — provides a permanent legal record of the fact of death;
   — enables a body to be disposed of; and
   — enables a person’s estate to be settled.

4. The medical certificate of cause of death (MCCD) is set out in two parts in accordance with World Health Organisation (WHO) recommendations in the International Statistical Classification of Diseases and Related Health Problems (ICD). It begins with the immediate, direct cause of death (line 1a) and then goes through the sequence of events or conditions that led to death ending with the underlying cause of death.

5. Part two enables information on any other diseases or injury that contributed to the death but is not part of the direct sequence to be recorded.

6. The MCCD allows for further information from investigations initiated ante-mortem or from autopsies to be notified to ONS at a later date eg to confirm meningitis is due to a certain bacterial infection.

7. It is the duty of the doctor who attended in the last illness to issue the MCCD if they are able to do so. There is no legal definition of “attended” though it is taken to mean the doctor who cared for the patient during his or her last illness. If no doctor who cared for the person can be found the death is referred to the coroner. Similarly deaths are referred to the coroner if the attending doctor has not seen the patient in the last 14 days or has not seen the body after death.

Use of information from death certificates

8. Information from death certificates is used for a variety of purposes:
   (i) Provision of comparable mortality statistics at local, national and international level.

   It can be used to measure the relative contributions of different diseases to overall mortality. This enables the health of the population to be monitored, ie assessing the contribution of different causes of death by geography, gender and age group.

   It can be used to monitor trends in causes of death across time, for example changes in lung cancer deaths related to changes in smoking rates.

   (ii) Information about the effectiveness of interventions.

   The Cancer Registries collect data from death certificates to monitor outcomes from different cancers. From this, survival rates for different groups of patients can be assessed. Interventions can be assessed using data from Cancer Registries to identify different rates of survival in different groups.

   (iii) Supporting targeted investigations.

   Information can be used to identify patterns of death where further targeting of investigations may be warranted, for example mortality rates following surgery.

   (iv) Designing and evaluating public health interventions.

   For example screening programmes such as Breast Screening.

   (v) Planning health services.

   (vi) Research into the health effects of exposures to a wide range of factors through the environment, work healthcare, etc.

   (vii) Providing information about an individual’s family medical history which, with related knowledge of genetics and familial diseases, may be important for family members.

9. Some further specific examples are given below to amplify some of the points above. The following examples are not exhaustive, but will hopefully serve as helpful illustrations of how information about deaths can influence policy and practice, and help to avoid further preventable deaths.
Suicide prevention

10. This area is of particular interest in the context of coroner reform, because we are dependent on information emerging from coroners’ inquests. Official suicides are those in which the coroner or official recorder has decided that there is clear evidence that the injury was self-inflicted and the deceased intended to take their own life. Open verdicts or undetermined injuries are those where there may be doubt about the deceased’s intentions. Research studies show that most open verdicts are in fact suicides. For the purposes of measuring overall suicides in England, official suicides and open verdicts are combined.

11. Details are collected when deaths are certified or registered. Most deaths are certified by a medical practitioner; however suspected suicides must be certified after a coroner’s inquest. Statistics on cause of death are collected by the Office for National Statistics and are passed to the Department of Health on an annual basis.

12. The national suicide prevention strategy was developed at the same time as the Tom Luce Review of Coroners’ Services and both DH and the National Institute for Mental Health England (NIMHE) took part in the consultation process. Issues we highlighted were:

— The need for support for people bereaved by suicide;
— The need for more consistent information from coroners in order to help analysis of data on suicides in order to inform research, develop interventions and learn lessons;
— Questioning the need to hold inquests in public in cases of probable suicide in public, thus reducing the family’s grief and limiting the press reporting of suicides, and in particular details on the method and location.

13. The information collected as part of the inquest process has indirect and, in some cases, direct impact on all six of the suicide prevention strategy’s key objectives:

— The information collected enables us to identify groups at high risk of suicide—young men, some occupational groups, etc (goal 1);
— People bereaved by suicide are recognised as vulnerable themselves to suicide (goal 2) and therefore the impact of the inquest process and the support provided to these people is very important;
— The inquest provides information on the circumstances that lead to a suicide, including the means by which the individual took his/her own life (goal 3);
— The role of the media in reporting the inquest deliberations may result in disclosure of details of method and location and could lead to sensationalist coverage (goal 4); How the coroner involves the media in the deliberations can have positive and sometimes negative results in terms of how the media report is written;
— Information obtained at inquests and through the more detailed coroners’ records can help when research is conducted into suicides (goal 5);
— Finally, the ability to consistently monitor suicide numbers and rates is key to ensuring that measures are working or to signal changes in the risk of suicide in particular groups. It is essential to have consistent historic trend information on suicides in order to monitor the Department’s Public Service Agreement (PSA) target, and to satisfy Treasury and the Prime Minister’s Delivery Unit (PMDU) that the trends reported do reflect what has actually occurred. It would also be enormously helpful to enhance the information collected, for example to include data on ethnic origin, sexual orientation and occupational status, wherever available, and to standardise across coroners’ courts the information they collect (goal 6).

Using information to inform interventions

14. The key to successful interventions in preventing suicide are learning lessons and having effective evidence based strategies and interventions in place. The following are some examples of research that have already made a difference;

— The National Confidential Inquiry (NCI) long-term research study which conducts an audit of suicides by people in contact with mental health services to make recommendations on improvements in clinical practice and policy on mental health. Information on individuals dying by suicide or receiving an open verdict at coroners’ inquests is forwarded to the NCI who then
determine which of these had been in contact with mental health services in the 12 months prior to death and seek further information on the circumstances of the death. The benefits of NCI investigations include:

— definitive figures on suicides;
— evidence on clinical safety;
— recommendations included in the NHS Plan (assertive outreach teams etc);
— safety standards adopted;
— specific recommendations on patient safety, ie the removal of ligatures as recommended in *Organisation with a Memory*, and early follow-up after discharge. Trusts are now monitored against these recommendations;
— safety checklist for services (12 points to a safer service);
— clinical standards in *Preventing Suicide: A Toolkit for Mental Health Services* adopted.

— Coroner based investigation into specific methods of suicide, funded through DH as part of the suicide prevention strategy. This investigation looked at specific methods of suicide—hangings, firearms, coproxamol poisoning. The information from coroners’ records helped identify how the danger of particular methods could be reduced—key to goal 3 of the suicide prevention strategy in reducing availability and lethality of methods of suicide. The research into coproxamol deaths led directly to the CSM decision to look at the efficacy of the drug. The research highlighted that around 400 deaths occurred in England and Wales where coproxamol was the main substance and these were either intentional or accidental deaths. This led to the decision to withdraw coproxamol.

— Similarly, work in recent years with motor manufacturers to change the shape of exhaust pipes to make it more difficult for people to attach hosepipes to them has contributed to a substantial reduction in the number of suicide deaths from motor vehicle exhaust gas—again a key action under goal 3 of the suicide prevention strategy.

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**Cardiovascular disease**

15. Coronary heart disease (CHD) is a preventable disease that kills more than 110,000 people in England every year.

16. Accurate data about deaths is key to monitoring the success of strategies for prevention and treatment. The Government is committed to reducing substantially the death rate from CHD and stroke and related diseases in people under 75 by at least 40% by 2010. Latest projections suggest this should now be achievable by around 2008.

17. In 1995–97 the number of deaths from cardiovascular disease was 69,800, but by 2000–02 (latest data available) this figure fell to 53,500. There is a reduction of approximately 16,000 deaths per year from CHD and stroke and related diseases.

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**Using information about deaths to inform prevention strategies**

18. Deaths from CHD are up to 5 times higher in people with diabetes. Diabetes affects 1.3 million people in England with possibly another 1 million undiagnosed. Type 2 diabetes can be delayed or prevented by tackling obesity and physical inactivity.

19. 20% of CHD related deaths in men and 17% of CHD cases in women are attributable to smoking. More than 106,000 people in the UK die every year due to smoking related illnesses (86,500 deaths a year in England). It costs the NHS up to £1.7 billion a year. That is why the White Paper “Smoking Kills” (1998) set in train a wide-ranging strategy for tobacco control. The initiatives to tackle the risk factors for CHD, such as stop smoking services and tobacco control measures such as reducing exposure to second hand smoke, reducing tobacco advertising and promotion, national communication campaigns and reducing smuggled and illicit tobacco and under age sales, are targeted towards both men and women.

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**Wider issues arising from the Shipman Inquiry**

**Professional regulation (5th report)**

20. Ministers are now considering the recommendations of the reviews carried out by the Chief Medical Officer on the regulation of doctors and by Andrew Foster, the former Director of Human Resources, on the regulation of the non-medical professions. The reviews considered, among other things,
— arrangements for the periodic revalidation of health professionals to ensure that they have kept their skills up to date, and
— arrangements for dealing with allegations of poor professional practice which provide robust protection for the public while being fair to professionals.

Decisions will be announced shortly.

General issues of professional performance (5th report)

21. We are working to embed into every NHS organisation the attitudes and processes of clinical governance. Much has already been achieved since the concept was first introduced in 1998. We will be setting out detailed proposals for further work in our response to the Shipman Inquiry’s 5th report later this year.

22. Primary Care Trusts, hospitals and other specialist trusts now look routinely at a range of indicators which may indicate poor clinical practice or behaviour.

23. Patient complaints, and concerns raised by fellow professionals, are another vital source of information which may indicate a performance problem. We are working to improve the handling of complaints in both secondary and primary care and will later this year consult on further proposals in the light of the recommendations in the Shipman Inquiry’s 5th report.

24. The NHS Redress Bill will, subject to parliament, provide another route for patients to raise concerns over serious errors in treatment and to ensure that healthcare organisations learn from their mistakes.

25. Once concerns have been raised about the performance of a healthcare professional, healthcare organisations have a range of options for dealing with them. In the case of doctors and dentists, this includes referral to the National Clinical Assessment Service. The overriding objective is to safeguard patients but also, where possible, to help the professional to put right any weaknesses and to return to safe practice.

Controlled drugs (4th report)

26. We have issued guidance to the NHS on new arrangements for the governance of controlled drugs (CDs). This will, subject to Parliament, be underpinned by a new statutory duty on all healthcare organisations to appoint an “Accountable Officer” for controlled drugs, and to coordinate information and action to protect patients.

27. We are implementing the Shipman Inquiry’s recommendations to tighten the safeguards on the prescribing of CDs through a combination of professional guidance and legislative change (amendments to the Misuse of Drugs Regulations).

28. We are also tightening up the audit trail for controlled drugs through a series of amendments to the Misuse of Controlled Drugs Regulations and through improvements in NHS IT systems. In particular, subject to Parliament,

— we will from the end of June be capturing information on private prescribing of CDs so that Accountable Officers will, for the first time, have a complete picture of CD prescribing in their area;
— we will be requiring patients or their representatives to provide identification and to sign for CDs when they collect them from a pharmacy or dispensing practice;
— we have piloted the Shipman Inquiry’s proposal for a “Patient Drug Record Card” to track the use of Schedule 2 injectable CDs in the community, and will shortly be announcing next steps in the light of this pilot.

Department of Health

June 2006

Appendix

The process that needs to be followed from when someone dies to burying or cremating the body is dictated by various pieces of legislation, and is different depending on whether the deceased is to be buried or cremated.

Registration

In England and Wales, a relative of the deceased or other qualified informant is required by law to register a death within 5 days of its occurrence, unless the death has been reported to the coroner.

A medical certificate of cause of death (MCCD) from a doctor, or a certificate of cause of death from a coroner, is required before the death can be registered. When (rarely) there is no doctor qualified to issue a MCCD and the coroner has not certified the cause of death following post-mortem examination or inquest, the death may be registered as “uncertified”.

Appendix
Medical Certificate of Cause of Death (MCCD)

Doctors completing MCCDs do so as a duty under the Births and Deaths Registration Act 1953.

The content of the MCCD is specified in the Registration of Births and Deaths Regulations 1987. These regulations also specify the circumstances in which the registrar should report a death to the coroner, which are:

- the deceased was not attended during his last illness by a registered medical practitioner; OR
- the registrar has been unable to obtain a duly completed MCCD; or
- it appears to the registrar from the particulars contained in the certificate that the deceased was not seen by the certifying medical practitioner either after death or within 14 days before death; OR
- the cause of death appears to be unknown; OR
- the registrar has cause to believe that the death was unnatural or to have been caused by violence or neglect, or by abortion, or to have been attended by suspicious circumstances; OR
- the death appears to the registrar to have occurred during an operation or before recovery from the effect of an anaesthetic; OR
- the death appears to the registrar from the contents of any MCCD to have been due to industrial disease or industrial poisoning.

Although there is no statutory requirement for doctors to refer deaths to the coroner, the prevailing practice is for certifying doctors to voluntarily refer if they have reason to suspect the death was:

- an accident;
- a suicide;
- related to the deceased’s employment; and
- occurred during or shortly after detention in police or prison custody.

Cremation

The process for approving the cremation of human remains is set out in the Cremation Regulations (for which DCA has responsibility), and is broadly:

1. Medical practitioner completes the medical certificate of cause of death (MCCD)

2. Application is made to the crematorium on statutory Form A—usually by executor or the next of kin. Details include relationship to the deceased, place, time & date of death, whether any reason to suspect violence, poison or neglect, whether any reason to think an examination of the remains is desirable, details of medical practitioner.

3. Form B completed by a medical practitioner. Questions include (not exhaustive) how long the doctor attended the deceased, when last seen alive, when the body was seen, what if any examination was made of the body, details of the cause and mode of death, details of any surgical interventions within a year before death, any reason to suspect poison, violence or neglect, any reason to suppose a further examination is necessary.

4. Form C completed by a different medical practitioner, who must not be a relative of the deceased or a relative or partner of the Form B doctor. This asks:
   - Have you seen the body of the deceased?
   - Have you carefully examined the body externally?
   - Have you seen and questioned the medical practitioner who gave the above certificate (ie Form B)?
   - Have you seen & questioned any other medical practitioner who attended the deceased (if so give details).
   - Have you seen & questioned any person who nursed the deceased during the last illness, or who was present at the death (give details & say if seen alone).
   - Have you seen & questioned any other person (details & say if seen alone).

The declaration confirms that the doctor knows of no reasonable cause to suspect that the deceased died either a violent or unnatural or sudden death of which the cause is unknown, or died in such a place or circumstances as to require an inquest. The form is sent to the medical referee (another doctor affiliated to the crematorium).
5. If the medical referee authorises a post mortem, the doctor completing the post-mortem (which may be the medical referee himself) completes Form D, confirming they have carried out a post mortem and indicating the cause of death, and that there is no reason to make any toxicological analysis or hold an inquest.

Form F (authority to cremate) is completed by the medical referee, authorising the superintendent of the crematorium to cremate the remains.

Evidence submitted by the British Medical Association (BMA)

I am writing on behalf of the British Medical Association with regard to the Inquiry being conducted by the Constitutional Affairs Committee into the reform of the coroners’ system and death certification in England and Wales.

The BMA is a voluntary, professional association representing doctors of all branches of medicine across the UK. Our current membership of over 134,000 includes over 16,500 medical students and nearly 4,000 overseas members. We are also an independent trade union and have represented doctors in negotiations since the beginning of the NHS in 1948. Therefore the BMA have a direct interest in the coroner reform process and hope that this response will be considered as being representative of the medical profession as a whole. The purpose of this submission is to outline the position of the Association on coroner reform.

The BMA welcomed the opportunity to comment on the 2003 Home Office position paper, which constituted the Government’s response to the Fundamental Review of Death Certification and Coroner Services (undertaken by Tom Luce) and the third report of the Shipman Inquiry. In the response to the Home Office position paper it was noted that the BMA had been calling for reform of the death certification system since the Brodrick Report of 1971. We agreed with the statement in the position paper that “Shipman’s activities, which went undetected for years, highlighted the weaknesses in the death certification system”. The Association broadly supported the key proposals for change listed in the position paper, but we emphasised that no system could ever provide complete protection against those intent on covering up criminal activity.

We believe the medical examiner role previously proposed in the Home Office position paper has merits; in particular, there is a need to bring together currently fragmented functions into a single organisational structure with clear accountabilities, to provide training and support in the certification process, and to encourage the assessment and audit of the certification processes. Our main reservations about the proposed medical examiner service are whether the medical profession could provide enough suitably qualified candidates for the full time medical examiner role, given current medical workforce shortages, and whether the service would provide an attractive career for doctors.

More fundamentally, we cannot see how a reformed structure could operate successfully without significant additional resources. We agree that any new system must be affordable and properly costed, but we do not believe it will be possible to introduce significant changes to the coroner and death certification service on a resource neutral basis. The Association supports the Government’s aim to provide a unified, coherent system of death registration and investigation. We believe that there should be a common approach whether death occurs in Hospital or in the community. It is hoped that the new legislation being planned by the Government will provide one seamless, accessible service, very much as we had hoped and in part proposed.

The Association feels the Government should explain its assumption that the service improvements in the coroner system can be delivered within current cost envelopes. One key objective of the new service is to improve detection of unnatural deaths. However this is likely to require consultant level expertise more often than previously, and hence have significant cost implications.

I recently met with officials from the DCA Coroners Division and we continue to maintain a constructive dialogue with this unit who are taking forward the coroner reform process. The BMA acknowledges the circumstances that have led to a delay in the reform process but would also wish to note the strong desire of the medical profession for progress. The current coroner and death certification system is no longer fit for purpose and doctors are increasingly bringing to our attention the difficulties with the uncertainty and delay in the reform process.

If the practical issues can be resolved then the reforms outlined previously by the Government could indeed deliver a world class coroner and death certification system.
The position of the BMA on coroner reform was clearly laid out in the detailed response by the BMA to the Home Office position paper issued in March 2004. There have been no substantial developments on coroner reform since the Home Office position paper was originally issued and the BMA response submitted. Therefore I would ask you to consider the original BMA response attached (not printed) which outlines our views of the current problems with the existing system and our responses to the existing proposals for reform.

Dr George Fernie
Chairman
BMA Forensic Medicine Committee
February 2006

Supplementary evidence submitted by the British Medical Association (BMA)

CORONER REFORM: THE GOVERNMENT’S DRAFT BILL

I am writing on behalf of the British Medical Association with regard to the inquiry being conducted by the Constitutional Affairs Committee into Coroner Reform.

The BMA submitted written evidence to the Committee in February this year but in order to aid our oral evidence session with the Committee on Tuesday 20 June, we examined the Draft Bill and have enclosed a further submission for the Committee to consider. This submission is very much an interim response, reflecting the recent publication of the Draft Bill. We will of course submit a more detailed and comprehensive response by the official deadline of the beginning of September. We hope that the enclosed submission will be of use to the Committee in the interim.

CORONERS REFORM—THE GOVERNMENT’S DRAFT BILL INITIAL RESPONSE OF THE BRITISH MEDICAL ASSOCIATION

1. We welcome the opportunity to reform Coroner Services. The BMA has been calling for reform of the death certification system since the Brodrick report of 1971.

2. We broadly support the key proposals for change, but we must emphasise that no system can ever provide complete protection against those intent on covering up criminal activity.

3. We believe the professionalisation of the coroner service has merits; in particular, there is a need to bring together currently fragmented functions into a single organisational structure with the leadership of a Chief Coroner. We welcome the fact that coroners will have adequate powers to carry out investigations, will be independent of Ministers, and will be responsible to the chief coroner.

4. The plans for reform of the system include proposals to establish a cadre of full-time, fully-trained coroners and giving the families of the deceased a proper legal status in the inquest system. This is supported by the Association.

5. We support the statement that the changes being proposed have to make the system sensitive to the needs of the bereaved. The balance between the duty of confidentiality owed by health professionals to deceased patients and the needs of bereaved relatives needs to be carefully considered. While “improved family liaison” is important, consideration needs to be given to any aspects of the health or medical care that the deceased person would have wanted to be kept private from relatives. The degree of routine information-sharing with relatives (who may be distant family members) is something we would like to see clarified further.

6. The Association believes that the public needs a very robust, independent system which is essentially legally-led, where coroners have effective powers to listen to concerns from bereaved families and initiate more investigations themselves. However this requires an even greater independence of view as well as independence from Government.

7. We cannot see how the reformed structure could operate successfully without significant additional resources. We agree that any new system must be affordable and properly costed with appropriate efficiencies, but we do not believe it will be possible to introduce these significant changes to the coroner and death certification service for the additional funding estimated in the draft coroners bill. There is a danger that the Government will be perceived as “tinkering with the system” rather than delivering a radical overhaul that the majority of medical practitioners believe is required. The BMA’s view is that the current proposals will deliver some improvements as far as it goes but do not go far enough.

8. The Association is disappointed that the Government are leaving the appointment and funding of Coroners with Local Authorities. A true national service would provide a better and more focused system. There is need for clarity on the local services commitment in light of the current plans to merge some police authorities.
9. The main concern for the Association is that it does not wish to endorse a reformed system that is not fit for purpose. In his evidence to the Constitutional Affairs Committee Michael Burgess (HM Coroner for Surrey) made several references to the current lack of resources and this indicates that there is a lack of confidence with the current arrangements. It is clear that for many years, some local authorities and police authorities have not provided sufficient funding for a coroner’s service and therefore many coroners have to complete their functions with inadequate court facilities and office facilities (as well as very limited coronial support staff). There is no indication in the draft bill that these conditions will improve significantly. There are numerous anecdotal reports of colleagues who find them selves unable to investigate sudden death properly because of financial constraint. Who should pay for the investigation which has no real bearing on the determination of natural/unnatural death, but which has significant implications for the family if there should be an underlying genetic cause? At the moment, the coroner won’t, and the NHS can’t, as it has no involvement, and so frequently, the investigation is not done. Similarly toxicology—looking for abnormal drug levels in unexpected deaths in the elderly would have stopped Shipman, but the funds for this are limited.

10. There is concern that it will be left to the local authority to decide how much professional and expert medical witnesses should be paid for attendance at an inquest. In the draft there remains the devolution of budgets to local authorities and the likely constraints on coroners who need medical advice. If there is to be a national approach with the introduction of a chief coroner, why is funding not national? Why should there remain the division between those local authorities who employ their own death investigators and those who rely upon the police? A small increase in coronial support staff would make a significant impact on the amount of investigatory work that can be undertaken by each coroner, however the explanatory notes indicate the current number of coronial support staff is adequate. We agree with the current Government position that post mortem examinations do not need to be performed as a matter of course (in the case of referrals to coroners). However, there do need to be some guidelines as to who does them, which ones to be done etc.

11. It is extremely disappointing that there are no plans to unify the certification process for medical cause of death certification and cremation. The Association believes that the opportunity of a lifetime to reform an outdated system set up in the 19th century has been lost.

12. The Association sees no sign that the objections of Dame Janet to the current method of immediate investigation, certification of death and disposal arrangements have been addressed. The DCA has scaled back the proposals considerably and this decision may impact on the deliberations of the Scottish Executive working party looking at these matters. In Scotland the BMA has written to the Review Group expressing concern that a “more economical” option has been favoured by the Scottish Executive. The majority of doctors are unable to see how the model advocated in Scotland can possibly work in practical terms and whilst they are still presently engaged this may not be for much longer.

13. The Association wishes to highlight again the insufficient training for doctors and medical students with regard to death certification.

14. We would like to see clarification of the qualifications of the coroner staff. In addition, we would like to see more about what skills/qualifications the medical examiners themselves will need to hold. The BMA needs to see more detailed proposals for formalising the provision of medical advice to Coroners before more detailed comments can be provided on this draft bill.

15. To attract doctors of sufficient quality and experience to the medical adviser role, the terms and conditions of service should match those of NHS doctors. There should be provision for professional support and continuing education. There should be a role for the BMA as the employees' representative with negotiating rights.

16. The current proposals do not appear to include any provision for Coroners’ post mortem reports to be made available to the deceased’s GP and/or hospital Consultant (where known) routinely and free of charge. Doctors report deaths to the coroner if the cause of death is unknown or if the deceased was not seen by the certifying doctor, either after death or within fourteen days prior to death or if there is anything violent, unnatural or suspicious about the death. Death may also be reported if due to an accident, self-neglect, industrial disease or related to the deceased’s employment, in cases of abortion, during an operation or prior to recovery from the effects of an anaesthetic, suicide or during or shortly after detention in police or prison custody. The main reason doctors refer deaths to coroners is where the death is sudden, unexpected or we are not in a position to certify what the cause of death is. If they do not subsequently receive a report from the coroner telling them what the cause of death is, then they cannot learn from the experience and are not in a position to discuss the cause of death with the deceased’s relatives. We believe this is a significant clinical governance issue as doctors cannot find out if they are making the correct diagnosis on patients who die unexpectedly and are therefore not in a position to learn from any errors or oversights they may have made.

17. While we cannot disagree that the system must be “affordable”, the decision as to how much money can realistically be spent on any new system of death certification is ultimately a political one. It is clear to personnel working in the current coroner system that the service is under-funded. This was recognised by Dame Janet Smith in the Shipman Inquiry Report who considered that “a new improved service is bound
to cost more than the old, which in some places appears to have been run on a shoestring”. The Association would wish to re-iterate the previous point made by Dr Michael Wilks on 12 June 2005 that the medical advisory service proposed needs resourcing, in skills, people and money.

18. We believe that the current proposals do provide some foundation on which to develop a more modernised coroner service with effective medical support. It provides a structure on which to build for the future. However as stated previously the resources available to deliver progress appear to be limited and the role and responsibilities of the medical adviser appear to be unclear. The medical input is crucial to this working and there has to be adequate provision for the type of advice and investigation needed otherwise we will remain with the system we have now that has its limitations. There are considerable hidden costs in the present service that are being provided from other sources such as the health service.

Dr George Fernie
Chairman
BMA Forensic Medicine Committee

June 2006

Evidence submitted by NSPCC

Executive summary

1. The NSPCC has long been concerned that the systems for investigating and reviewing child deaths are inadequate for ascertaining both the extent to which maltreatment is a factor in child deaths and how child deaths might be prevented. Any proposed changes to the coroner system should aim to create a system that is fit for the purpose of identifying, and helping to prevent, child deaths from abuse and neglect.

2. It is of critical importance that the evolving interpretation of Human Rights law as it affects the state’s obligation to investigate deaths should be central to reform. As stated in the case of McKerr v The UK (May 4, 2001), there is a need for the court to “subject deprivations of life to the most careful scrutiny, taking into consideration not only the actions of state agents but also all the surrounding circumstances.” We believe that this approach should be the touchstone for investigating child deaths, and the test by which reform of the coroner system should be judged in relation to children.

3. The NSPCC welcomed the statement in the Home Office Position Paper on Coroner Reform24 that a reformed coroner system should have a clear focus on learning the lessons from deaths in order to develop strategies to avoid preventable deaths in future. We are concerned, however, that this paper, and the recent Department for Constitutional Affairs (DCA) briefing25, does not give sufficient attention to child deaths, nor to the need for family and social factors to be an integral part of assessing a child’s death and determining its cause.

Problems with the existing system

4. Different studies of child deaths suggest that deaths potentially related to child maltreatment are sometimes missed.26 Furthermore, “complex decision-making around child death [including the influence of parents’ grief and the emotions of professionals] may be directly linked to an under-estimation of child homicides within official statistics”.27 It has been proposed that in some cases a Sudden Infant Death Syndrome (SIDS) diagnosis can be used to mask child abuse and to avoid asking awkward questions—“thus SIDS, in accepting uncertainty, has paradoxically acted to close down further enquiry.”28

5. It is important that reformed systems should redress the current limitations of the homicide figures, which are considered to be an under-estimate of the true number of child deaths following abuse and neglect for a number of reasons, including:

— The legal difficulty of proof of homicide
— The loss or lack of identification of a child’s body
— Misdiagnosed “sudden infant death (SIDS) syndrome” deaths
— Cases where maltreatment is not the immediate cause of death and the child dies of “natural causes” including accidents.

25 Department for Constitutional Affairs (February 2006) Coroners Service Reform Briefing Note
The need for improved statistics

6. The “Statistics of Deaths Reported to Coroners: England and Wales”, an annual statistical bulletin produced by the Home Office, includes details of the number of deaths reported to coroners and the proportion these form of all registered deaths. The number of post-mortems conducted, inquests held and verdicts returned at these inquests are all recorded. The information is broken down by sex but not by age. This is a serious omission. Evidence from the Office of National Statistics publication “Mortality Statistics—Childhood (Series DH3)”, and research on child deaths referred to coroners show that child deaths reported to coroners have a very different profile to that of all deaths.

7. It would greatly assist child protection professionals to monitor the effects of their prevention efforts if the Coroners’ statistics were broken down by age to distinguish between the child and adult deaths. Ideally this would be: under 1, 1-4, 5-15 and 16 and over, in line with the Office of National Statistics’ mortality data. Statistical data should be comparable across England, Wales and Northern Ireland.

8. To give a more accurate picture of the number of children killed in any one year the Office of National Statistics should produce a fresh table within Mortality Statistics showing the total child homicides over the past five years with the numbers of deaths awaiting the outcome of criminal proceedings (category E988.8) outstanding in each year.

Training for coroners and coroners’ officers

9. The NSPCC is concerned that coroners and coroners’ officers receive very little, if any, training in child protection issues, and believes that—in common with all professionals who work with children and their carers—they would benefit from a greater understanding of child maltreatment and child homicide. There is a need for improved training which:

— Enables all professionals who work with children and their carers to recognise the factors that increase the vulnerability of babies and young children;
— Enables investigative and medical practitioners to develop the expertise and skills so that they can inquire into unexplained child deaths in an informed way that is both sensitive and rigorous;
— Integrates lessons from inquiries into child deaths into all levels of inter-agency training.

10. We thus strongly recommend that coroners should receive training in understanding child maltreatment, and child protection processes, and in the complexities involved in determining why a child has died, including the part that can be played by abuse and neglect. An important element of such training should be awareness that the ability to define a child’s death as suspicious is informed by the process of investigation itself, including post mortems.

We would like the Government to implement the Luce Review recommendation that in each coroner area there should be at least one coroner’s officer with some specialisation in handling children’s deaths.

Post mortems

11. The NSPCC considers that coroners’ decisions about post mortems should be informed by an unequivocal requirement to accord priority to the rights and interests of the child, and other children in the family, recognising that the interests of the “family” are not necessarily those of children, nor of the public, wider, interest in gaining a fuller understanding of why children die.

12. It is important to understand that the post mortem is integral to the process of gaining a fuller understanding of the death in question, including whether any aspects of the death are suspicious. A study conducted in an American teaching hospital found that cases of suspected child abuse and neglect were at times confused with deaths by natural causes; importantly, the final diagnosis of most child abuse and neglect was not made until autopsy stage. The authors of this study concluded: “The frequency of misleading history, missed subtle findings on clinical examination, and unsuspected evidence of trauma at autopsy emphasise the need for thorough physical evaluation, including autopsy in all cases of unexpected child deaths.”

13. For this reason, we consider that post-mortems should be carried out in all cases of unexpected child death.

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30 Op. cit p 241
14. All post mortems on children should be carried out by a pathologist with recent expertise and training in paediatric pathology.\(^{33}\) We are aware, and concerned, that there is a continuing national shortage of paediatric pathologists, as evidenced by the problems for coroners of ordering post mortems where the nearest paediatric pathologist is over 100 miles away and the law has to be broken in that a body must be moved beyond the neighbouring jurisdiction.\(^{34}\) We recommend that the workforce strategy being developed as part of the Every Child Matters Change for Children Programme should consider what action should be taken to rectify this situation.

**THE MEDICAL EXAMINER**

15. The Home Office Position Paper states that the medical examiner and their staff will have a clinical background. However, research on child deaths emphasises the importance of assessing not only the medical evidence relating to the death in question, but also family and social factors, including the child’s relationships, in order to determine the cause of death and develop meaningful strategies for preventing future deaths. In *The relationship between child death and child maltreatment—a research study on the attribution of cause of death in hospital settings*, May-Chahal and colleagues highlight the danger of over-attribution of cause of death in hospital settings, issues of hierarchy in the medical profession can also come into play when considering cause of death.

16. We therefore recommend that the proposed regular training and continuous professional development\(^ {35}\) of the medical examiner and their staff should include appropriate training in child maltreatment, child protection processes and child homicide similar to that recommended for coroners. In addition, this should also enable them both to assess the type of information that is required about a child’s family and social circumstances and enable them to interpret such information with well-informed confidence. Consideration should also be given to the background and qualifications of the medical examiner’s staff and whether additional experience/expertise in social care and paediatric knowledge is required—either as part of the formal team, or as a resource to be drawn on when considering child deaths.

**LINKS BETWEEN THE CORONER AND CHILD PROTECTION SYSTEMS AND PROCESSES**

17. Since the publication of the Home Office Position Paper in 2004, there have been welcome developments in child death investigation and review. Section 14 (2) of the Children Act 2004 has given the new Local Safeguarding Children Boards (LSCBs), which replace Area Child Protection Committees from April 2006, powers of investigation and review. Regulations and guidance will require LSCBs to have in place by April 2008 an agreed multi-agency protocol for investigating all unexpected child deaths, and to have established a child death review team to review all child deaths.

18. The reform of the coroner system needs to take full account of these developments, and clarify how coroners will work with LSCBs on child deaths. The Luce Review recommended that there should be standing protocols in all areas between the coroner and child protection agencies setting out how the child’s agencies should be involved in death investigations and how the coroner and his staff should work with them.\(^ {36}\) The NSPCC supports this recommendation.

19. An important area that would benefit from such clarification is the status of serious case reviews (case management reviews in Northern Ireland) which are carried out by local agencies when a child dies and abuse or neglect is known or suspected to be a factor in the death.

20. The purpose of such case reviews is to:

- establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard children;
- identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a consequence, and
- improve inter-agency working and better safeguard children.\(^ {37}\)

21. The Area Child Protection Committee (from April 2006 the Local Safeguarding Children Board), which is responsible for such reviews, must produce an executive summary of the review and make this publicly available. Disclosure of the full report, however, has the potential not only to breach the confidentiality of the personal information it contains, but also to compromise the capacity to secure full and open participation in such reviews from the different agencies and professionals involved.

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\(^{33}\) Sudden unexpected death in infancy (September 2004). The report of a working group convened by The Royal College of Pathologists and The Royal College of Paediatrics and Child Health. Chair: The Baroness Helena Kennedy, p 38

\(^{34}\) Personal communication from Andre Rebello, HM Coroner for the City of Liverpool, 1 February 2006


22. The NSPCC is thus concerned that the proposal to give coroners new powers to obtain information to help their investigations should not result in unhelpful disclosures of full case review reports. A national [that is, England, Wales and Northern Ireland] memorandum of understanding between the Coroners and the Department for Education and Skills, the Welsh Assembly Government and the Department of Health Social Services and Public Safety (DHSSPS) in Northern Ireland would be very helpful to address this issue. We are aware that work is being developed on such a memorandum in Northern Ireland, and the potential for adapting this for application across all three jurisdictions should be explored.

23. In 2003, the Which of you did it? report, which addressed the problems of achieving criminal convictions when a child dies or is seriously injured by parents or carers, recommended that a national protocol should be introduced for the management of parallel civil and criminal proceedings to both improve the quality of risk analysis in specific decisions and to reduce delay in civil processes. This recommendation should be considered as part of the reform of the coroner system.

CRITERIA FOR PUBLIC INQUESTS INTO CHILD DEATHS

24. Public scrutiny is an important element of the judicial process. Inevitably, concerns arise when inquiries are announced as being private, or “administrative”, rather public, as commentators question whose interests are being served by conducting proceedings in private. This is especially the case when proceedings are being paid for by public money, and when their findings contribute important knowledge both to the way in which public services are delivered, and to collective human experience within communities. While we recognise that it can be traumatic for families for proceedings to be held in public, such a process arguably serves the public interest more effectively than holding proceedings in private. Where children are concerned, this is perhaps of even greater importance, as they are a very vulnerable group in society, without any voice of their own. They depend and rely on others to act in their best interests. When this does not happen, systems must be in place to investigate and understand how and why failures have occurred, in the interests of preventing future harm to children.

25. The DCA briefing paper states that “In limited and specific cases, such as some suicides and child deaths, coroners will have a new discretion to complete their investigations and decide on the facts without holding inquiries, where no public interest is served in doing so”. We are concerned about the basis on which such decisions may be made. It is crucial for those making decisions about public and administrative proceedings, where the death of a child is concerned, to adopt a child-focused perspective, and undertake full and effective inquiries with the joint aims of:

- achieving justice for the dead child
- serving the interests of any surviving or future siblings and
- serving the wider interests of children as a whole.

26. The NSPCC fully concurs with the recommendation of the Luce Review that all traumatic and unexplained deaths of children should be the subject of a public inquest, “unless the Statutory Medical Assessor certifies beyond reasonable doubt that the death is from natural disease, without any evidence of abuse and neglect”. In addition, we consider that inquests into the deaths of certain children should always be the subject of a public inquest, namely:

- children who die while in foster or residential care
- children who are, or have been, ‘in need’ as defined by s17 of the Children Act 1989
- children who are the subject of a statutory care, supervision or emergency protection order and
- children whose names are, or have been, on the child protection register. (When the register ceases to exist, this group will constitute children who are, or who have been, the subject of a child protection plan.)

CORONER’S AUTHORITY OVER TISSUE RETENTION

27. The NSPCC is concerned that the Coroners Rules 9 and 12 have been amended so that the period for retaining tissues after post-mortem cannot extend beyond the point when the death is either certified on pink form B, or an inquest is concluded, unless parental consent is given. This is because it is considered at this stage that the coroner is functus officio, that is, that he or she has no further legitimate authority over the death, and their decisions about tissue retention periods are thus annulled.

28. Our concerns centre principally on unexpected deaths in infancy. We know from experience that some infant deaths, originally thought to be natural, have subsequently been found to be caused unnaturally. This knowledge may result from further investigation undertaken after the death of a sibling infant, during which archived tissue, retained after the post-mortem conducted on the first infant, is re-examined.

38 NSPCC (2003) Which of you did it? Problems of achieving criminal convictions when a child dies or is seriously injured by parents or carers, London: NSPCC
29. It is also the case that tissue archived in this way may exonerate parents, who may be under strong suspicion of having killed their infants.

30. The Kennedy report\(^4\) recommended prolonged tissue retention periods in all cases. This was also the view of Carpenter et al who, in their Lancet paper on repeat sudden infant death, state that “adequate post-mortem material must be retained from every unexplained infant death for re-examination in the event of recurrence”.\(^4\)

31. We believe it is self-evident that the parents least likely to consent to such retention are those involved in cases where such retention is most warranted. This is not in children’s best interests. In the interests of protecting and securing justice for children who have been killed, and for parents who may be unjustly accused of homicide, the NSPCC believes that coroners must retain the authority to order, if necessary without consent, the retention of tissues for prolonged periods to enable any re-examination that may be required by future events and knowledge pertaining to individual cases.

32. We are concerned that the new arrangements could increase both the risk that unnatural infant deaths will be missed, and the potential for wrongful convictions of parents for killing their children.

“\text{RULE 43}” Comments

33. The NSPCC strongly supports the Luce Review’s proposal that coroners “Rule 43” comments should have more impact, and should be the subject of regular and consistent monitoring of the public (or private) services at which they are directed, such as in the reports of relevant inspectorates.

34. We propose that Rule 43 comments that relate to children should be routinely submitted to the Children’s Commissioners in England, Wales and Northern Ireland, and that their offices should have a function to ensure that such comments are appropriately monitored and followed up.

\textit{NSPCC}

\textit{February 2006}

\section*{Evidence submitted by Mrs Pip Finucane, trustee, Victims’ Voice}

Victims’ Voice is an umbrella organisation, which provides a “voice” for its organisation and individual members to raise issues that arise when people are suddenly bereaved. Individual member organisations offer specialist support and guidance to enable people to cope with the consequent involvement of police, coroners, mortuaries and hospitals, and the criminal justice system.

My husband was killed crossing the road near our home in 1995 and in 1996, I started to take a particular interest in the problems people had dealing with coroners’ enquiries and I worked on the RoadPeace helpline for three years. In 1998, I became involved in the drafting of what became the Home Office leaflet \textit{When Sudden Death Occurs}, first published in 2000, now available in Welsh and seven ethnic languages.

\begin{quote}
The \textit{Sudden Death and the Coroner} booklet followed, but the Home Office had declined to publish a follow-up booklet and \textit{Sudden Death and the Coroner} was first published by Victims’ Voice in December 2002. It is currently funded by a Department of Health S64 grant, as part of Victims’ Voice \textit{Sudden Death and the Coroner} Project. It is being used by police forces and coroners officers, for training and to give to bereaved people and increasingly, is being used in hospitals and mortuaries. Liaison Forum meetings are also funded by the grant and a “Flyer” about the Project is included with supplementary documents to give you background information.
\end{quote}

\section*{Inquiry into reform of the Coroner Service}

This submission is made from the perspective of suddenly bereaved people.

1. \textbf{Introduction}

The first quotation in the Luce Report was from a submission by Victims’ Voice:

“The bereaved are precipitated into a devastating situation and are having to deal with agencies and procedures unknown to them and from which they feel totally excluded.”

The last quotation was from a submission made by the Coroners’ Society:


\(^4\) Op cit at note 15, p 34
The present Service has for far too long been inadequately resourced and been compromised in what it can do. Outmoded laws and regulations, insufficient staff, lack of resources and poor training have all contributed to the need for reform. It will be most important for there to be a full commitment to any proposed changes that are recommended and implemented, including proper funding, to ensure the objectives of the system are achieved”.

The first quotation gives a clear message about the need for information and sustained communication and the Coroner’s Society stated clearly what the Government must do to achieve effective change.

Lack of immediate oral and written information about post mortems and a coroner’s involvement, failure to maintain communication, time taken to release bodies and delays in inquest hearings and the conduct of post mortems and inquests continue to be concerns for suddenly bereaved people.

This submission deals with the information and training issues, both of which affect how good or bad bereaved people perceive their experience of the Coroner Service to have been. If information and communication are good, many of the difficulties in coping with coronial processes are eased and added distress avoided.

2. BEFORE DEALING WITH THE PARTICULAR ISSUES, CONSIDER:

(a) the order of events: sudden death; post mortem; investigation; inquest.

(b) the circumstances of the death: for example, violent; road crash; disaster; in custody or an institution; infant death; suicide; at work; at home; in hospital; alleged clinical negligence. All present different problems for the coroner and the different investigating agencies involved.

(c) the front line public personnel involved: police (CID, road policing, transport); coroners’ officers; hospital staff—A & E, ICU, mortuary, bereavement, chaplain.

3. INFORMATION

(a) Again and again, the failure to provide immediate information is raised. Why is this such an issue? Because from the moment you are told of the death, information becomes crucial to helping you cope. And, post mortems need to take place as soon as possible.

(b) It is the responsibility of the coroner to inform next-of-kin of their rights. The coroner’s officer will normally do this, but how soon bereaved relatives are contacted by a coroner’s officer and given information is uncertain. It will depend on how soon a coroner is informed of a death, staff availability, workload, and day of week—coroner’s officers are not generally available at week-ends; many local authorities and police forces will not pay for week-end work or call-out.

(c) What happens also depends on the circumstances of the death—relatives bereaved by murder or road death are assigned a police Family Liaison Officer who now has a statutory obligation, under the Home Office Victims’ Code of Practice, to provide specialist homicide and road death packs, published by the Home Office and a charity respectively. Some post mortem and coroner information is included in the packs, but each pack differs in content.

(d) Relatives bereaved in other circumstances in the community or hospital may be given some information before contact with a coroner’s officer, if personnel trained in dealing with sudden bereavement are available. NHS acute hospitals are now developing bereavement services and mortuary staff are also seeking bereavement training. Some hospitals are centralising the responsibility, but in others, the responsibility for bereavement is fragmented.

(e) What happened when someone was killed in a car crash on a Friday is graphically illustrated by N’s Story, which is attached (see Appendix). N was not contacted by a coroner’s officer after the week-end or at anytime before the inquest.

(The treatment of N two years ago was particularly appalling, but similar incidents still happen. The police force involved acted to improve things, but FLO training and that of mortuary technicians are seriously affected by lack of funding and cut-backs.)

4. INFORMATION LITERATURE

(a) In 2000, the Home Office (now DCA) leaflet When Sudden Death Occurs was published, but the HO declined to follow with a booklet to deal with the questions that immediately arise. Victims’ Voice published a booklet Sudden Death and the Coroner—Coroner’s Post Mortem and Inquests—Information for Suddenly Bereaved People, in Dec 2002. This backs-up the difficult explanations given at a time when bereaved people are unable to “take-in” information and need to have written information available.

(b) The provision of immediate information about post mortems and coroners should be a statutory obligation required of the Coroner Service. Literature that can be used in all sudden death cases should be available and the DCA has been asked if it will provide a booklet as well as the leaflet. A Charter is in preparation to set out the rights of bereaved people and performance standards of the Service.
5. Training

(a) In dealing with the Victims’ Voice Sudden Death and the Coroner Project, speaking to coroners, coroners’ officers, police officers, hospital and mortuary staff across the country, it is very clear that understaffing means that even the minimal training that is available cannot be undertaken because personnel are not released to do it. This is happening across all agencies, is a particular difficulty in trying to raise present standards and inevitably contributes to the continued poor response and conduct bereaved people experience from the present Coroner Service.

(b) In a large city jurisdiction, only one coroners’ officer out of fourteen has had any professional training in the last five years.

(c) There are endemic staff shortages in police, coroner, pathology, hospital and community bereavement and trauma services. Some additional funding has been made available, but for bereaved people and overstretched staff, it is far too little and years late. The goodwill and dedication of staff, in all agencies, are being exploited and for the bereaved, it means added distress and misery and in the longer term, increased ill health and social care needs, which in turn increase the burden on the NHS and Social Services.

6. Proposals for reform

(a) The DCA proposals have moved some way from the proposals in the HO Position Paper and no longer include the formation of a national Coroner Service, in which coroners’ officers would be employed by the Service.

(b) A chief coroner, full-time coroners, fewer districts and medical support are welcome proposals. But, will the processes of coronial law actually become more efficient, so long as the Coroner Service continues to be fragmented and under-resourced?

(c) The training situation highlights the unrealistic expectation that a Coroner Service can be efficient where key personnel are responsible to other Services. Is it right that the post be recruited on such terms and, perhaps more to the point, would the best candidates for the post of Chief Coroner want to do the job under those conditions?

(d) A national Coroner Service, with all personnel working within it responsible to the Chief Coroner, is urgently needed. That governments have repeatedly ignored the need for radical reform, widely agreed as necessary, makes it very clear where suddenly bereaved people figure in the order of things. This time funds should be found to commit to the “proper, effective and humane service” that the Minister, Harriet Harman wants.

_Pip Finucane_  
Trustee  
Victims’ Voice  
February 2006

Appendix

The following account is of the personal experience of N when his wife was killed in a road crash. At the time, N contacted SCARD (Support and Care after Road Death and Injury) for help and now hopes that by telling his story others will be better treated and supported.

N is a 63 year old ex miner and his wife was a secretary for the local Health Care Trust. Married for forty years with two children, both enjoyed being involved in the lives of their eight grandchildren. They did most things together and their main interests were entering their Pedigree dogs into shows around the Country and taking walks in a nearby forest.

Friday, 19 March 2004 was a dry fine day. N was preparing a favourite meal for his wife, due home from work at about 5.45 pm. She never arrived.

By 6.15 pm N, now beside himself with worry, was informed by his granddaughter that there had been a crash on the Axxx and that some of the nearby roads were blocked. He had a dreadful feeling that something was very wrong. He immediately rang the local Police Station to ask if they had any information about the crash and who was involved. The Police asked whom he was inquiring about, then replied that they would get back to him if they found out anything.

N felt that he could not just sit and do nothing, so he got into his van and set off to drive the four miles to the crash site. Whilst on his journey, a Police car passed him going in the opposite direction; thoughts went through his mind “I wonder if that car is going to my home”.

He arrived at a roundabout near the crash site; it was blocked by a police patrol vehicle. The Police officer came over to N’s van. N asked if he knew what vehicle had been involved in the accident. The officer asked his name and requested that he pull over to the side. N sat for seven or eight minutes watching the officer talking on his radio. The first Police car he had seen earlier then arrived and pulled up to the side of his van.
N was invited to sit in the rear of the second police car and was told that his wife had died in the crash. After a couple of minutes, he was asked was he ok to drive? N then drove his van back home, followed by the second Police car.

When N arrived home Sue, his daughter-in-law, was waiting for him. N was distraught and unable to take in what the Police were telling him; he could not believe that his wife was dead. The police informed him that he had to go with them to the nearest hospital to see his wife and identify her. N, who was in an extreme emotional state, pleaded with the Police. He felt could not deal with identification that night, but was told he must.

He and Sue were put into a police car and driven to the hospital where they were dumped in A & E by the Police Officer, who then left. No-one came to them to ask who they were, what were they waiting for, or informed them what was happening or why there was a delay.

After an hour and ten minutes, the Police Officer reappeared and said “Sorry mate we are at the wrong place, we should be in the Mortuary car park.” They then got back into the patrol car and were driven round to the Mortuary car park where they were left sitting in the car for over another hour, in the darkness.

Eventually another car came onto the car park, pulled up outside the mortuary and flashed its lights at the Police car. N told the Police Officer “I can’t take much more; I’m feeling ill with shock”. He said again that he was petrified about having to identify his wife.

A man, thought to be a Mortuary technician, then approached the Police car passenger window where N was sitting and said, “Do you want to see her now?” The Police officer interjected “No, we’ll wait for the traffic officer”. The man then said “Personally, I think it should be left until Monday”. N said “what are you trying to tell me?” and the man replied “Well she’s not a pretty sight”.

N had voiced his reluctance to view his wife at least twice that night, but because of the comments of the Police Officer earlier, he had been led to believe it was the only legal way of identification.

N again voiced his reluctance, but the Police Officer then said to N “Sorry it has to be done tonight. It is Friday evening and it must be completed before the weekend”. They then sat for another 15 minutes in the back of the police car.

The Traffic Officer they had been waiting for then arrived and they were taken into the mortuary where N was asked questions and personal details about his wife.

N was then asked was he ready and led to a side room. He had no doubt that it was his wife though, in his words, “it didn’t look like her”. Part of her forehead, which was injured, was covered with a piece of white cloth and was still bloody. He kissed her. He registered in his mind that a large bunch of plastic flowers had been laid across his wife’s body. After some time had passed N asked about his wife’s clothes. He was told “you wouldn’t want to see them”. But later he was given her handbag. When he opened it, he was appalled to find his wife’s glasses pushed inside, still splattered with blood.

N and Sue were then driven home by the Police Officer. After being given a “blue binder”, the Police Officer left, telling them not to read it for two or three days.

N sat with several members of his family for a time and they left after N assured them he would be alright. He then spent the next six hours between 12.30 am and 6.30 am, repeatedly redialling his wife’s work’s answer-phone, just to hear her voice. His daughter-in-law stayed with him all night.

At 6.30 am, N rang the Police station to beg them not to do a Post Mortem; he couldn’t bear the thought of it and couldn’t see the need; it was clear she had died of her injuries. He was told by the Officer who answered the phone that “she is no longer your wife”.

The following morning, Saturday, N’s son arrived and found his father distraught at the Officer’s comment about “she was no longer his wife”. On the Monday, his son rang the Police to complain and the following day an Inspector and a WPC came to his home. The Inspector told N that the Officer had said the wrong thing, but it wasn’t meant “like that”. He also confirmed that N did not have to make a “visual” identification.

The Monday was three days after his wife’s death and N decided to ring the hospital and plead with the senior technician not to do a post mortem. The Senior Technician thought N was ringing about the identification and asked N “Are you coming down this afternoon?” N replied, “I have already identified her, I was brought down on Friday”. The Technician was astounded, saying “You’re joking, there is no way you should have been allowed to see her like this”. He further added “Those bloody coppers and their paperwork”.

Although N had protested, a post mortem was carried out. No-one had explained that this is normal practice after traumatic deaths and a coroner does not need the consent of next-of-kin. But, N should have been told when and where the post mortem would take place and that he could have a medical representative present.

One week later his beloved wife was laid to rest. The week following the funeral, a WPC called at N’s home, introducing herself as a Family Liaison Officer (FLO). She had a conversation with N lasting about ten minutes.
The FLO rang him a week or so later. N told her he had burned the blue binder that he had been given on the night of his wife’s death because the information contained said he did not have to make a visual identification, which he had been forced to do. The FLO said she would call again and would bring another “blue binder”. She duly arrived the following day. As she came into the house, her mobile phone rang and ignoring N, she answered it, saying to the caller “I won’t be a minute”. N was angry at this and told her “don’t let me keep you”. The FLO handed him another blue binder and left. This was also burned. He never saw an FLO again.

N’s wife had left her work at the usual time. It is thought she decided to stop at a garden centre on the way home as it was Mother’s day in two days time. She had rejoined the main road and had reached her carriage way when her car was hit by a speeding coach, travelling at over 60 mph in the opposite direction. The speed limit for a coach on that stretch of road is 50 mph.

The coach hit Mrs N’s car on the driver’s door. Emergency services arrived within minutes, but it took three and a half hours to free Mrs N. N was told his wife had died instantly.

The driver of the coach was giving an ex colleague, who was sat in the co-driver’s seat, a lift. They had commented to each other about the “near miss” the coach had with another car a few seconds earlier. The driver of this car came forward later.

N had made it clear to the Police right from the start that he wanted to be involved with the judicial process surrounding his wife’s death. He was assured that he would be informed. Despite all the reassurances, N received a phone call from an officer some weeks later and was told that the driver had been charged. N asked when the case would go to court and he was informed that the case had been in court the day before. It was over and done with!

The driver was fined £60 and given three penalty points.

This catalogue of unbelievable and shockingly insensitive and inappropriate treatment of N has left him severely depressed, disillusioned and obsessional about his dreadful treatment by all concerned. The ignorance of the law with respect to identification and post mortems and the “inconvenience” of a traumatic death on a Friday are equally shocking. The assurances of the police to keep n informed meant nothing.

This story is not an isolated one, nor is the sentence, which reflects the attitude of our society to loss of life on great Britain’s roads.

Supplementary evidence submitted by Mrs Pip Finucane, trustee, Victims’ Voice

RESPONSE TO ORAL EVIDENCE GIVEN BY RT HON HARRIET HARMAN QC MP

Q238 “Pre-legislative scrutiny” by panel of bereaved people.

Mr Vaz pointed out that if a Panel was used, it should have been before the draft Bill was published and not once the Bill is in the Commons. And, the selection of members for a Panel should not be done by coroners—the sample would not be random.

Would a Panel serve any useful purpose anyway? The Home Office was proposing a National Coroner Service, but the draft Bill’s proposals mean continued dependence on local authority and police priorities for their spending and bereaved people continuing to suffer the problems widely reported to the Fundamental Review.

Q246 Consistency of service across the coronial system?

The Minister refers to minimum standards—the aim should be high standards subject to some form of quality assurance accreditation of the roles involved and the management of the Service.

Why is it that if government departments are tendering for a service, a would be contractor will have to demonstrate a level of competency, for example an ISO certification? The opposite seems to apply when government is responsible for the service and in the case of the Coroner Service, the failure to recognise the Coroner’s Officer role and adequately fund it demonstrates this. Difficulties between Coroners’ Officers and police Family Liaison Officers, because the status and role of Coroner’s Officers is not recognised and clear, are still being reported.
Q256  Appeals

At present people do not seek judicial review or quashing of an inquest because of the cost and difficulty in obtaining legal aid. Appeals may increase, especially with more people able to make them for a wider range of complaints or issues.

Next-of-kin may object to less close relatives or friends being included as “properly interested persons”. Disputes occur at present about who is next of kin or who is to be the relatives’ spokesperson. Coroners can at present, under Rule 20(2), accept people they consider “properly interested” but not listed under the Rule.

Ms Harman feels it will be “very interesting to see what people do appeal or complain about”. We know what suddenly bereaved people complain about and unless front-line performance is improved, the same complaints will be made. Wait-and-see what happens feels like treating the limited reform as an experiment, rather than aiming for a well resourced National Service that should reduce the need to complain.

Q275  Coroners’ Officers

Ms Harman agrees that coroners’ officers “will have the most contact with bereaved relatives and their job is very important indeed” and that “the training for Coroners’ Officers is very important indeed.” But, in spite of the views of those working in the present Service and the recommendations of the Luce Review and Third Shipman Inquiry, Ms Harman stated that if she “was given a tonne of money by the Treasury” she would not do things differently. This does not suggest any real understanding of what bereaved people experience or the difficulties of those working in the Service.

A lot is expected of a Chief Coroner who, without executive authority, is expected to ensure consistent performance. Would anyone apply for the job of Chief Executive of a commercial company if told that key staff would be employed by another company and the CE would not have direct control of them?

Q272  Death Certification

There are complaints about inaccurate death certification, but how common are entry omissions on the Medical Cause of Death Certificate? A bereaved person has contacted Victims’ Voice about MRSA being left off the certificate and there seems to be confusion about whether MRSA is a notifiable disease. How will this kind of query be dealt with under the proposed reform?

Pip Finucane
Trustee
Victims’ Voice
July 2006

Evidence submitted by the Department for Constitutional Affairs (DCA)

1. INTRODUCTION

1.1 This paper responds to the Constitutional Affairs Select Committee’s call for evidence on reform of the coroner system and death certification. The evidence is presented in the following sections:

SECTION 2: focuses on problems within the current system and the need for reform

SECTION 3: outlines our proposals for coroner reform


SECTION 5: outlines work on improving death certification, including work on clinical governance and patient safety

SECTION 6: refers the Committee to research on coroner services and death investigation in other jurisdictions.

1.2 This memorandum includes the substance of the briefing note on coroner service reform made available to MPs at the time of the announcement on reform in the House of Commons on 6 February.
2. THE NEED FOR REFORM

2.1 The current system is fragmented, non-accountable, variable in quality and consistency, and in some respects, ineffective. Most coroners are part time (83 out of 111). Practice varies across jurisdictions in the process of investigations and inquests, the use made of post mortems and the availability of coroners’ officers and other support staff. In some areas bereaved people have limited information available to them, and limited opportunities to be involved.

2.2 The current arrangements for the investigation and certification of deaths, and for the authorisation of burials and cremation are rooted in the 19th century. They overlay an older system which can be traced back to the Middle Ages.

2.3 Part of the legislative framework in which coroners work is archaic. The present system is largely enshrined in the Coroners Act of 1887, although with some important modifications and modernising measures introduced in 1926, and some further changes in 1977 and in 1980. The current coroner legislation, the Coroners Act 1988, is essentially a consolidating statute: the main features of today’s law would be entirely familiar to coroner of nearly 120 years ago.

2.4 The Broderick Committee, which reported in 1971, made the most significant recommendations of change to the coroner system in the 20th century. However, these were largely dependent on obtaining parliamentary time for new legislation. In the event, though some changes were made to legislation (notably the repeal of power to commit for trial in 1977), the system was not changed in the way the Committee envisaged.

2.5 Over the last 15 years a range of different cases, including the sinking of the Marchioness, Hillsborough, deaths in police custody, and the murders committed by Harold Shipman, have highlighted the inadequacies of the current system. At the same time, it has become evident that the legal and structural framework within which the system operates lacks the flexibility to evolve to meet modern expectations.

2.6 In this context, the then Home Secretary and Secretary of State for Health commissioned the Shipman Inquiry (January 2001), chaired By Dame Janet Smith, and the Fundamental Review of Death Certification and Investigation (July 2001), chaired by Mr Tom Luce. Both of these reported in 2003 and identified weaknesses in the coroner system which included:

— an absence of quality controls and independent safeguards;
— the exclusion of the family or friends of those who have died;
— a lack of consistency, leadership or training by or for coroners;
— a lack of involvement of the family in coroner investigations;
— the unnecessary use of public inquests in some cases; and
— an absence of medical skills.

3. PROPOSALS FOR CORONER REFORM

3.1 The Minister of State Harriet Harman announced proposals for coroner service reform in the House of Commons on 6 February. These measures are based on three main aims:

— an improved service for bereaved families and others touched by the service;
— a service with good national leadership, as well as the best features of a locally based service; and
— more effective investigations and operation.

Coroner reform will be achieved in the following ways.

A better service for bereaved people

3.2 Bereaved people will have better opportunities to raise concerns about a death with the coroner, even if the doctor has already signed a death certificate. They will have clear legal standing in the coroner’s investigation and processes. The standard of service they can expect to receive throughout the coroner service will be set out in a coroners’ charter for bereaved people. The charter will set out guidelines and standards to ensure there is an effective response in cases of sudden and unexpected deaths, including fewer delays. Better contact between coroners and bereaved people, will help improve understanding of the cause and circumstances of the death. The charter will ensure that bereaved people understand the coroner system and their rights within it—for example, the right to be informed and consulted about post-mortems, other aspects of the coroner’s investigations, and their opportunities for involvement in the inquest process. The rights of appeal against decisions of coroners will not always require proceedings in the High Court in the first instance.
Avoiding unnecessary inquests

3.3 Coroners will have discretion not to hold an inquest in limited cases, for example some suicides and child deaths, where no public interest would be served by a public hearing. In these cases, the coroner will investigate the death and issue a report which will be made available to the family and others with an interest, and the general findings made public. In such cases the pain and grief that can arise for the families from a hearing in open court can be avoided. There will be no duty to inquire into deaths that appear to be more than 50 years old. Coroners will have discretion not to proceed to an inquest where there are criminal or other investigations or other proceedings in connection with the death that appear likely to resolve the issues that an inquest would have determined. They will however need to review the position when such investigations are concluded.

National leadership, national standards

3.4 A Chief Coroner, supported by a small team, will be appointed to give professional leadership, to raise standards, to commission audits or inspections, and to respond to representations from bereaved people or other interested parties to investigations about how the service has handled their case. The Chief Coroner will be responsible for the monitoring of the coroners’ charter for bereaved people, co-ordinating training for coroners and producing national leaflets and other information about the coroners system. The Chief Coroner will be accountable to Government Ministers for his or her performance. An advisory Coronial Council will be appointed to act as a further check on standards and will advise the Chief Coroner on what service and strategic issues may need further scrutiny. The Council will include independent lay members and representatives of voluntary groups.

Full time coroners

3.5 We will improve all round performance through a service made up of full-time coroners operating in line with national guidance and responding to the needs of the bereaved, and to cultural sensitivities in the areas they serve, but committed to ensuring that investigations are carried out efficiently and effectively. Ministers will have new powers to determine the size and boundaries of coroner districts to create a smaller number of full time coroner areas aligned largely with local justice boundaries, to which full time coroners (probably 60-65) will be appointed. The coroners will be supported by assistant coroners to act for the coroner in his or her absence.

Local as well as national accountability

3.6 Local authorities will continue to appoint coroners with the centre playing a more active part to ensure that all appointments follow standard procedures for fair and open recruitment. All new appointees to the service will be required to have a legal qualification, with transitional provision for those few coroners who have medical qualifications only to apply for jobs in the new service. Coroners’ officers will continue to be employed by either the police or local authority, with the transfer between the two subject to local agreement as is the case now.

Improved investigations and inquests

3.7 We will publish criteria for deaths which should be reported to, and investigated by, coroners. Outdated boundary restrictions on investigations and post-mortems will be relaxed. Bereaved people will be given the opportunity to participate at significant stages of the investigation. We will give new powers to coroners to obtain information from those reluctant to provide it. We will provide for judges, or counsel to inquests, to be appointed in particularly complex cases. Coroners will be able to hold pre-inquest hearings in which the scope, issues and conduct of the inquest can be established.

3.8 We will provide for coroners to investigate deaths outside England and Wales in specified circumstances or when directed by the Lord Chancellor. The duty to investigate will be expressed in terms found by the courts to be compatible with the requirements of Article 2 of the European Convention on Human Rights. New measures will be introduced for the protection of children who are witnesses in inquests.

Improved medical capacity

3.9 A Chief Medical Adviser will be appointed to support the Chief Coroner to give advice on medical best practice and medical issues related to coroners’ investigations. At a local level, funding will be provided to coroners to ensure appropriate independent local medical advice to support their investigation.
Treasure

3.10 Assessing whether a particular find should be classed as treasure will be removed from the mainstream of coroners’ work. A new national coroner for treasure will be appointed, to take on the work currently carried out by coroners at a local level. This will enable other coroners to focus on their core work. The rights, under the Treasure Act 1996, of those who use the coroners’ service in this way will not otherwise be affected.

Current Work

3.11 We are taking important interim steps to improve the service to the public by funding local initiatives that offer information and support to bereaved families when they attend court. This includes the London based Association of the Coroners Court Support Service (CCSS), which supports families and witnesses immediately before, during and after an inquest.

3.12 We are also providing training and start up costs for plans by Nottingham Victim Support for a witness scheme in the local coroners court, and are discussing the possibility of starting schemes in Teesside and Norwich with the local Victim Support teams there.

3.13 In recent years we have introduced an enhanced programme of coroner training. More than 300 places have been taken up by coroners and their deputies in the last 12 months on courses ranging from inquiring into prison deaths to handling major emergencies. We are also looking to improve training opportunities for coroners’ officers.

4. Shipman Inquiry and the Fundamental Review of Death Certification and Investigation

4.1 As stated above, our proposals have been developed following the two major reviews that examined the Coroner Service, the Fundamental Review of Death Certification and Investigation, the Shipman Inquiry Third Report, and the subsequent 2004 Home Office paper “Reforming the Coroner and Death Certification Service—Position Paper”.

4.2 We are taking forward significant proposals from these reports, including:
- involvement for families secured through a charter for bereaved people, with rights of appeal or review;
- no duty to hold a public inquest where there is no public interest;
- the Chief Coroner having the power to appoint judges in complex cases;
- juries only being mandatory in cases of death in custody and during the case of police investigations;
- coroners having the power to enter premises and seize property required for their investigation;
- coroners having the discretion to investigate deaths abroad where the body is returned to England and Wales;
- the appointment of whole time coroners with a retirement age of 70; and
- the appointment of a Chief Coroner to provide central leadership and guidance, an advisory Coronial Council and Chief Medical Adviser.

4.3 Secondary legislation will be used to take forward many of the more detailed recommendations, such as the requirement to give public notice of the time and place of inquests.

4.4 Other recommendations such as those relating to the type and content of training provided to coroners and their staff are already being implemented and will continue to be taken forward by the Chief Coroner and Coronial Council in the reformed service.

5. Death Certification

5.1 We have continued to examine the earlier proposals that all deaths, some 514,000 in England and Wales in 2004, should be subject to an additional, independent medical scrutiny by the coroner service.

5.2 We are seeking a system which strikes the right balance between cost, risk, delays and the rights of families to proceed quickly with funeral arrangements. We are not sure that the proposals to have all deaths referred to coroners achieves this delicate balance, but we will be looking further at this and do not exclude the possibility of wide-ranging change in the long term.

5.3 Work is already in hand to strengthen the death (including cremation) certification process, including updated guidance to all involved in death certification—the ONS Death Certification Advisory Group issued updated guidance in May 2005 for certifiers (doctors, medical referees etc) to clarify their responsibilities under current legislation. This covered reporting deaths to the coroner, and guidance on how to complete the medical certificate as to cause of death in a wide range of circumstances, with examples given.
5.4 Visits are made to the 200 or so crematoria in England and Wales to inspect cremation certificates. The evidence gleaned from these visits indicates that the guidance is being used. There are prosecutions where professionals appear to have deliberately falsified information. Coroners visit hospitals, care homes and medical schools to train on the need to report to a coroner. Coroners also encourage doctors to contact their office if they have any doubt or need any advice in relation to death certification.

5.5 Over 40% of deaths are in any event currently referred in some way to the coroner. This is both a significant proportion and a rising trend, and demonstrates the extent to which doctors contact a coroner when they have a query or question on certification.

5.6 The DCA’s coroner reforms do not stand alone. They will be complemented by further work being taken forward in the Department of Health, aimed at improving patient safety and promoting quality in the NHS.

5.7 The Department of Health is working to embed into every NHS organisation the attitudes and processes of clinical governance. Clinical governance is both an attitude and a set of processes to ensure that healthcare organisations maintain high standards of quality and safety and strive for continuous quality improvement. Key processes in the context of protecting patients against poor professional performance include:

- analysis of patient complaints and concerns raised by fellow professionals;
- reporting and analysis of avoidable errors and near misses;
- participation of all clinicians in clinical audit;
- scrutiny of routine indicators of clinical performance; and
- regular appraisal of all doctors (to be extended in due course to other healthcare professionals).

5.8 Much has already been achieved since the concept was first introduced in 1998. The Department of Health will be setting out detailed proposals for further work in the response to the Shipman Inquiry’s 5th report later this year. Examples of on-going work being led by the Department of Health are:

- primary care trusts, hospitals and other specialist trusts now look routinely at a range of indicators which may indicate poor clinical practice or behaviour;
- patient complaints, and concerns raised by fellow professionals, are another vital source of information which may indicate a performance problem, and the Department of Health is working to improve the handling of complaints in both secondary and primary care and will later this year consult on further proposals in the light of the recommendations in the Shipman Inquiry’s 5th report;
- the NHS Redress Bill will, subject to parliament, provide another route through which to identify errors in treatment and to ensure that healthcare organisations learn from their mistakes;
- once concerns have been raised about the performance of a healthcare professional, healthcare organisations have a range of options for dealing with them, and in the case of doctors and dentists, this includes referral to the National Clinical Assessment Service; the overriding objective is to safeguard patients but also, where possible, to help the professional to put right any weaknesses and to return to safe practice;
- the Department of Health is issuing guidance to the NHS on new arrangements for the governance of controlled drugs, and this will, subject to Parliament, be underpinned by a new statutory duty on all healthcare organisations to appoint an “Accountable Officer” for controlled drugs, and to coordinate information and action to protect patient; ands
- the Department of Health is also tightening up the audit trail for controlled drugs through a series of amendments to the Misuse of Controlled Drugs regulations and through improvements in NHS IT systems.

5.9 Taken with coroner service reforms, these measures will create a system and environment where there is a much reduced likelihood of another Shipman going undetected for so long.

6. CORONER SERVICES AND DEATH INVESTIGATION IN OTHER JURISDICTIONS

6.1 Both Dame Janet Smith in her Third Report and Tom Luce in the Fundamental Review of Death Certification and Investigation examined systems that exist in other jurisdictions, including those in Ontario, British Colombia and Alberta in Canada, New South Wales and Victoria in Australia, Maryland in the United States, Scotland and New Zealand.

6.2 In most Commonwealth countries, the coroner system has retained two distinctive characteristics—being a specialist death investigation service and undertaking a judicial-style of inquiry into finding the cause of death. Coroners also tend to be appointed rather than elected and are usually doctors or lawyers.

6.3 In Australia, death investigation is the responsibility of the individual states and in Canada, of the provinces. In both countries, there have been very substantial reforms in recent decades.
6.4 With variations in detail, the general direction of these reforms has been moving away from independent locally appointed judicial style city and county coroners holding a large number of public inquests, towards the development of a single coroner service for the state or province led by a Chief Coroner. The large majority of investigations are treated as a private and administrative service to the deceased and the family and not as a public process. Public inquests are also held on a much smaller scale than formerly and are restricted to certain mandatory categories including deaths in prison or detention.

6.5 Coroners in the USA are similarly either doctors or lawyers but they are usually elected to post, although no set qualifications are prescribed. Their inquiries into deaths are usually through private rather than public inquests, though the outcomes, at least in traumatic cases, are usually published.

6.6 We have taken account of this information in developing our proposals and we refer the Committee to the full evidence in the relevant sections of the Dame Janet Smith and Tom Luce reports.

Department for Constitutional Affairs

February 2006

Supplementary evidence submitted by Rt Hon Harriet Harman QC MP, Minister of State, Department for Constitutional Affairs

COSTS AND FUNDING OF CORONER SERVICE REFORM

There are two issues in relation to the funding of Coroner Reform that I said I’d write to the Select Committee on following my oral evidence on 27 June. These were affordability of the programme to DCA and the start-up and running costs for the Office of Chief Coroner.

Just to recap on the overall figures; my Department has estimated the costs of implementing the changes contained in the draft Coroner Bill in terms both of annual running costs and one-off transitional costs (£6m p.a. and £15m respectively). These costs will inevitably be refined and discussed with stakeholders, for example the Local Government Association, but at this stage the Department is confident the figures are a reasonable estimate.

In terms of the first issue, affordability; currently the DCA has allocated 2006–07 funds and will shortly be considering 2007–08 allocation for which the overall Departmental funding limits are known. The relative priority of all programmes will be considered as part of this. Funding for 2008–09 and beyond, however, is dependant upon the CSR 07 settlement which has not yet been agreed, and therefore it is not possible to form firm views at this stage on how this will be allocated.

The Department will inevitably face challenges on prioritisation for both 07–08 and the SR07 period. However, we are committed to reforming the Coroners service as quickly as possible, taking account of the financial parameters in which we have to operate.

On the second issue, start-up and running costs for the Chief Coroner office. It is envisaged that the office will comprise the Chief Coroner, a Deputy Chief Coroner and a support team of between six and eight. The start-up cost is around £1.3m and includes recruitment, IT and accommodation requirements. The running costs of the office are estimated at around £1m p.a. including all salaries, on-costs, accommodation, IT and some programme spend.

I do trust that this gives the Committee the information it requires.

Rt Hon Harriet Harman QC MP
Minister of State
Department for Constitutional Affairs
July 2006

Evidence submitted by INQUEST

1. INQUEST is the only voluntary organisation in England and Wales that works directly with the families and friends of those who die in all forms of state custody—in prison, young offender institutions, immigration detention centres, police custody or while being detained by police or following pursuit, and those detained under the Mental Health Act—to provide an independent free legal and advice service to bereaved people on inquest procedures and their rights in the Coroner’s Court. It was set up in 1981. It provides specialist advice to lawyers, the bereaved, advice agencies, policy makers, the media and the general public on contentious deaths and their investigation. It also monitors deaths in custody where such information is publicly available and identify trends and patterns arising.
2. INQUEST also provides generic advice on the inquest system to bereaved families and publishes free for any bereaved family—Inquests—An Information Pack for Families, Friends and Advisors43—that explains the whole process and where to find emotional and practical support. We have provided this service in the absence of a similar service from the current inquest system. Since we have published our pack in August 2004 we have distributed more than 350 hard copies and it has been downloaded over 5,200 times from our website. Since 1996 the organisation has worked directly to support over 2,000 families facing inquests.

3. This submission is made on behalf of INQUEST by Deborah Coles and Helen Shaw. They have been the co-directors of INQUEST since 1990 and 1994 respectively and are joint editors of Inquest Law, the quarterly journal of the INQUEST Lawyers Group. Deborah is a trustee of the charities Women In Prison and the Centre For Corporate Accountability and is a member of the BBC Charitable Appeals Committee. Helen was appointed as a non-executive member of the Human Tissue Authority in April 2005 and was previously (April 2001—March 2004) a non-executive member of the Retained Organs Commission. She is also a trustee of the charity National Bereavement Partnership. They are joint members of the Independent Police Complaints Commission Advisory Group and the Ministerial Group on Suicides in Prison. They are co-authors of the forthcoming INQUEST publication Families’ Experiences of the Investigation of Contentious Deaths and Deborah is co-author with Barry Goldson of In the Care Of the State, Child Deaths in Penal Custody (INQUEST 2005).

4. INQUEST published its submission to the Fundamental Review of Coroner Services in 200344 which outlined concerns about the operation of the inquest system at that time regardless of circumstance of death. We also gave oral and written evidence to the Joint Committee on Human Rights Inquiry into Deaths in Custody 2004 which addressed the problems with the inquest system alongside other matters. INQUEST will be publishing a new report on Families’ Experiences of the Investigation of Contentious Deaths in April 2006 and hope this will contribute to the reform process.

5. INQUEST believes that the current inquest system is failing and that this is heightened in deaths that involve questions of state or corporate accountability.

6. The coroner’s system is one of the most neglected areas of law. In contrast to the constant evolution of other legal and administrative structures and a more rights-based approach generally to public functions and services the coroner’s court has failed to evolve. This means that its standards fail to reflect modern concerns about the rights of those participating in legal proceedings. The resources and structure of the current system militate against the delivery of a service that addresses the needs of post-death investigation in the 21st century.

7. INQUEST has always argued that the right to an inquest is fundamental after a sudden and unnatural death. Any new system needs to operate within a framework that ensures openness, accountability, compatibility with the Human Rights Act and sensitivity to bereaved people and the public.

8. To establish such a framework there need to be clear national protocols for all aspects of post-death investigation. Those protocols need to enshrine clearly defined mechanisms of accountability, minimum levels of service delivery and a system of sanctions where practice falls below acceptable standards. Above all it needs to be a system that balances the needs of the state with those of bereaved people and ensures that all participants have an equality of resources and information. Whilst the process will be painful for bereaved people, it will be more bearable if the system is seen to have legitimacy and meaningful outcomes.

9. This submission summarises the concerns that have emerged based on 25 years of advising and supporting bereaved families, monitoring post-death investigations and attending inquests around the country.

10. From our work with bereaved people we have identified the following problems within the current system:

   a. Lack of provision of clear, accessible information for bereaved people about their rights in relation to the inquest system and coroner’s post mortem;
   b. Lack of understanding and sensitivity within the system to religious and cultural beliefs;
   c. No shared understanding of the function and purpose of post-mortem examination;
   d. Lack of explanation to families about their rights and funding for a second post-mortem;
   e. Lack of explanation and public understanding of the legal status of the body and problems with different standards and practice in relation to bereaved families’ access to the body;
   f. Insensitivity of coroners and others in relation to post-mortem evidence;
   g. Inconsistency of quality and extent of coroner’s post-mortems;
   h. The formality of the procedure frequently more than many given to expect;

43 INQUEST 2004, also available from www.inquest.org.uk
44 How The Inquest System Fails Bereaved People (INQUEST 2003)
i. Variable time delays and approach to inquests into deaths in similar circumstances dependent on geographical area;

j. Variable quality of courts and lack of private space for bereaved people;

k. Inappropriate delays in holding the inquest;

l. Variable treatment on a range of issues dependent on geographical area;

m. Good practice dependent on the approach of individual coroners and coroner’s officers rather than agreed and inspected quality standards;

n. Varying levels of legal knowledge and understanding of relevant issues amongst coroners and lack of compulsory training;

o. Insensitive treatment of families before and during the hearing—by coroner/coroner’s officers and other advocates for Interested Persons;

p. Lack of career structure and training for coroner’s officers;

q. Lack of clear accountability as no national coroner service;

r. Lack of easily accessible and effective complaints procedure;

s. Rules of coroner’s jurisdiction prevent the hearing of complex cases before specialist coroners;

t. Lack of right to disclosure of documentary evidence;

u. Narrow legal remit of the inquest;

v. Lack of central monitoring of coroner’s Rule 43 concerns and lack of duty to respond;

w. Perception by bereaved people that the inquest does not function to prevent future deaths occurring in similar circumstances;

x. Problems with lack of non-means tested funding for legal representation

y. Negative impact of the above on physical and mental health of bereaved people;

z. Lack of referrals to legal, social and health service providers, including voluntary sector providers;

aa. Lack of follow-up communication about action being taken where the death has occurred in an institution. Bereaved families frequently describe how they know that the inquest cannot bring back their relative but that if lessons are learned to prevent similar deaths it will have some meaning for them.

11. These factors have serious consequences for families faced with an unexpected or violent death. The narrow focus of the inquiry puts artificial and invidious limits on the scope and style of conduct of the coroner’s inquiry, which often exclude from the inquest the issues of greatest concern to the family. The inquest is usually the only investigation of death to which a family has access. Importantly, for the public interest and democratic accountability, it is the only public forum in which contentious deaths will be subject to scrutiny. Inquests are too often at risk, particularly in the absence of legal representation for the family, of being opportunities for official and sanitised versions of deaths to be given judicial approval—rather than being an opportunity for the family to contest the evidence presented, to discover the truth and full circumstances surrounding the death of their loved one.

12. Despite some examples of good practice, an outmoded administrative mindset means that families are marginal to the overall process, whereas they should be central. Death is far more significant for the bereaved than for the doctors, police, coroner and lawyers involved, for whom it is ultimately a professional matter.

13. There have been some developments seeking to soften the hard edges of legal procedures following death, and individual coroners do often try on an ad hoc basis to be sensitive to families’ feelings and concerns. The position however remains that families’ legal rights in proceedings are restricted: the inquiry is not for them, and the administrative framework is not directed at their full inclusion in the process. Families are not recognised properly as stakeholders with an interest in the final outcome. The Government’s review is an important opportunity to change the inquest system fundamentally.

14. Bereaved families have frequently described the experience as one that adds to rather than diminishes distress, marginalises them and leaves more questions than answers. Many agencies have little or no understanding of the particular experience of the inquest system including lawyers, generic advice agencies and bereavement agencies. Lawyers are not routinely taught about inquests during their training. Coupled with the lack of access to public funding in most inquest cases, this means that often families have sought advice from lawyers that has been inadequate, expensive and sometimes wrong.

15. Overwhelmingly our work with these families has resulted in an outpouring of anger and distress from bereaved people and raises some fundamental questions about society’s collective ability to deal with the aftermath of death. It affirms what we suspected, that far from being the isolated or highly controversial cases or incidents that the system proves incapable of dealing with, it is ill equipped to deal with most deaths and most families suffer additional distress and grief as a result.
16. The significance in this context of the coroner’s court—as a point of contact with public services for most “at risk” families, regardless of how and where their loved one’s death occurred—is at once clear. Its potential role in guaranteeing informed and effective access to appropriate bereavement intervention options for bereaved families must therefore be a central concern in developing a new system.

INQUEST’S SERVICE

17. The aim of our casework service is to advise families and empower them through the provision of information and advice about their rights. Because of the length of time from the death to the conclusion of the investigation and inquest process our support can last for a number of years.

18. We operate a telephone-based service offering free support, advice and information to all bereaved people facing an inquest and their basic rights in the coroner’s court. There is no other organisation in England and Wales with such specialist knowledge about the inquest system. Our informed casework team provides this specialist advice as well as sending out written information, such as our comprehensive Information Pack45 and leaflets concerning specific areas of death. We also provide information to bereaved people about how to access other services and in many non-custody related deaths we will provide both advice and referrals to other organisations eg road traffic related deaths to RoadPeace, work related deaths to the Centre for Corporate Accountability, deaths in hospital to AvMA. We also monitor any legal issues arising from these cases that concern the inquest system.

PARTicular problems following deaths in custody

19. In the context of all of the problems described above there are particular concerns about how deaths in custody are dealt with and INQUEST outlined these in both written and oral evidence to the Joint Committee on Human Rights in 2003 and 2004.46

20. The key role of the public inquest in contentious deaths is that it is often the only public forum in which there is any scrutiny of the death. The importance of the investigation being in public cannot be underestimated.

21. With custody-related deaths the lack of support and appropriate assistance is more acute with families feeling doubly victimised—they have suffered a death and because of its nature they are treated as though they are criminals.

22. All deaths in custody involve an inquest so the potential role of the Coroner’s Service in guaranteeing informed and effective access to appropriate bereavement intervention options for bereaved families must therefore be a central concern in developing a new system.

23. Finding out how someone has died is a fundamental human right and an essential part of the bereavement process and in coming to terms with the death. All of the families who have sought our assistance have been motivated by a need to establish the truth for their own peace of mind, and to prevent others going through the same experience. Above all, they want an acknowledgement of fault or responsibility where appropriate, an apology where an apology is due, for justice to be seen to be done and for lessons to be learnt.

24. Maximising the possibility for families and friends to discover the truth is the guiding principle of INQUEST’s casework service. The family can have a real information deficit after a death in custody. They have a very steep learning curve to understand the various investigations that are initiated by such a death. Some professionals argue that the family should not be overloaded with information. But all families have told us how access to proper information and advice is crucial in ensuring that they are aware of their rights and it is the responsibility of the state to ensure that this happens at the earliest possible opportunity.

25. This should include information about access to the body, post-mortems, organ retention, rights regarding disclosure, the inquest process, and legal rights. These principles apply equally to deaths in other circumstances.

26. In our experience the nature of the circumstances of many of the deaths on which we work inherently attracts prejudice and strong feelings. The majority of families we work with do not experience the system as compassionate. Families feel overwhelmingly excluded, dissatisfied and let down by it as a process for establishing the facts. 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.

27. The limited ambit of investigations, ineffective inquiries and the failure to prosecute those responsible have all been issues for bereaved families. They have also increasingly become an issue in law both in the ECHR and in the domestic courts.

45 Also available to download from www.inquest.org.uk
LEGAL DEVELOPMENTS

28. The most significant recent development in coronial law has been the implementation of the Human Rights Act and the direct incorporation of Article 2 (the right to protect and safeguard life) into domestic law. Alongside this two significant House of Lords judgments (Amin\(^{47}\) and Middleton and Sacker\(^{48}\)) have impacted on procedure in coroners courts.

29. The obligation on the state to protect the right to life requires the state taking appropriate measures to protect life, to investigate deaths and ill treatment in custody thoroughly and to prosecute where there is sufficient evidence to justify proceedings.

AMIN

30. The decision of the House of Lords in the case of the SSHD ex-parte Amin (October 2003), established consistent minimum standards for the state’s duty to investigate deaths in custody.\(^{49}\)

31. The House of Lords ruled that whichever form the investigation takes there are minimum standards, which must be met as set out in Jordan v UK\(^{50}\). The Court concluded in Jordan that there were five essential requirements of the investigatory obligation: independence; effectiveness; promptness and reasonable expedition; public scrutiny and accessibility to the family of the deceased. The lack of an investigation which embodies the requisite qualities will and of itself constitute a violation of Article 2.

32. The Court ruled that such requirements apply with at least equal force to a “state neglect” or omission case (relevant to deaths in police custody) as to a state “lethal hands” case.

33. Many of INQUEST’s concerns about the inquest process were put forward for the family at the Amin hearing including: inconsistency of disclosure of evidence to the family despite the Home Office circular; inconsistency of funding; the narrow boundaries to the jury’s findings; coroners’ current restrictions upon system neglect. The Amin judgment recognized these concerns as legitimate.

34. There is now strong recognition of the need for more effective investigation than can be currently provided by inquests. The issues raised about individual and system neglect in the Amin judgment, although rare, are sadly not unique. Until reformed substantially there is strong judicial recognition for the need for more effective investigations than can be provided currently by inquests and provides an important incentive to accelerate the programme for inquest reform.

35. This legally significant case has been brought about because of the courageous struggle by the family of the deceased whose campaigning will contribute to the future protection of vulnerable prisoners. Lord Bingham recognised this as one of main purposes of the investigation and thereby humanely connected the needs of the bereaved with the duties of the state.\(^{51}\)

MIDDLETON AND SACKER

36. In the House of Lords cases of Middleton and Sacker (11 March 2004) their Lordships affirmed that Article 2 of the ECHR required there to be an effective official investigation into a death involving the state. Both cases concerned prisoners who had hanged themselves in prison in circumstances where prison officers and health care staff might have done more to prevent the death.

37. The critical function of a coroner’s inquest is to determine how a person came by their death. The word “how”, as used in inquest law, is contained in section 11(5)(b)(ii) of the 1988 CA and rule 36(1)(b) of the 1984 Coroners Rules.

38. Before Middleton, the case of Jamieson\(^{52}\) had held that “how” in the primary legislation should be interpreted as “by what means” and not in “what circumstances”

39. The effect of that judgment was threefold:

a. First, to narrow the circumstances in which state responsibility for failing to prevent a suicide could be reflected in the conclusion of a jury;

b. Second, it limited the scope of the inquiry to the means and not the circumstances by which the death had come about; and

c. Third, Jamieson required inquest juries to follow a highly restrictive concept of causation based on the requirement of a “clear and direct causal link” to the death as opposed to a requirement for them to be satisfied that an act or omission had acted as a “material contributory cause”—that is to say “a more than minimal cause” of a death—a test that we know operates in other areas of civil and criminal law every day of the week.

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\(^{47}\) R v. Secretary of State for the Home Department ex parte Amin [2003] UKHL 51


\(^{49}\) See “Amin: The Legal Significance”\(^{\text{a}}\). Paddy O’Connor QC, Inquest Law issue 6, January 2004

\(^{50}\) Jordan and ors v. UK (2001) 37 EHRR 52

\(^{51}\) O’Connor op cit

\(^{52}\) R v. North Humberside Coroner ex parte Jamieson [1995] QB 1
40. As a result of Middleton, the word ‘how’ is now to be interpreted as “by what means and in what circumstances”.

41. Inquest juries now have more opportunity to draw attention to any failings in the circumstances surrounding the death through the use of more narrative verdicts, or in answers to questions put to them on factual matters by the coroner.

42. This recent ruling signifies a major breakthrough for inquest law. The essence of these decisions is that they require an inquest to return verdicts which properly reflect:
   a. Whether a person takes their own life in part because the dangers of their doing so were not recognised by the prison authorities;
   b. Whether appropriate precautions could have been taken to prevent the death.

43. These two judgments have positively impacted on the inquest system and we hope that the spirit and actuality of the judgments will be reflected in the proposed reforms of the system. But they have also demonstrated how under-resourced and unfit the current system is to meet the requirements of the current law.

FUNDING

44. For families to participate effectively in the investigation and inquest process they need legal representation. Despite welcome reforms to the funding regime, INQUEST is still dealing with ongoing problems in obtaining public funding for legal representation for families and their operation is proving an additional stress for already distressed families who find themselves enmeshed in a legal system following a death in custody about which they have no choice. INQUEST Lawyers Group members are constantly engaged in huge amounts of work to obtain funding for legal representation with little uniformity of approach to decision making in the various Legal Services Commission (LSC) offices across England and Wales. Much work is still undertaken on behalf of bereaved people pro bono.

45. It has often been the lawyers instructed by the family who have pushed these boundaries to secure funding for some families. But this funding is sporadic and needs to be consistent. It still remains the case that unlimited public funding is available for experienced, good quality lawyers to represent the police, Prison Service and other bodies, while those representing families have to make lengthy and time-consuming representations to the Legal Services Commission for the little funding they receive. INQUEST is also concerned that the introduction of limited public funding has not been accompanied by a concurrent introduction of appropriate quality standards for those representing bereaved people. We have witnessed and heard of lawyers representing families sitting through weeks of inquest hearings and making little or no verbal intervention at all.

DELAY IN CUSTODY INQUESTS

46. Another illustration of how the system is failing is the serious delay from the death through to the investigation and subsequent inquest. Delays of one or two years are not uncommon—in part due to the length of time such investigations take, the lack of resources available to coroners and the fact that these are jury inquests and can last up to two weeks or longer. This is often made worse by the shortage of suitably qualified forensic pathologists and other experts. The delay clearly causes all concerned great difficulty but this is particularly so for bereaved people who have described how their lives have been put on hold until they have been through the inquest process. INQUEST’s evidence-based research on families’ experience of the inquest system has highlighted the detrimental effects that delays in finding out how a relative has died has placed on the physical and mental health of family members.53

47. As there is no public scrutiny of the death for such a long period, the opportunity for identifying what went wrong and to seek to prevent recurrences in the future, learning the lessons and preventing other deaths is seriously delayed.

CONCLUSION

48. In conclusion we consider the system is long overdue for reform and can provide further and more detailed evidence to illustrate INQUEST’s concerns if required.

Deborah Coles
Helen Shaw
Co-directors
INQUEST

February 2006

53 Chapter 5—How The Inquest System Fails Bereaved People (INQUEST 2003)
Evidence submitted by the Foundation for the Study of Infant Deaths

With regard to the DCA’s “Coroner Service Reform Briefing Note” of Feb 06, following are FSID’s comments:

FSID wholeheartedly supports the DCA’s aims on page 1 of the Briefing Note, we agree with the case for reform outlined in the paper, and in general we support the proposals outlined, in particular the need for coroners to have better medical advice and support to help them in their investigations. There are a few specific points we would like to raise.

1. Page 1, second column, first bullet point—states that coroners should have discretion not to hold an inquest. FSID has no objection in principle. We know that inquests can be terrifying and confusing for bereaved parents. FSID has argued for inquests to take place in private in the case of sudden unexpected infant death (see the Kennedy report), as an alternative to the painful intrusion into personal lives caused by public inquests with the press present. However, whether or not an inquest is held, and whether public or private, it is essential in the case of sudden unexpected and unexplained infant death that there is a comprehensive multi-disciplinary medical/forensic/social services investigation into the death, undertaken to a standard protocol based on that recommended in the Kennedy report, the results of which are submitted to and taken into account by coroners. FSID would like to emphasise that all sudden unexplained infant deaths must have a full multi-disciplinary investigation, whether or not the death seems suspicious to any of the professionals, eg police, coroner, paediatrician. FSID has published a paper, “Sudden unexpected death and covert homicide in infancy”, S Levene and C J Bacon, Arch. Dis. Child 2004;89:443-447, which demonstrates that factors of infant death often considered to be suspicious may have no basis in fact. We can provide a copy of the paper if desired.

2. Page 1, second column, last paragraph—refers to the rights of families to proceed quickly with funeral arrangements. We support this, but would like to point out that, as shown in the survey of parents’ views in the Kennedy report, parents also want the investigation of their baby’s death to be as thorough as possible in order to have the best chance of discovering why their baby died. Parents will be willing to accept a delay in arriving at the cause of death in the interest of getting a more accurate diagnosis, as long as this does not delay the funeral. A comprehensive investigation need not delay the funeral and burial/cremation.

3. Page 5, first column, fifth bullet point—points out that tissues cannot be retained after the coroner no longer needs them, as per the recent revision to the Coroners Rules. But FSID would like to take this opportunity to repeat what we stated in our submissions to Luce, and what was recommended in the Kennedy report, that these new rules run counter to the wishes and interests of parents whose babies have died from sudden unexpected and unexplained infant death. The majority of bereaved parents agree that tissues (but not whole organs) should be retained routinely and indefinitely for diagnostic purposes. The definition of cot death or sudden unexpected death in infancy includes that no cause or explanation is found at the time of death, but later developments, such as the death of another child in the family, or medical advances, may make it extremely valuable to re-examine retained tissues. The value of such retained material in the case of sudden infant death has been recognised by every investigation that has looked into it, including that of the RCPATH and the Retained Organs Commission. These views have, incomprehensibly, been ignored by those making decisions about the new Coroners Rules.

In conclusion FSID welcomes the major points in the Briefing Note, including the need for an improved service for bereaved families, national guidance for coroners including training, medical involvement, and audit. With regard to medical involvement, I would like to mention just one more point: we and the Kennedy report have recommended that, in addition to or as part of the involvement of the proposed Chief Medical Advisor, it is essential at the local level that a paediatrician visit the home when a death has taken place to take a complete medical history and view the scene of death to assess possible environmental factors, and that information from this home visit should be part of the multi-disciplinary investigation made available to the coronial investigation.

Attached (not printed) are three documents: FSID’s submission Oct 01 to the Home Office Review of Coroners’ System chaired by Tom Luce; FSID’s submission to the consultation paper published in August 02 by Tom Luce; and FSID’s response to the Shipman Inquiry discussion paper of Oct 02. These outline FSID’s views on the present system and our recommendations for reform. I would also draw your attention to Appendix 1 of “Sudden unexpected death in infancy”, report of a working group convened by RCPATH and RCPCH, chaired by Baroness Helena Kennedy, published in 2004—this is a chapter titled, “Parents’ perspective on the investigation of sudden unexpected death in infancy”, written by FSID.

Joyce Epstein
Director
Foundation for the Study of Infant Deaths

May 2006
Evidence submitted by the Society of Local Authority Chief Executives and Senior Managers (SOLACE)

ABOUT SOLACE

SOLACE (Society of Local Authority Chief Executives and Senior Managers) is the representative body for senior strategic managers working in the public sector. Through its policy and professional development activities, the Society promotes excellence in public service. Its commercial arm, SOLACE Enterprises, provides high quality, customer-focused and practical support to local government and the public and voluntary sectors, both in the UK and internationally. The SOLACE Foundation carries out educational and other work which falls within the charitable aspects of the Society’s objectives.

INTRODUCTION

1. The Society of Local Authorities Chief Executives and Senior Managers (“SOLACE”) represents the interest of Chief Executives and Senior Officers in England and Wales.

   Members of SOLACE have special interest in the quality of services delivered to the community.

2. The Local authorities have a role to play in the coroners’ system and death certification as they manage Register Offices of Births, Marriages and Deaths. Local authorities also appoint coroners and through a consortium of local authorities fund coronial districts.

PERCEIVED FAILINGS IN THE CURRENT SYSTEM

3. The proposed reform by the Government is welcomed by SOLACE. As every aspect of service delivery by local government has been modernised and continues to innovate in the way services are provided to the community, the coroner service lags behind.

4. SOLACE would endorse the Government’s view that the service provided for bereaved families and others must be improved.

5. The inquiry system has in many respects been ineffective and has led to numerous judicial challenges and public campaigns by families who feel let down by the system. Public confidence in the system is extremely low. The systems seem rather remote from the community.

6. The coroners’ system is arcane, unfriendly and not easily accessible to bereaved families. The system is shrouded in near secrecy in the absence of transparency and accountability.

7. Very few bereaved families know anything about the coroners’ system before they themselves have to use it. There is little information in the public domain about how the system works. Whilst local authorities do fund the coroner courts, they also have very limited information about the service to make available to the community.

8. There is no real partnership between local authorities and coroners. Neither do local authorities have genuine management responsibilities for coroners. We agree fundamentally with the LGA’s point that that as long as the ultimate power to ‘hire and fire’ remains with the Lord Chancellor then there is a serious accountability gap in the coroners’ service. Councils will pay the bills but have no control over performance and policy.

9. Bereaved families have often complained about the lack of information about the coroners’ service and effective support from the coroners’ service. Very often bereaved families feel remote from the system and find they become frustrated in the absence of transparency and clarity about what they can expect from the system.

10. Local authorities are equally frustrated about having to fund a service that is costly and which they have little control over in terms of the quality of service provided to the community.

Proposed Reform

11. A BETTER SERVICE FOR BEREAVED PEOPLE

   This proposal is welcomed by SOLACE.

   — The proposal to provide bereaved people with better opportunities to raise concerns is a positive step.

   Currently bereaved people do not have mechanism for raising concerns other than to take legal action. This is in contrast with local government services for example where the community can complain internally and if they remain dissatisfied they can complain to the Ombudsman.
— The proposal to give bereaved families clear legal standing in the coroner’s investigation and processes would be a radical move to show greater transparency in the system and make it more accessible. Bereaved families feel disengaged from the system and few feel that they have any legal rights at all to question how the system should work for them.

— The proposed coroners’ charter for bereaved people will demonstrate that the service is a modern one, which takes into consideration the needs of its users. This will also be in line with the significant progress made by local authorities to provide a high quality service to the public. For example, local authorities have Community Strategies, Business Plans, Local Strategic Partnerships and Local Area Agreements, all aimed at providing quality services to the community. In developing such a charter, like local authorities do, the public must be consulted.

— It is agreed that by setting out guidelines and standards to ensure an effective response in cases of sudden and unexpected deaths, this will help improve the relationship between bereaved families and coroners. Better understanding of the cause and circumstances of deaths may remove the suspicion and frustration felt by bereaved families.

— The proposed closer involvement of bereaved families by, for example, informing and consulting them about post-mortems and other aspects of investigations and their opportunities for involvement in the inquest will significantly improve public confidence in the coroners’ system.

— The proposed right to seek a review of coroners’ decisions will be an important improvement to the service and in line with the Human Rights Act.

— It is agreed that better information and support and bereavement services would enhance the quality of the coroners’ system further. At present many families have to research for such services independently when it should be readily available through the coroners’ service.

12. AVOIDING UNNECESSARY INQUESTS

— It is accepted that in certain cases where the causing of death is both obvious and very distressing, bereaved families should not routinely be put through an inquest. In such circumstances, the system should be sufficiently flexible to enable a coroner and the family to reach agreement that an inquest is not necessary. An example of such a case would be certain suicide where there is no doubt that the deceased had taken their own life. In these circumstances the proposal that the coroner will investigate and publish a report and avoid a public hearing is welcomed. It is essential that the bereaved family’s views are taken into consideration before making a final decision on the best approach to the situation.

— It is agreed that the duty to inquire into deaths that are over 50 years old should be removed.

13. NATIONAL LEADERSHIP, NATIONAL STANDARDS

The proposed Chief Coroner with a small team to run the coroners’ service will be an important step. Such a service will perform an important function in leading the service. Whilst local authorities have been concerned with over regulation of locally provided services, the proposed audits and inspections of coroners’ service is necessary to bring the service up to standard very quickly.

— The proposed monitoring arrangements, governance and setting up of an Advisory Coronial Council are welcomed.

14. FULL TIME CORONERS

SOLACE agrees that coroners should be appointed on a full-time basis. They should operate in line with national guidance and respond to the needs of bereaved families and also take into consideration cultural sensitivities in the community they serve.

Whilst it is proposed to engage one coroner for counties and two or more for metropolitan areas, SOLACE would urge the government to determine the numbers required following careful assessment of the workloads. If the service is to improve and become responsive it must be adequately resourced. At least there should be sufficient numbers of trained and experienced assistant coroners to support the full time coroners.

15. LOCAL AS WELL AS NATIONAL ACCOUNTABILITY

SOLACE is of the view that local authorities should either have full control over the coroners’ system operating in their area or the Government should set up an independent body for coroners. The existing hybrid arrangement between local authorities and the Government is unworkable and dilutes the governance and management arrangements.
The body responsible for appointing Chief Coroners and Assistant Coroners should also be responsible for appointing Coroner’s Officers. The three-way arrangement between local authorities, Government and the police is a recipe for disaster and that has been the main cause of the lack of progress in achieving a modern coroners’ service. Leadership and accountability for the service must rest with one body.

16. IMPROVED INVESTIGATIONS AND INQUESTS

SOLACE would welcome published criteria for deaths, which should be reported to, and investigated by, coroners. Bereaved families may find this useful when faced with sudden or uncertain deaths. Furthermore building in flexibility into the system rather than the current restrictions will be essential to a modern service.

— Bereavement is one of the most challenging experiences for people and being involved in the various stages of an investigation by a coroner is part of the healing process. People like to feel in control, involved and supported. By excluding bereaved families from the process they will find the service to be an uncaring and remote.

— The proposal to appoint judges or Counsel to particularly complex inquest is welcomed. Consideration should also be given to providing similar support to bereaved families through public funding of inquests.

17. CONCLUSIONS

a. SOLACE welcomes the proposed reform of the coroners’ systems.

b. The proposed reform should be expedited as such reform is long overdue and in the interim the public continues to receive a costly but sub-standard service in some cases.

c. Bereaved families should have greater involvement and a voice in the process.

d. Local authorities should have full control of the coroners’ system. Alternatively they should be fully integrated with the DCA’s judicial system or under an independent body.

e. A national Chief Coroners’ body should be set up to regulate and inspect the service.

f. The service should receive adequate funding.

g. Public funding should be made available for families who have to attend inquests, particularly in complex cases.

SOLACE
May 2006

Evidence submitted by State Coroner of Victoria and Victorian Institute of Forensic Medicine, Coronial Services Centre, Southbank, Victoria, Australia

ABBREVIATIONS
ABS Australian Bureau of Statistics
CCOPMM Consultative Council on Obstetric and Paediatric Mortality and Morbidity
CCRTF Consultative Committee on Road Traffic Fatalities
CLS Clinical Liaison Service
CSC Coronial Services Centre
NCIS National Coroners Information System
VIFM Victorian Institute of Forensic Medicine
WRDIU Work Related Death Investigation Unit

RECOMMENDATIONS

Based on the experiences of the State Coroner of Victoria and the Victorian Institute of Forensic Medicine in developing and operating an integrated approach to Death investigation in our State we offer the following suggestions:

1. New legislation should be developed that establishes a framework for more than just a future coroners’ jurisdiction. Such legislation should include the legal basis for a model of death investigation that integrates public health and safety as well as providing for the administration of justice.

2. A integrated and accessible National Coronial investigation data system would have the capacity to significantly assist many public and private agencies in a range of activities including policy development and research. Such information can contribute to a number of administrative and operational areas of public administration including death audit, occupational health and safety, health care evaluation, grief
and bereavement management, road safety and law enforcement management. In addition, expert systems software development can lead to early detection of trends in preventable deaths through automatic monitoring of all coroners’ death data.

3. A long term strategy for policy development in this area is needed. Reforming the coroners’ jurisdiction only contributes to part of the changes needed to maximise the benefits to the community of an effective and proactive death investigation process. Clearly it will take many years, probably a decade or more, for institutions to be established and specialist personnel recruited and trained so as to support coroners in the technical and procedural aspects of their work. The final goal and the pathway towards its implementation must be agreed.

4. The needs of families should be integrated within the administrative and operational aspects of coroners’ offices. This includes bereavement and associated support services as well as information services that have a strong medical focus on family health promotion and disease prevention.

5. Specialist training for all coroners and their staff in public health, risk management, therapeutic jurisprudence, investigation management and bereavement is necessary for the efficient operation of a coronial death investigation service.

EXECUTIVE SUMMARY

The Victorian Coronial Services centre houses two separate but inextricably linked organisations, the State Coroners’ Office of Victoria and the Victorian Institute of Forensic Medicine. The collaborative approach taken by these organisations has lead to mutual and whole of government benefits for the Victorian community particularly with respect to public health and safety and the administration of Justice.

STATE CORONERS’ OFFICE

The State Coroners’ Office in Victoria operates a State-wide coronial death investigation service that directly coordinates the work of all coroners, police, forensic pathologists, and other forensic death investigators. The Office provides a highly visible, public death investigation process that is recognised as being independent of government and private and public sector agencies. The work of the Victorian State Coroners’ Office is regularly referred to in the public media and in the publications of State agencies, academic institutions and government departments where the public health and safety role of the Coroner is acknowledged at the highest level.

The idea that the coroner might have a pivotal role in contributing to the prevention of death and injury in the local community is not new. It appears to go back almost as far in time as the beginnings of the jurisdiction itself. Whilst the coroner is not the sole agency working on any particular safety issue, the ability to provide an independent judicial overview of death investigations, to collect timely and detailed data on deaths investigate, to draw together the common threads of a series of deaths, to make recommendations and provide that information to government and the community, is unique and we believe it saves lives.

For such a system to be effective requires coroners to have particular expertise in investigation management, public health, occupational health and safety and risk management in additional to their judicial skills. The appointment of full time judicial officers in this role is essential if coroners are to be able to develop and maintain these skills for the benefit of the community.

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.

Most importantly modern coroners’ jurisdictions should be designed to ensure that the legacy of the deceased is both positive and lasting. Truly a modern coroners system should ensure that “the dead speak for the living”.

VICTORIAN INSTITUTE OF FORENSIC MEDICINE

The Victorian Institute of Forensic Medicine through its varied scientific, medical and legal work provides a centralised system for forensic medical and scientific service delivery within the State of Victoria as well as Nationally and Internationally.

The Institute has no operational or administrative links with the health care sector or the police service and operates as an independent statutory agency within the Department of Justice Law and Equity division. (It was previously located within the Courts division of the Department of Justice.) This position of independence is enhanced by the Institute’s governance structure with the Institute’s Director being directly responsible to a governing statutory Council currently chaired by the Chief Justice of the Supreme Court of Victoria, the state’s highest judicial officer.
The institute provides the judicial system in Victoria with its clinical forensic medicine service (police surgeons), its forensic pathology service and a small component of its forensic science service. The Institute contributes to injury and disease prevention as well as enhancing the delivery of health care services in the following ways:

— provision of information to government and public health and safety organisations resulting in policy changes and public awareness campaigns for the purposes of injury prevention;
— provision of legal advice on the implementation of government policy in the health care sector and justice system;
— provision of information to family members about familial health risks including the possibility of genetic risk factors for disease; and
— provision of tissue and organs for medical treatment and research in an ethical and publicly acceptable manner.

A centralised system of forensic medicine services is able to provide world renowned experts in the field of forensic science, clinical forensic medicine and forensic pathology to advise government on emerging death and injury issues and development of sustainable solutions.

The Institute contributes to undergraduate medicine and law courses in Victoria and elsewhere in Australia and as a centre of excellence is able to provide postgraduate educational facilities and courses internationally. The provision of state of the art facilities encourages recruitment to these specialist areas of medical practice that are often difficult to manage from a human resources and national manpower perspective.

Linkage of a government forensic medicine service agency with a university academic department provides an operational environment that can deliver cutting edge medical and legal research and implementation of new technology to assist in the determination of the nature and extent of existing and emerging injury and disease.

**INTRODUCTION**

*Coroner’s death investigation*

Systems for the investigation of deaths are found in most societies. They sit alongside and intersect importantly with criminal investigations and trials, civil actions for negligence, and disciplinary hearings into unprofessional conduct by persons such as doctors, nurses, pharmacists, and police. However, they are distinctive in a variety of ways.

Commonly, death investigation systems involve a combination of medical, legal and administrative structures. The differences among jurisdictions arise from a variety of interrelated factors including social, religious, political and legal influences, as well as the development of the medical profession and its specialities (especially the forensic).

The coroner has ancient origins, dating back arguably to the ninth century but on any view to the 1194 Council of Eyre. It has of course changed dramatically over the years, particularly during the 19th and 20th centuries. Crucial aspects of the coroner’s jurisdiction have been abolished and quasi-criminal functions of the jurisdiction of coroner have gone the way of outlawry, abjuring of the realm and deodands. Despite this there is a remarkable similarity between some features of the ancient and the modern process of inquest.

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. Indeed it could be said today that:

**Coroners are an institution in quest of a role and inquests anomalous trials notionally without adversaries.**

This is not to denigrate the public importance of a coroner’s inquiry into deaths that the community considers critical. The coroner has always been a figure of public interest and coroners’ inquisitions have functioned as narratives to clarify public anxieties and misapprehensions about the circumstances of deaths. Indeed getting the story right is an integral part of the enduring nature of publicly held inquests.

Another characteristic of the past 20 years has been the emergence of multiple sources of criticism of the institution of coroner and the performance of coroners. The critiques have been thoroughgoing. They have included the extent to which coroners have in fact spoken for the dead to protect the living, the calibre of coroners, their propensity on occasions to go beyond their legislative mandate, and their ability, even in principle, to advance recommendations for public health and safety that are capable of implementation. Concerns have been raised that coroners are handicapped in their investigations by their almost complete reliance upon both police and medical practitioners—in short, that they lack the capacity to undertake...
difficult inquiries when those who are the subject of suspicions are also the gatekeepers responsible for reporting reportable deaths. Allegations of insensitivity to families of deceased persons have been levied and assertions made that findings as to causes and circumstances of death have lacked legal rigour and factual accuracy. Questions have also been asked about whether those who are the subject of coroners’ riders or recommendations should at least account for why they propose not to comply with them.

What does our community today need with respect to Coroners? Our society is more complex than the medieval landscape in which coroners commenced their work and our community is far more demanding with respect to information and assertion of human rights. The inherent robustness of coroners’ investigations demonstrated by the survival of the jurisdiction over the last millennium speaks well for its ability to adapt to meet changing community expectations. The public nature of its inquests, the respect in which it is held, and its function to inquire in a rigorous way into circumstances and causes of death that have aroused public concern are its strengths. Unfortunately public understanding of the true potential role of the coroner is low. What is needed now is a readjustment of the jurisdiction’s underpinning legislation so that its public health and prophylactic role are overtly recognised. In addition, there is a need for a brave step into the unknown so that it can effectively address its deficits, particularly its previous inability to proceed in an adequately resourced and integrated way.

Despite the antiquity of coroners and their courts, the question for the 21st century is whether they meet our contemporary needs, and if not, whether they can be moulded and refashioned so that they do.

The Coroners role in public health and safety

The background of the coroner was in significant part that of a revenue raiser and functionary of the Crown. Today most coroners have lost their financial responsibilities and cannot compensate victims of the deceased. Few have the power to commit for criminal trial. Their inquests are but a shadow of what they once were. However, inquests held by coroners are evolving. They generate remarkable interest on the part of the media and in some jurisdictions are an increasingly substantial area of legal practice—at first instance and increasingly on appeal.

Creative suggestions for changed safety practice have been an aspect of coroners’ verdicts from at least the thirteenth century, but in reality, they have been but a modest element of the coronial role until recently, often in the form of brief proposals advanced by coroners’ juries, encouraged by some coroners but discouraged by others. In addition, the quality of such recommendations has varied significantly. Some have been gratuous expressions of sympathy or revulsion. Others have proposed changes in the context of a particular death but with little potential to be extrapolated more generally. There are as yet no reliable data on the extent to which coroners’ recommendations have been implemented or have even been capable of implementation although this is now the subject of empirical research in Australia.

The public stand taken by a few early coroners in advocating practices leading to improvements in public health and safety is well documented. Some coronors in fourteenth-century England, for instance, ordered that wells be filled to prevent further drownings.55 Coronors’ recommendations, reflecting a broad perspective and a pragmatic bent towards reducing the incidence and causes of injury and death, may be seen, too. In 1821 a coroner’s jury in Middlesex gave the following account of a man found suffocated:

. . . in a certain pond by certain gas water which is thrown into the said pond by persons employed by a certain gas company to the jurors unknown. That the throwing of the said gas water appears to the said jurors to be a serious evil; and the said jurors recommend to the parish aforesaid to take proper measures to remedy the said evil.56

To similar effect an Auckland coroner’s jury on 15 June 1863 in relation to the death of Thomas Johnson, who had been found dead 23 feet below a cliff: called

. . . the attention of the Authorities . . . to the dangerous condition of the cliff along the south shore, which might be greatly obviated by the erection of a suitable fence on the summit.57

Another Auckland jury on 27 August 1861 drew attention
to the danger accruing to careless, and drunk, persons, from want of a guard chain at the sides of the Queen Street Wharf, and that in cases of accident the life buoy be accessible at all times.58

What is less clear is whether this public safety responsibility was generally accepted and acted on by coroners and government, or whether prophylactic recommendations until recent times have simply been the actions of a few enlightened coroners and juries who found themselves with the opportunity to do something constructive for the living.

57 L Gluckman, Touching on Deaths: A Medical History of Early Auckland Based on the First 384 Inquests, Doppelganger, Auckland, 2000, p 268
58 Ibid, pp 281–82
Indeed, the rider component of inquest verdicts, abolished in England and Wales since 1980, was always a very subsidiary aspect of the inquisition, the subject of little treatment in coroners’ manuals, and rarely given much exposure until recent times. Now it is only once in approximately 50 inquests in England and Wales that any form of a recommendation is made.69

What, then, is the source of the public health and occupational health and safety orientation of coroners’ role in the modern era? Coroners’ inquests in England were investigated by a Parliamentary Select Committee in 1860. This occurred in the context of tensions between coroners and magistrates on the one hand and between coroners and police forces on the other.60 The public health responsibility of the coroner was explicitly recognised by the Committee, which accepted the view of the coroners and sanitarians that inquests should be held in all cases of sudden or accidental death “for denunciation of the guilty, for the comfort of the innocent, and for the information of the public, who should be taught the nature and extent of the dangers that surround them”.61

By 2003, the way to the future was exemplified by the recommendation of Dame Janet Smith that 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 that give rise to issues relating to public safety, public health, and the prevention of avoidable death and injury; and
— to provide public scrutiny of those deaths that occur in circumstances in which there exists the possibility of an abuse of power.62

The World Health Organisation has maintained that the important factor in preventing death is being able to break the lethal chain of events and begin treatment. From the standpoint of public health, the most effective form of intervention is elimination of the prime causes of risks. This has been a fundamental orientation of modern coroners’ practice, particularly in Canada and Australia.63 However, with the increased focus upon prophylaxis comes a series of challenges for the office of coroner.

How should the public health and safety aspect of the coroner’s role be balanced with the administrative and judicial role centred upon determining the cause of the death. It could perhaps be said that if identification of a deceased person and determination of the cause of death were the sole functions of a coroner then death investigation would perhaps be better performed by Medical Examiner. It is the capacity of coroners to integrate a wide range of medical and non-medical specialist investigators in an independent judicial forum that provides the coroners office with the capacity to conduct thorough investigations that can lead to the development of recommendations for the prevention of death and injury.

Perhaps the major challenge to the role of coroners in death and injury prevention lies in the fact that technically it is still the case that coroners’ recommendations can be utterly ignored and rejected by those to whom they are directed. The Alberta practice whereby such recommendations are collated in the annual report of the Attorney-General, together with any implementation of the recommendations, is a constructive compromise. Another would be institution of an obligation on the part of the Chief Coroner to place before parliament each year a comprehensive report in relation to the work of her or his coroners.

As described above, the potency of coroners arises from several factors, of which the following four are perhaps the most important with respect to death and injury prevention:

— the inclusion of technical specialists as agents for the coroner in investigations;
— the fact that they emanate from public hearings in which evidence is tested;
— the stature within the community of individual coroners;
— the persuasiveness of particular recommendations; and
— the coverage given by the media to their recommendations and findings.

The highly specialised and technical nature of many human activities including industrial processes and therapeutic treatment events require highly specialised investigation of adverse incidents. Where such specialist investigations are carried out solely within the industry or speciality involved, or by a regulatory agency associated with that area of activity this can lead to a narrow approach to investigation that may omit broader issues that may have considerable importance for incident prevention. The external and independent nature of a coronial investigation that has access to specialist advice and investigative services and integrates the family and their legal representatives into the process of investigation provides a more effective framework for identifying the key issues surrounding the death.

61 Registrar-General, Nineteenth Annual Report, 1857–58, XXIII, pp 1, 198
For example, in one series of inquests into a number of hanging deaths in custody in a newly established privately operated Victorian prison, it was submitted that had:

“... previous coronial recommendations and findings been implemented (A I’s) life may have been saved. A process for the reporting on implementation of coronial recommendations must be developed and may require a legislative framework.” 64

This inquest series and the recommendations resulted in significant redesign of prison cells to reduce hanging points with the development of the “Building Design Review Project” by the Victorian Office of Corrections.

In another inquest on a death following mistaken administration by a nurse of concentrated potassium chloride (instead of using sodium chloride by way of a line flushing procedure) the family told the Coroner that:

“... We’ve got to live with this through the human error which looking back on your recommendations of 95 I think it was, which had they been carried they could well—this incident could very well been prevented.”

And:

“... the girl who I feel sorry for, the nurse, she should never have been put in that situation where she could make that error.” 65

The mistaken administration of potassium chloride instead of the flushing agent sodium chloride caused the death and this error resulted from the fact that the substance is clear and the clear plastic ampoules are nearly identical (apart from the writing on the outside of the ampoule) with no easily identifiable warning label to identify the ampoule containing the potassium chloride.

Diseases associated with domestic and industrial asbestos exposure are another example of the coroner developing a proactive approach to public health issues that raise major family concerns.

The repetitive nature of incidents involving avoidable causes of death poses particular challenges for coroners. In making recommendations how does the coroner ensure that the recommendations are safe, prudent and practical? Having made recommendations what is, or should be, the role of the coroner or others with respect to ensuring that recommendations are implemented? A commitment is needed from governments to provide adequate resources for coroners’ offices, to appoint appropriately qualified and experienced investigators, and to construct systems by which coroners’ recommendations are seriously analysed with a view to planned and managed implementation.

A truly effective death investigation system should at the least be able to monitor the implementation of coroners’ recommendations. It should play an ongoing role as a catalyst for changes designed both to protect the public from avoidable harm and to maximise community well-being. However, this requires liberation of the institution of the coroner from some of the traditional constraints of the judicial model, and a re-evaluation of the administrative roles that linger from centuries gone by.

Current medico-legal systems for injury and death prevention in Victoria

Coroners Systems

The enactment of the 1985 Coroners Act in Victoria represented a turning point for the jurisdiction in Australia. It was the first modern amendment to Australian coronial legislation and it changed the way death investigation was undertaken in the State at a fundamental level. Not only did the legislation change the way in which the coroners’ death investigation process was carried out at a judicial level but the legislation established an institution for forensic pathology that removed the majority of the provision of coronial autopsies away from the healthcare sector. Importantly the legislation provide for the appointment of a Chief coroner or State coroner who had the following functions:

The functions of the State Coroner are as follows:

(a) to ensure that a State coronial system is administered and operated efficiently;
(b) to oversee and co-ordinate coronial services;
(c) to ensure that all reportable deaths reported to a coroner are investigated;
(d) to ensure that an inquest is held whenever it is desirable to do so;
(e) to issue guidelines to coroners to help them carry out their duties; and
(f) such other functions as are conferred or imposed on the State Coroner under this Act66.
The role of the State Coroner includes responsibilities that go beyond their judicial duties and includes administrative and managerial aspects of the statewide coroner's service. By implication at least this provides the State Coroner with significant powers to ensure that the functions of office of coroner are effectively performed throughout the State and allows for a level of audit and review of service provision.

With respect to injury and death prevention the main roles of the coroner are found in sections 19 and 21 of the act with section 19(2) and section 21(2) dealing with the matter of the coroner identifying and reporting on matters “connected with the death” that have implications for public health or safety. The phrase “connected with the death” is of considerable importance as it limits the scope of comments or recommendations to matters that are directly associated with the death and prevents the coroner for making far-reaching broader comments that might be inappropriate coming from a judicial officer.

19. Findings and Comments of Coroner
(1) A coroner investigating a death must find if possible—
   (a) the identity of the deceased; and
   (b) how death occurred; and
   (c) the cause of death; and
   (d) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act 1996.

(2) A coroner may comment on any matter connected with the death including public health or safety or the administration of justice.

(3) A coroner must not include in a finding or comment any statement that a person is or may be guilty of an offence.

(4) If a coroner has determined under section 17(3) not to conduct or complete an inquest, the coroner is only required to make a finding relating to any of the matters referred to in paragraphs (a) to (e) of sub-section (1) if the coroner believes it is desirable.

21. Reports
(1) A coroner may report to the Attorney-General on a death which the coroner investigated.

(2) A coroner may make recommendations to any Minister or public statutory authority on any matter connected with a death which the coroner investigated, including public health or safety or the administration of justice.

(3) A coroner must report to the Director of Public Prosecutions if the coroner believes that an indictable offence has been committed in connection with a death which the coroner investigated.

In order to carry out these functions the State Coroner’s office in Victoria employs five full-time coroners, up to 20 clerks of court and administrative officers and has a police unit of nine officers from the police prosecutions division attached to the court as the State Coroner’s Assistants Office. Other coroners’ staff includes counselling and bereavement support staff as well as contracted research officers.

The processes involved in investigating a death at the State coroner's office in Victoria are set out in the flow chart overleaf.
This flow chart outlines the major steps taken by the State coroner’s office in Victoria following the reporting of a death. The name in brackets in each of the boxes refers to the individuals or agency concerned with completing that task. As can be seen in Victoria the Victorian Institute of Forensic Medicine and Victoria police whose staff the State coroner’s assistance office have a major role to play in case management and investigation. Other significant individuals and agencies include the “next of kin” (NOK), general duties police, general medical practitioners and hospital staff.

They chart indicates the major office processes and decisions taken with respect to a death investigation however, it does not cover all the activities that arise out of the death investigation process. In box 10.3.1 the heading “further investigation” covers a very wide range of activities on the part of police, scientific and technical experts and government agencies. Whilst there are always opportunities to improve our service, importantly, there are a number of points of communication with families which occurred in addition to the tasks identified in the chart. Communication with families occurs at a number of times during the death investigation. Communication occurs in relation to visual identification of a deceased person by a family member or friend of the deceased. Formal communication advising the “next of kin” (NOK) that they have the power to object to autopsy pursuant to section 29 or to request an autopsy pursuant to section 28 of the coroner’s act in Victoria (1985). Communication between the family and police investigators, including the staff of the coroner’s assistance office, occurs throughout the investigation. Finally there is communication between the “next of kin” (NOK) court clerks and administration staff regarding the progression of the case and advice regarding the decisions taken by the coroner and the eventual coronial findings made.

Other family communication occurs between these staff of the donor tissue bank of Victoria and families regarding the retention of tissue an autopsy for transplantation, teaching or research. A specialised counselling service is also available at the State coroner’s office to help support families at a time of potentially great grief. It is not uncommon for counselling staff to arrange family appointments with pathologists, police or court staff in order to provide further information or feedback regarding the death. In the case of deaths when natural diseases identified that may have implications for other family members a formal process of communication with the family and/or they’re treating medical practitioner is undertaken.

The time taken to complete the process listed above will vary considerably depending on the nature of the death and the range and extent of investigatory activities that are required. The coroner has a responsibility to ensure that all interested parties are involved in the process leading up to finding including any inquest and where multiple interested parties are involved the timescale may become prolonged. Whilst the majority of coroner’s death investigations will be completed and a finding made within a few months cases involving complex inquests with major interest issues may take several years.

Victorian Institute of Forensic Medicine Systems

The Victorian Institute of Forensic Medicine (VIFM), formerly the Victorian Institute of Forensic Pathology is a Statutory Agency created in 1985 as by Section 64(2) of the Coroners Act (1985) (Vic). It is a body corporate with perpetual succession and is operated under the Justice portfolio of the Victorian government. In addition the VIFM is the Monash University Department of Forensic Medicine and is also affiliated with Melbourne University. The establishment of the dual institutions of the State Coroners Office and the Victorian Institute of Forensic Medicine within the same building known as the Coronial Services Centre (CSC) was an Australian first, and is the envy of other institutions of forensic medicine. This initiative in the 1980’s is an example of a coordinated approach to death investigation between forensic medicine and law that has many of the advantages of a Medical Examiners system whilst retaining the benefits of a judicial Coroners system.

According to the Act the objectives of the institute are to:

- provide, promote, and assist in the provision of forensic pathology and related services in Victoria and, as far as practicable, oversee and co-ordinate those services in Victoria;
- promote, provide and assist in the postgraduate instruction and training of trainee specialist pathologists in the field of forensic pathology in Victoria;
- provide training facilities for doctors, medical undergraduates and such other persons as may be considered appropriate by Council to assist in the proper functioning of the Institute; and
- conduct research in the fields of forensic pathology, forensic science, clinical forensic medicine and associated fields as approved by Council.

Since it was established VIFM has developed in line with the changing demands placed upon it and has planned strategically at a detailed business level to meet future demands. The core forensic service of undertaking medical death investigations following the referral of a case to a coroner is only one of a number of professional services provided by the Institute. Expertise and information are supplied to a range of stakeholders both within Government and other organisations. These services include:

- clinical forensic medical examinations;
- scientific services, including human identification, drug testing and DNA testing;
- conducting public health research;
- providing expert opinions;
— operating the Donor Tissue Bank of Victoria; and
— contributing to various Federal, state and public reviews and inquiries.

As a statutory authority with a formal statutory requirement to provide teaching and research services, VIFM also undertakes a range of teaching and training activities at both an undergraduate and postgraduate level for medicine, science and law students. In addition the Institute provides a range of courses and programs for other individuals and organisations including emergency service providers and the general public.

In recent years International training in forensic medicine and Disaster Victim Identification has taken a particular prominence with many overseas training Fellow attending at the Institute for training and courses being delivered in many countries in the local Indio-pacific region.

For death and injury prevention to be effective five processes are essential. These are:
— Thorough case investigation.
— Related case data analysis.
— Targeted topic based research.
— Communication of results.
— Implementation of Change.

The Victorian Institute of Forensic medicine contributes to all these five areas of death and injury prevention activity both with respect to the routine death investigations performed for the coroner and with the establishment of specialist research units within the Institute. Much of the work of the institute in this area can be found in the annual reports generated for Parliament and in the Institute’s contributions to the international medical and scientific literature.

From an operational perspective the institute is divided into four main service areas being: forensic medical services, forensic scientific services, corporate services and the Donor Tissue Bank of Victoria. All of these major service areas contribute to research and development and take part in the broader aspects of death and injury prevention.

The Donor Tissue Bank of Victoria provides a framework for the ethical retrieval of cadaveric organs and tissues for therapeutic transplantation, research and teaching. As a result of the operational framework of the tissue bank the Institute and the State Coroners’ Office in Victoria has been relatively immune to the highly negative publicity that has surrounded tissue and organ retention at autopsy that has been experienced in other jurisdictions.

Within these The Institute’s service areas are a number of specialist groups and units that have contributed specifically to death and injury prevention. These include:
— the clinical liaison service;
— the work-related death investigation unit;
— the consultative committee on road traffic fatalities;
— the National coroner’s information system;
— the multiple child death investigation service;
— the sudden infant death scene investigation team; and
— the sudden unexpected death in epilepsy investigation team.

These units operate collaboratively with the State Coroners’ Office, the Victoria police and other statutory agencies, government departments and organisations.

The Institute publishes a wide range of newsletters, reviews and monographs, many in conjunction with the State Coroner that have the function of communicating to the wider community key issues relating to public health and safety.

There is a strong linkage between scientific and justice services at the Coronial Services Centre which is perhaps illustrated best in the following slide.

National Systems

National Coroners Information System

The development in Australia of the National Coroners Information System by the Victorian Institute of Forensic Medicine is perhaps the world’s first comprehensive national database of coronial information. It contains data including all demographic information on each death reported to coroner throughout Australia and includes coronial findings and verdicts, specialist medical and toxicology reports, and other details regarding the results of specialist investigations. Operating through the medium of secure Internet database access the system has attracted international interest (from New Zealand, England and Canada).

The Database contains the result of over 100,000 coroners death investigations. There are over 40 authorised organisations which have access to the system (equating to approximately 120 third party users), with around 250 death investigation users also registered to access the data (coroners, forensic scientists, pathologists, coroners police, researchers).

At the launch of the National Coroners Information System the Honourable Rob Hulls Attorney General of Victoria stated:

“The NCIS represents a world first in providing an Internet accessible database of coronial information across Australia. Coronial data is a rich source of information about the causes of preventable deaths in this country. (The NCIS) will provide a means of accessing data in a timely way and will increase the potential for coronial information to contribute to a reduction in preventable death and injury in Australia and in doing so, it will reduce both the emotional and financial burden of lost life in our community. The NCIS will revolutionise the way we investigate and respond to preventable deaths in Australia”.

VICTORIAN INSTITUTE OF FORENSIC MEDICINE
David Ranson - Deputy Director
The need for a National Coroners Information System

The coroners in Australia agree that the most compelling justification for the existence of the coronial jurisdiction is its ability to contribute to the prevention of injury and death. This is achieved by identification of fatal hazards and risk factors combined with the making of recommendations to reduce the risk of injury and death. In this way, coroners' findings assist in developing public policy in areas such as product safety, health, transport, and workplace safety. They can also assist in the investigation of criminal offences.

The National Coroners Information System enables the rapid identification of up to date information on deaths investigated by all coroners’ jurisdictions in Australia.

The benefits of the National Coroners Information System

The National Coroners Information System:

— makes inquests more efficient and effective by enabling coroners in each jurisdiction to quickly access up-to-date information about similar cases to those being investigated;
— assists in the early identification of systemic or wide ranging risk factors;
— informs policy makers both in government and non-government sectors about factors which contribute to preventable death and injury; and
— enables researchers to access and analyse comprehensive national data.

Background

The idea for a national database for coronial information has been considered in Australia for over 10 years. Australia’s eight separate coronial jurisdictions each have their own systems of data collection and storage. Prior to the establishment of the database in some Australian jurisdictions, coronial records had been based on a manual filing system without indexes which could have identified clusters of similar cases.

In 1994 the Australian Coroners’ Society commissioned the National Injury Surveillance Unit of the Australian Institute of Health and Welfare to undertake a feasibility study on a national database for coronial information. This study was funded by the Australian Commonwealth Department of Health and Aged Care. The feasibility study recommended the establishment of a national database of coronial information. The recommendations of the study were taken up by the Australian Coroners’ Society.

In September 1997 the Australian Coroners’ Society endorsed a business plan for development and management of the National Coroners Information System put forward by a Monash University consortium called the Monash University National Centre for Coronial Information. The consortium was made up of the Victorian Institute of Forensic Medicine (a statutory agency of the Victorian Department of Justice and which is also the Department of Forensic Medicine at Monash University), Monash University’s Department of Epidemiology and Preventive Medicine, and the Monash University Accident Research Centre.

In 2004 operation and management of the database was transferred from Monash University to the Department of Justice in Victoria with the database being operated by the Victorian Institute of Forensic Medicine. The governance structure now, comprises a three tiered structure. The three levels of governance are:

— the NCIS Committee (comprised of Victorian Institute of Forensic Medicine representatives, an injury prevention representative, and two State coroner representatives);
— the Victorian Institute of Forensic Medicine Council; and
— the NCIS Board of Management (comprised of a representative of each of the funding agencies and chaired by a State Department of Justice chief executive officer).

The current line of responsibility line can now be traced back directly to the Standing Committee of Attorney Generals of Australia.

What the database provides

The source of data for the National Coroners Information System is Coroners’ files67.

The database contains both coded and non-coded data. There is a facility to search variables and full text data using particular words or expressions.

The NCIS core data include:

— case demographics (name, age, sex, marital status, indigenous status, place of birth);
— cause of death details (pathological);
— incident circumstances (time, location, activity);

67 Transcripts of inquests are not included on the database
— key textual information:
  — police reports;
  — autopsy reports;
  — toxicology reports;
  — coronial findings;
  — investigation information (specialist investigations eg engineering reports); and
  — data entry information (who entered the data).

The database is maintained at a central location at the VIFM. However, data entry is mainly undertaken locally by coronial jurisdictions. The staffing of the National Coroners Information System comprises six staff including the general manager, the quality manager, a coronial liaison officer, and an administration assistant as well as a database manager and programmer.

**Specialist modules**

Modules for drug-related deaths and suicide are already being developed with the help of targeted funding from key government agencies. Other specialist modules include work-related deaths, drownings, firearm-related deaths and road traffic deaths.

**Technical development**

A pilot project commenced in the Australian Capital Territory on 1 July 1998. The Australian Capital Territory coronial office began entering core data items directly into the National Coroners Information System via the internet. An evaluation of the pilot database was undertaken in February 1999. The report found that the NCIS was feasible as a remote data entry and retrieval system. On 1 December 1998 New South Wales was brought on-line. On 1 February 1999 Victoria was brought on-line.

In response to the needs of other jurisdictions, the National Coroners Information System developed a computerised case management tool designed to meet the needs of local coroners' offices for data entry. A number of coroner’s offices in different jurisdictions have installed this case management system. This computerised case management system obviates the need to enter data directly via the internet.

**Access**

National Coroners Information System data is held centrally but is not accessible by unauthorised users. The data is only accessible to the coronial staff of the jurisdiction to which the data relates, the staff at the National Coroners Information System and persons with specific research ethics committee approval for a particular class of access to which coroners have agreed.

**Support and funding**

Current funding and direct operational support for the project has been provided by all Attorneys-Generals and state and commonwealth ministers responsible for health, industrial and workplace relations, police, transport and consumer affairs.

**Data access**

Access to the data stored on the NCIS is available to all contributing State and Territory coroners and their authorised staff without charge.

Legitimate researchers can be granted access to particular areas of the database following a review of their research proposal by a scientific committee and ethical clearance by a properly constituted ethics committee. Access to the contents of the database however still remains at the discretion of the relevant coroners in order that they can carry out their statutory functions.

**Recent uses of the NCIS**

A number of recent injury/death prevention initiatives in Australia have either originated from, or been supported by, data sourced from the National Coroners Information System. These initiatives include:
Launch of a national safety campaign

A national safety campaign concerning working under vehicles was launched on 18 February this year by the Federal Minister for Ageing, Julie Bishop. This joint campaign by the Australian Department of Health and Ageing and the ACCC was prompted by new figures from the National Coroners Information System which showed that 19 home mechanics died in Australia over the past four years as a result of incidents associated with the incorrect use of jacks. As part of this campaign, a safety alert brochure has been produced and can be downloaded from the ACCC website.

TAFE course for farmers in all terrain vehicle safety

In July 2004, an accredited TAFE training program was developed in Tasmania for farmers, who can now enrol in the three tiered program to increase awareness and safety concerning ATV use. To be provided by Stay Upright, the Tasmanian course received approval for development in part due to figures from the NCIS which showed 57 ATV related deaths had occurred in Australia since July 2000.

Increased awareness of dangers associated with blind/curtain cords

In July 2003, a request was made to the Research Centre for Injury Surveillance, Flinders University by the Commonwealth Health Department, to supply information regarding deaths of infants and young children due to strangulation by blind or curtain cords. They were able to use the National Coroners Information System to identify a number of these fatalities which occurred since the National Coroners Information System data collection began in July 2000. The number of the cases they found prompted them to lodge an “Issue of Concern” to the National Coroners Information System, which was subsequently passed along to all State and Chief Coroners around Australia. A brochure concerning Blind and Curtain Cord Safety was also produced by the Commonwealth Consumer Safety Unit within Treasury and the Department of Health and Ageing around this time.

In May 2004, the Blind Makers Association of Australia contacted the National Coroners Information System and requested de-identified case information concerning the nature of these fatalities, to present to their members at the Annual Conference. This material was used to demonstrate to manufacturers, the necessity of new regulations concerning the blind manufacture.

The NCIS has contributed to death and injury prevention in the following ways:

— providing data for coronial investigations;
— issue monitoring;
— data source for injury research reports;
— improving government awareness;
— increased publicity about dangers; and
— changes in product manufacture.

Over 40 third party organisations or government agencies have successfully applied to access the NCIS, and are using the data to assist in research activities as varied as:

— national diving related fatalities;
— monitoring of child deaths in NSW;
— monitoring of product safety nationally;
— trauma related fatalities in ACT and NSW; and
— drug associated deaths in Victoria.

A number of these agencies have used the information from the NCIS to assist in the production of research reports. Some of the more recent reports which have used NCIS data include:

Issues of Concern

In some instances, it may become clear to third party users that there is a significant issue of public health and safety (IOCPSH), which must be brought to the attention of relevant authorities. Current legislation permits a coroner to make recommendations to the Attorney-General on any matter connected with a death, or series of deaths, that is in the interest of public health and safety. Accordingly, it is essential that State and Chief Coroners are informed of any IOCPSH identified by third party users of the NCIS. The Victorian Institute of Forensic Medicine (VIFM) through the NCIS team are the contact point between agencies that become aware of an IOCPSH and the State/Chief Coroners, who are able to take appropriate action. For the purposes of the IOCPSH Reporting Guidelines for NCIS users, the following definition of an Issue of Concern is broadly relied upon:

“Any identified risk factor that has the potential to cause death or injury, regardless of whether there is pre-existing knowledge of such factors, that requires further investigation or action to prevent future death or injury”

Issues of concern (both formal and informal) have included:
- child deaths due to strangulation by a blind or curtain cord;
- deaths involving augers (mechanical digging equipment);
- car jack deaths;
- all Terrain Vehicle deaths, and
- motorised mobility scooters for the aged.

In the majority of cases, coroners have subsequently notified their Attorney-General’s Department; manufacturers or relevant safety agencies about the issue for their consideration.

Ad hoc information requests

The NCIS has also been used to provide de-identified statistical information to a range of agencies and organisations. A sample of these is outlined below:
- NSW Police: The number of intentional self harm deaths that involved alcohol to assist in preparing police response to the 2003 Parliamentary Summit on Alcohol Abuse;
- Wyndham City Council: The number of drug related deaths in the Wyndham region and Melbourne Metropolitan Local Government Areas to assist the council in policy planning in this area;
- Canberra Hospital: The number of deaths involving the effect of a poison, poisonous substance or medicament to assist the Clinical Pharmacology and Toxicology Department of the Canberra Hospital;
- The Canberra Times: The number of national sporting related deaths;
- The Herald-Sun: The number of deaths associated with solvent abuse;
- Of Substance magazine: The number of deaths due to house fires caused by cigarettes;
- Australian Nursing Federation: The number of deaths of residents in aged care facilities caused by maladministration of medication to assist in a submission for legislative change concerning the administration of medication in Aged Care Facilities.

Conclusion

Since the establishment of the database there has been very considerable interest in its operations from a number of jurisdictions around the world. There appears to be a recognised need for such data and given the international dimension of community and environmental hazards we may expect to see data linkage is being developed between a number of national coronial databases in the future. With the responsibility of the coroner for the identification of deceased persons and the current tensions in relation to disasters involving mass loss of life such databases may also prove of considerable value in managing community problems such as missing persons and disaster victim identification.

Contributions to injury prevention

According to the World Health Organisation, an injury is defined as:

“the physical damage that results when a human body is suddenly or briefly subjected to intolerable levels of energy. It can be a bodily lesion resulting from acute exposure to energy in amounts that exceed the threshold of physiological tolerance, or it can be an impairment of
function resulting from a lack of one or more vital elements (i.e., air, water, warmth), as in drowning, strangulation or freezing. The time between exposure to the energy and the appearance of an injury is short. The energy causing an injury may be:

- mechanical (e.g., an impact with a moving or stationary object, such as a surface, knife or vehicle);
- radiant (e.g., a blinding light or a shock wave from an explosion);
- thermal (e.g., air or water that is too hot or too cold);
- electrical; or
- chemical (e.g., a poison or an intoxicating or mind-altering substance such as alcohol or a drug).  

Fatal Injury

Complex physical trauma

The State Coroners’ Office in Victoria has contributed to the understanding of the causation of a wide variety of potentially preventable deaths.

It is almost impossible to give examples of all the situations in which coroners’ recommendations have lead directly to legislative and policy changes however, formal action regarding coroners’ recommendations have occurred following coroners’ findings in cases involving:

- Forklift related deaths.
- Pedestrian safety in the workplace.
- Wire-rope barriers on major roadways.
- Tractor roll-overs.
- Drowning of children in domestic swimming pools and agricultural dams.
- Drowning of children in public swimming pools.
- Accidental child hangings from blind and curtain cords.
- Design issues in prams and cots.
- Electronic stability control system in motor vehicles.
- The use of personal floatation devices in recreational boating.
- Smoke and thermal detection systems in hostels and care facilities.
- Prison cell design (reduction in hanging points).
- Use of restraint systems in health care.
- Electrical appliance safety and design.
- Installation of residual current detection safety devices in homes.
- Occupational safety systems and procedures for wild fire management.
- Safe design of fire appliances.
- Safety in motor sport (including Formula 1), recreational fishing and parachuting.
- Police use of fatal force.
- Police pursuit management.
- Garbage disposal truck hazards.

Work Related Death Investigation Unit

The work related death investigation unit was established in 2005 at the Coronial Services Centre. The unit was funded by the Attorney General and is operated for the State Coroner by the Victorian Institute of Forensic Medicine. The Unit reviews all deaths occurring in the workplace and provides initial prevention information to the investigating Coroner and indirectly to WorkSafe Victoria the government agency charged with industrial safety regulation. The unit also provides detailed research and case review of industrial deaths including safety system reviews and reviews of workplace safety policy and procedure documents. The unit employs research and investigative staff and is supported by a number of experts in occupational health and safety.

69 The outcome of a coroners investigation in Victoria is a narrative finding containing the information required in s 19 of the Coroners Act 1985 (Vic). Formal verdicts are NOT used
Forensic Toxicology

Forensic Toxicology consists of the scientific application of the detection of drugs and poisons in biological systems for medico-legal purposes. This includes the analysis of blood and other specimens for alcohol, drugs of abuse, a large range of over-the-counter and prescription drugs in cases reported to the coroner. Victorian Institute of Forensic Medicine staff working in forensic toxicology have contributed to prevention efforts in four important areas:

— the role of alcohol and drugs in increased risk of transport operator crashes;
— heroin-related deaths;
— methadone-related deaths; and
— dispensing of prescription drugs.

This work involved not only the detection of emerging trends in deaths and describing the epidemiology, but also notifying and advising government and safety experts on reducing these deaths via a range of countermeasures.

Heroin-related deaths

Following an increase in deaths attributed to intravenous use of heroin in Victoria in 1996, research work was undertaken to monitor the issue. A series of eight newsletters were produced between 1999 and 2005, tracing the number of deaths and common themes amongst such deaths since 1991.

Number of heroin-related deaths in Victoria by year (1991–2004)

The research monitored the deaths over time and examined the factors of age, gender, occupation, presence of hepatitis C, location of death, presence of other drugs and a comparison between heroin deaths and other drug related deaths. The most recent results from this study showed that:

— there have been a total of 2,033 heroin-related deaths in Victoria from 1991–2004;
— the number of deaths attributed to the intravenous use of heroin decreased dramatically in Victoria in 2001. In 1991, the number of such deaths was 46. These had increased to 176 in 1997, 268 in 1998, 359 in 1999 and 331 in 2000. The year 2001 had only 50 heroin-related deaths in Victoria. This dramatic decrease reflected the heroin shortage at the time in Victoria;
— heroin-related deaths in Victoria more than doubled between 2001 (n = 50) and 2003 (n = 117), which raises concern for the possibility of a similar increase to that which happened during the 1990s. 2005 data indicates similar results to 2004 (n = 120), without a significant increase, which is encouraging; and
— the average heroin death is typified by a median age of 34 years (male) and 33 years (female), the age ranging from 14 to 63.
Also during this time, a range of other activities involving the Coroners Office and staff from the Institute’s forensic toxicology department were being undertaken to understand the nature of intravenous heroin deaths and determine the risk factors.

**Contributions to Medical Treatment**

Deaths associated with adverse medical treatment events are a major issue in most developed nations and form a significant part of the costs incurred in both public and private health care.

Traditionally Coroners have had difficulty in investigating such cases and relying on hospital pathologists or forensic pathologists has been proved to be unsatisfactory given their limited knowledge of the highly technical and specialist nature of advanced therapeutics. What was needed was the integration of clinical skills into the coroner’s investigation process and this was provided by the Victorian Institute of Forensic medicine forming a number of specialist investigation units to assist the State Coroner.

**Specialist Investigations Units**

Consultative Committee on Road Traffic Fatalities

The Consultative Committee on Road Traffic Fatalities (CCRTF) was established in 1992 as a joint initiative of the Victorian Institute of Forensic Medicine, The Royal Australasian College of Surgeons and Monash University. The Committee was funded by the Transport Accident Commission (TAC) and operated under immunity provided by Section 139 of the Health Services Act 1988. The Committee reviewed the medical management and the mechanisms of injury of individuals dying following treatment for injuries sustained in road traffic accidents.

The CCRTF had three principle objectives:
- identification of organisational and clinical errors or inadequacies;
- assessment as to whether individual problems have contributed to mortality; and
- assessment of the potential preventability of individual deaths.

The benefit of the Committee’s work included:
- identification of problems in the delivery of road trauma services in Victoria required for planning improvements in trauma care delivery;
- the establishment of a comprehensive clinico-pathological database of road traffic fatalities providing a baseline against which the effectiveness of changes in trauma care can be measured; and
- improvement in the management of patients with injuries from all causes not only road trauma.

The CCRTF was an integral part of the setting up of the new trauma care system in Victoria. Following its introduction the analysis of preventable and potentially preventable deaths is shown in the following graph.
Death Preventability Assessment by CCRTF

Using these figures and the published road toll for the years 2002-05 CCRTF considered that the following lives have been saved in part due to their work.

### Estimated Lives Saved from Work of CCRTF

<table>
<thead>
<tr>
<th></th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Road Toll</td>
<td>397</td>
<td>330</td>
<td>343</td>
<td>346</td>
<td></td>
</tr>
<tr>
<td>Saving preventable</td>
<td>8</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>29</td>
</tr>
<tr>
<td>and potentially</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>preventable deaths</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Saving preventable</td>
<td>32</td>
<td>26</td>
<td>27</td>
<td>28</td>
<td>113</td>
</tr>
<tr>
<td>and potentially</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>preventable deaths</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Clinical Liaison Service

The Clinical Liaison Service (CLS) is a unique initiative of the Victorian Institute of Forensic Medicine and the State Coroner’s Office to improve patient safety. The need to establish this service was supported by an expanding body of research evidence indicating that addressing the contributing underlying system factors may prevent a significant proportion of adverse events. It was recognized that there was an increasing need for data relating to patient safety in health care institutions and that the existing coronial information regarding deaths in health care settings was a valuable and under utilized resource. Furthermore, there is a need for a systematic process to ensure that the coronial recommendations and findings are applied towards system improvements.

Surveillance and early warning systems

The Clinical Liaison Service has formulated a validated method for classifying and recording information that may be related to adverse events within health care institutions. This information has uses, including the analysis of individual or clusters of such cases and the reporting of trends that may be useful in the early recognition of underlying systems issues in health care organisations.
Reforms to improve coronial and health care systems

The Clinical Liaison Service is exploring how coronial data can be used effectively to inform changes to the health care system and whether there are possible reforms to the coronial process that will enhance the value of coronial data for patient safety initiatives. In addition the Clinical Liaison Service is identifying reform priorities that reflect the interests of coroners, health departments and health care professionals throughout Australia for patient safety.

Prevention of fall-related deaths in hospitals

In 2003 the Clinical Liaison Service convened a forum with key stakeholders on the role of the Coronial process in the investigation of fall-related deaths in hospitals and nursing homes. A Falls Working Party was established consisting of a multidisciplinary team of coronial staff, researchers, policy makers and health care providers to undertake:

- assist non-Coroner’s staff to better understand the Coronial process in Victoria, particularly in relation to the investigation of fall-related deaths; and
- devise an Investigation Standard for deaths following a fall in hospital. This was distributed to all rural and metropolitan public hospitals and was implemented in November 2003. The Investigation Standard is now being used to investigate all fall-related deaths that are reported to the Coroner from health care institutions.

The following three articles were published from this project:


Following from the success of the development of the falls in hospital investigation standard, the CLS is now convening a Working Party to standardise the Coronial investigative procedure for cases involving the problems with the communication of abnormal radiological findings.

Formal action regarding coroners’ recommendations have occurred following coroners findings70 in Medical treatment related cases involving:

- Management of Deep Vein Thrombosis
- Abdominal pain management
- Spinal anaesthesia
- Narcotic prescription and administration
- Inadvertent intravenous administration of potassium chloride
- Interventional cardiology
- Fluid resuscitation of infants.

Contributions to life enhancement

Donor Tissue Bank of Victoria

The DTBV was established in 1989 as a central facility to retrieve, process, store and distribute cardiac and related tissue, musculoskeletal tissue (tendons, ligaments and bones), skin and corneas. Tissue is retrieved from deceased reported to the State Coroner. The DTBV has responsibility for family liaison, retention of tissue for transplantation and research.

Tissue Retention for Transplantation

Tissue for transplantation involves transplant and Family Liaison Coordinators from the DTBV to identify potential donors, confirm suitability for donation and obtain Coroner’s and Pathologist’s permission to approach next of kin to offer the option of donation. If next of kin consent to the donation, tissue is retrieved before an autopsy is performed. Specially trained scientists retrieve the tissue and then process it to make it suitable for implantation. Tissue is provided to hospitals at the request of surgeons. The DTBV also has a live donor program where patients undergoing total hip replacement can donate femoral heads to the tissue bank.

70 The outcome of a coroners investigation in Victoria is a narrative finding containing the information required in s 19 of the Coroners Act 1985 (Vic). Formal verdicts are NOT used
The following table shows the number of tissue donations that have been made in the last three years.

### Number of tissue donations for 2003–05

<table>
<thead>
<tr>
<th>Tissue Type</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac</td>
<td>51</td>
<td>37</td>
<td>35</td>
<td>123</td>
</tr>
<tr>
<td>Cornea</td>
<td>33</td>
<td>46</td>
<td>32</td>
<td>111</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>62</td>
<td>63</td>
<td>55</td>
<td>480</td>
</tr>
<tr>
<td>Skin</td>
<td>87</td>
<td>100</td>
<td>88</td>
<td>275</td>
</tr>
</tbody>
</table>

Tissue Retention for Research

Tissue for Research involves transplant and Family Liaison Coordinators offering to the families of recently deceased the opportunity to consider donation of tissue for specific research projects previously approved by an Ethics Committee. Tissue is only retrieved with the express permission of families. If next-of-kin consent to the donation, tissue is retrieved at the time of the autopsy. The tissue is retrieved by specialist staff and then passed onto the researchers for their investigations. There are currently nine approved projects that the DTBV coordinated donor selection and retrieval as follows.

### Ethics Committee Approved Projects for Tissue Retention for Research Purposes

<table>
<thead>
<tr>
<th>Project</th>
<th>Investigator/Institute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Assessment of Victorian Children from Birth to Five years of Age Using Photographic and Radiographic Techniques</td>
<td>Dr Anthony Hill, Honorary Forensic Odontologist, Victorian Institute of Forensic Medicine</td>
</tr>
<tr>
<td>Novel sites of Leptin production and action</td>
<td>Lyn Ireland, Kellie Hamilton, Baker Heart Research Institute</td>
</tr>
<tr>
<td>Genetic and Proteomic Studies of Human Motor Neurone Disease</td>
<td>A/Prof Surindar Cheema, Howard Florey Institute</td>
</tr>
<tr>
<td>Effects of Antibiotic Incubation Conditions on Heart Valve Pathology</td>
<td>A/Prof Catriona McLean, Alfred Hospital</td>
</tr>
<tr>
<td>Investigation into antibiotic loading of bone grafts using iontophoresis</td>
<td>Ms Kasia Michalak, The University of Western Australia</td>
</tr>
<tr>
<td>Collection of Human Femoral Tissue for Study of the Structure and Histological Properties of Bone</td>
<td>Prof John Clements, Dental School—Melbourne</td>
</tr>
<tr>
<td>Histological and Radiographic Examination of Fresh Temporal Bones implanted with Perimodiolar Electrode Array</td>
<td>Prof Tykociński, Royal Victorian Eye and Ear Hospital (RVEEH)</td>
</tr>
<tr>
<td>For the relatives of the sufferers of schizophrenia &amp; bipolar disorder</td>
<td>A/Prof Colin Masters, Mental Health Institute of Victoria</td>
</tr>
<tr>
<td>For the relatives of those diagnosed with Alzheimer's disease or other Dementia's</td>
<td>A/Prof Colin Masters, Mental Health Institute (1) Alfred Hospital (2)</td>
</tr>
</tbody>
</table>

Health Information Program

The Health Information Program, which began in 2002, is a service provided to families about information gleaned at autopsy, which may be of importance for the health of surviving family members. This information may be passed on to the family's GP, a specialist, or family members can meet with the pathologist and a Transplant and Family Liaison Coordinator. The criteria for the program consists of anyone who is found at autopsy to have:

- significant heart disease aged 50 years and under;
- a genetic disorder that can be passed between siblings and offspring (no age barrier);
- haematological (clotting) disorders; and
- cardiac disorders or defects (electro-physiology/arrhythmias) eg Long QT syndrome, cardiomyopathy;
- Communicable infections diseases (In addition to mandatory reporting to public health authorities).
The following table demonstrate the level of activity in this area:

### Family Contact from the Health Information Program Statistics for 2004 and 2005

<table>
<thead>
<tr>
<th>Family Contacts</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family to liaise with General Practitioner</td>
<td>109</td>
<td>103</td>
</tr>
<tr>
<td>No response from family</td>
<td>40</td>
<td>20</td>
</tr>
<tr>
<td>Family already taken action</td>
<td>12</td>
<td>14</td>
</tr>
<tr>
<td>Family referred to genetic counsellor</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Family do not wish to take action</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Family referred to other specialist</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Family declined information</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Family referred to VIFM staff</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Family member adopted</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>No family</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Family referred to cardiologist</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Family referred to haematologist</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Family referred to GP and cardiologist</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Family referred to GP and haematologist</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Family referred to GP and specialist</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>190</strong></td>
<td><strong>171</strong></td>
</tr>
</tbody>
</table>

### Family Follow Up Information, 2002–05

<table>
<thead>
<tr>
<th>Condition</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer Related Conditions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast</td>
<td>1</td>
<td>2</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>3</td>
<td>4</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Haematological</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Kidney</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Lung</td>
<td>2</td>
<td>0</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Prostate</td>
<td>4</td>
<td>12</td>
<td>12</td>
<td>20</td>
</tr>
<tr>
<td>Testes</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Thyroid</td>
<td>3</td>
<td>5</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Uterus</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Uterus/Ovary</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Heart Conditions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiomegaly</td>
<td>1</td>
<td>17</td>
<td>17</td>
<td>8</td>
</tr>
<tr>
<td>Cardiomyopathy</td>
<td>6</td>
<td>5</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>Conduction System Defects</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>Coronary Artery Atherosclerosis &lt; 50 years old</td>
<td>38</td>
<td>58</td>
<td>58</td>
<td>64</td>
</tr>
<tr>
<td>Hypercholesterolaemia</td>
<td>10</td>
<td>4</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Ischaemic Heart disease &lt; 50 years old</td>
<td>38</td>
<td>36</td>
<td>40</td>
<td>28</td>
</tr>
<tr>
<td>Other Conditions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haemochromatosis</td>
<td>4</td>
<td>8</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Hereditary Thrombophilias</td>
<td>2</td>
<td>5</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>Marfans syndrome</td>
<td>0</td>
<td>6</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>36</td>
<td>66</td>
<td>38</td>
</tr>
<tr>
<td>SIDS</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>129</strong></td>
<td><strong>211</strong></td>
<td><strong>281</strong></td>
<td><strong>242</strong></td>
</tr>
</tbody>
</table>

**Conclusion**

Families regularly express the desire to see something positive for the community to come from a coroner’s inquiry so that another family is not put in their position. The experience of Coroners is that this type of comment is generally made either directly by a family spokesperson (when a family is not represented at an inquest) or is made through their barrister when the family is represented. Often this wish is also expressed in the correspondence from the family during the course of the investigation.
A number of senior barristers who regularly appear in the jurisdiction were canvassed for this submission (representing either families, medical clinicians, hospitals, government departments, companies or other agencies) and they confirmed the view that many families and the parties involved in the incident are keen to see that the coroner make positive suggestions on improvements in systems. Specifically, families are desirous of the fact that the relevant agencies undertake prevention activities following an inquest so that the loss of their family member is not in vain. By way of example, Mr. John Olle, a barrister who has been regularly practicing in the jurisdiction for about 17 years, wrote:

“Since the late 1980’s I have developed a specialist Coroners Court practice. I have appeared for families of the deceased, Government Departments, Government and non Government organizations, hospitals, manufacturers, employers, service providers and numerous individuals involved in the coronial process.

With rare exception, the aforesaid participants would embrace a coronial process which unerringly focused on learning, improvement and prevention, with no mandate or interest in attributing blame or culpability. Such a system would replace ambiguity and uncertainty with trust and cooperation. Coronial resources would be expended in a most productive manner and importantly would ensure that the legacy of the deceased is both positive and lasting.”

Even in the current system operating in Victoria there are a number of examples where the involved agencies have made submissions to the investigating coroner about the type of recommendations that may be effective. Some companies have also embraced the process. By way of example, in a work-related inquest into a death in a quarry, the investigating coroner said that following the incident:

“. . . (the Company, which was named in the finding) appropriately looked at what it could do to prevent this type of incident occurring again at any of its workplaces . . . (and) . . . on a positive note . . . (it) took the view that the inquest process should be aimed at identifying the factors and contributing to the safety debate. In this regard the shortcomings of its operations prior to the incident were readily admitted.”

Principles of therapeutic jurisprudence have a unique part to play in the operation of a coroner’s investigation including any inquest. Therapeutic jurisprudence is the study of the role of the law as a potentially therapeutic or counter-therapeutic agent. It explores ways in which, consistent with the principles of justice, the knowledge, theories, and insights of health and related disciplines can help shape the law. As Christopher Slobogin put it, it is “the use of social science to study the extent to which a legal rule of practice promotes the psychological or physical well-being of the people it affects”. Therapeutic jurisprudence gives specific recognition to the health repercussions of each aspect of the operation of the law in practice, including the coronial legislation and medico-legal practice. It needs to be acknowledged, however, that therapeutic jurisprudence is not an integrated doctrine or philosophy. Rather, it is an eclectic taxonomy, drawing upon a range of different approaches toward law, including victimology, public health law, critical legal studies, law and society, restorative justice, positive psychology, pragmatic psychology, preventive law, and other modern perspectives. In the Coronial sphere it offers the possibility for an ancient legal process to create a therapeutic opportunity by building a bridge between the health disciplines and the operation of the law so that each can draw creatively upon the other in helping families as well as the community at large come to terms with particular deaths.

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.

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:

71 Email to State Coroner dated 9 June 2006
72 See for example the Linton Wildfire Inquest, Australian Grand Prix, Kew Residential Services Fire, Dandenong Ranges Fires and deaths, Port Phillip Prison Inquests
73 Coroner’s Case Number: 3678/02, Finding Recommendations and Comments, pp 9–10
74 C Slobogin, “Therapeutic Jurisprudence: Five Dilemmas to Ponder”, in Wexler and Winick (eds), Law in a Therapeutic Key, p 775
A coronial system that goes beyond blame and has, as its raison d’etre, 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.

Graeme Johnstone BJuris, LLB
State Coroner of Victoria

Associate Professor David Ranson BMedSci, BM, BS, LLB, FRCPath, FRCPA, DMJ
Deputy Director—Victorian Institute of Forensic Medicine

23 June 2006

APPENDICES

A number of individuals and organisations were requested to provide comments on the role of the coroner in injury and death prevention for inclusion in this report (not printed). These demonstrate the changing role of the coroner as it is perceived by key agencies and groups in the community. They reveal a high level of community acceptance and positive attitude to the preventative approach taken by modern coroners in Australia.

Also included are a number of newsletters produced by some of the specialist units at the Coronial Services Centre in Victoria (not printed).

Evidence submitted by Ian G McCreath MBE, HM Coroner for North Northumberland

I was considerably disheartened, when I first studied the draft Bill and accompanying documentation, and had started to draft a much longer letter to you, but I have been able to shorten it considerably by virtue of my having read the Oral Evidence given to your Committee on 13 June. I agree with virtually everything all the witnesses said during the course of their evidence, that day.

However, I make a number of personal comments below, and hope they will be found useful. I start with details of my circumstances.

1. I was born on 24 November 1944, was admitted as a solicitor in July 1967, and was appointed Her Majesty’s Coroner for North Northumberland with effect from 3 December 1979, having served as the Deputy Coroner for a couple of years before that.

I am currently Chairman of the Northern Coroners’ Society, the members of which are drawn from the jurisdictions in the extreme North of England ie Northumberland, Cumbria, Durham, Tyne & Wear, Newcastle-upon-Tyne, Hartlepool and Sunderland.

It has not been possible for the members of the Northern Coroners’ Society to meet since the Bill was published as quite a number of them have been on holiday, but we hope to meet before the DCA road show at Leeds on 7 July.

The result is that what I say below must be regarded as personal comment, not necessarily agreed by the whole membership of the Northern Society.

2. As to the Bill, I comment first on Section 33.

I am very surprised that the Regulatory Impact Assessment is so vague about funding the “provision and maintenance” of proper accommodation for the service in future.

Vic Round covered this admirably during his evidence, but let me tell you about my own personal experiences.

I have great difficulty in booking Court accommodation for any Inquest which lasts more than a couple of days.

Prison death Inquests nearly always do, and I have in recent years had to deal with quite a number of these, as a result of deaths at Acklington Prison or Castington Young Offenders Institution.

It has perhaps not been explained as yet that if it is appropriate (and it often is) for a serving prisoner or prisoners to give evidence at such an Inquest, I am assured that he can only be produced at a “secure” building. I therefore have to arrange to hear much of the evidence at a prison death Inquest at eg Morpeth Town Hall or Morpeth County Court, then book time at Alnwick Magistrates’ Court House, when the evidence of serving prisoner(s) is due to be heard. You can imagine how frustratingly inconvenient all this is, not least to the jury, the problem with the court room at Alnwick being that it is too small for a jury inquest.

Bedlington Magistrates’ Court would perhaps be a suitable venue for future prison death Inquests following the creation of the new jurisdictions, but accommodating a prison death Inquest would undoubtedly cause considerable inconvenience and delays in relation to the administration of criminal justice as even that Court couldn’t currently provide a Coroner’s courtroom for more than two, or possibly three, consecutive days.
I explain this to give you one concrete example of the nature and extent of the problems associated with section 33.

It does not seem to me that the many issues surrounding the provision of proper accommodation for the new service have been addressed in any meaningful way, as yet.

3. In some areas (eg north of Broomhill, near Morpeth right up to the Scottish Border), ordinary Police Officers deal with the work which is dealt with elsewhere by Coroners Officers.

So if a death occurs eg in Wooler it will be dealt with by the Wooler Police Officer who happens to be on duty at the relevant time, and he deals with the bereaved, makes the necessary report to me etc.

So literally any Police Officer can suddenly be faced with reporting a sudden death to me, and dealing with the bereaved. Sometimes this all works out satisfactorily, but often the service to me and the bereaved family by an inexperienced Police Officer is going to be lacking.

The Bill doesn’t attempt to tackle problems of this nature, and centralising the Coroner’s office servicing my area eg in Newcastle would surely have a detrimental effect on what is already an unsatisfactory situation.

4. With regard to Schedule 1 of the Bill, I wholeheartedly agree with what Victor Round said on this issue in answer to question 108, with particular reference to the fact that there does not seem to be any intention on the part of the Government to have any meaningful dialogue with the likes of myself.

We have all been invited to one of four DCA Road shows, the last of which is to one at Leeds on 7 July, when Coroners’ Officers, Coroners’ Administrative St4 Local Authority representatives and Police representatives have also been invited.

I do not anticipate that any meaningful progress will be made on that occasion. How could it be?

It is extremely difficult to envisage how the new jurisdictions in Northumberland, Newcastleupon-Tyne etc. are going to be structured, but if this is going to happen, surely the dialogue with to existing Coroners and their Deputies should start sooner rather than later, and to new jurisdictions defined into legislation.

I am in a quasi-redundancy situation, as I am not interested in becoming a full time Coroner for obvious reasons, but might still have something to offer in the future.

An employer would have to consult with even the most junior employee in a case where redundancy has arisen.

If the DCA’s intention has been to demoralise part-time Coroners such as myself it has succeeded.

5. As to section 4 of the Bill, occasionally a road accident occurs in England, but the fatally injured person dies in Scotland eg Borders General Hospital.

Sometimes the body of the deceased person would not be brought back into England eg if to deceased person had been resident in Scotland. On other occasions, the body might be brought back into England for the purpose of a funeral, and that would give the Coroner jurisdiction under section 1.

So section 4 effectively rules out jurisdiction unless the body of the deceased is at some stage situated within the area of an English Coroner. Is that what is intended?

If a fatal incident eg a serious accident in the work place occurs in England, but the fatally injured person dies in Scotland, there would never be a Fatal Accident Inquiry, because Scottish jurisdiction is based, as you know, on whereabouts of to relevant incident

In the past, Coroners like me have tried to deal with such situations on a pragmatic basis, but the combined effect of sections 1 and 4 of the Bill is that some fatal incidents would escape the scrutiny of an Inquest or a Fatal Accident Inquiry.

So Section 4 of the Bill merely confirms what is presently an unsatisfactory situation, unless to body of the deceased person is brought into England after death, at the whim of the family of the deceased.

6. The Removal of Bodies Regulations 1954 apply to a simple situation where eg a person who lives in Scotland dies in England, often Berwick Infirmary, from natural causes, and the funeral is to be taken in Scotland. Similarly, they apply where someone who lives in England and dies in England has expressed a wish to be cremated in Scotland eg Warriston in Edinburgh.

When we met, I told you that I have never had occasion to refuse an application for a Removal Order under these Regulations, throughout my 26 years of service as Coroner for North Northumberland.

I do wonder whether these Regulations serve any useful purpose in relation to transfers to Scotland, and note that they are not mentioned in the Bill.

My office issued 48 Removal Orders under these Regulations in 2005, and it seems to me that it would be worthwhile for the Parliamentary Draftsmen to take a little time to consider insertion of an amendment to the Regulations to the effect that they don’t apply to removals into Scotland.
7. I have not endeavoured to make out a case for justifying the retention of small jurisdictions such as North Northumberland, although the Bill suggests a case for this. Nor have I commented on a number of issues arising from the Bill which others will no doubt speak about eg the inadequacy of the envisaged expenditure on medical assistance for Coroners, but I can personally elaborate on such issues if that would serve a useful purpose.

In summary, I fear the DCA does not yet fully understand the way in which the current service operates, and does not seem to be prepared to spend sufficient money on curing the current defects of the service, which have been in existence for far too long.

Ian G McCreath MBE
HM Coroner for North Northumberland
June 2006

Supplementary evidence submitted by Ian G McCreath MBE, HM Coroner for North Northumberland

I feel compelled to write to you again, following my attendance at the DCA Roadshow at Leeds on 8 July.

I am very concerned as to the continuity of the Coronial Service to an acceptable level, from now until the new Coronial System is put into operation.

It was made clear by the DCA Officials who spoke at the Roadshow that neither Coroners, Deputy Coroners, Assistant Deputy Coroners, Coroners’ Officers nor Coroners’ Clerical Staff can be regarded as having any continuing job security at all.

Quite apart from the concerns being felt by Coroners, Deputy Coroners and Assistant Deputy Coroners, Coroners’ Officers and clerical staff must clearly also be very concerned, for the following reasons.

It was explained that the Government is in negotiations with Police Authority Representatives and with Local Government Associations over the possibility of all Coroners’ Officers being employed in future by Local Authorities rather than Police Authorities.

This means that at some unknown time in the future, many Coroners’ Officers may be faced with having to apply for a new job with a Local Authority without any guarantee of success, not least because it was suggested that Local Authorities tend to favour existing employees when job applications are being considered.

Secondly, it was stated that there would be no question of continuity of the employment of clerical staff who currently work in solicitors’ offices within such offices, when the legislation is brought into force.

There was a reference to such persons possibly being offered work in the new service, but then it was stated by the DCA Officials that there is no map in existence, as yet, showing any provisional boundaries for the new jurisdictions.

In addition, there was significant disquiet on the part of the Local Government representatives present, as to where the money will come from for the purpose of their fulfilling their obligations under clause 33 of the Bill.

Furthermore, the manner in which any future consultation with those presently working within the service is to be conducted was not made clear. This was perhaps the most distressing news of all.

There must be a major concern that many, who carry out an extremely valuable service to the bereaved at present, will seek to leave the Coronial Service between now and April 2009 if opportunities for more secure employment elsewhere arise. Needless to say, replacing any such individuals would only be possible on temporary contracts of employment of unknown duration.

I write this letter as one individual working in the service at present, greatly concerned for the future wellbeing of the Coronial Service in North Northumberland and the rest of England and Wales.

I do not know whether this letter will be too late for use as evidence before the Constitutional Affairs Committee, but I would have no objection to it being used as such, if that is possible.

Ian G McCreath MBE
HM Coroner for North Northumberland
June 2006
Evidence submitted by Caroline Beasley-Murray, HM Coroner for Essex & Thurrock

ABOUT THE WRITER

I am legally qualified (a former barrister) and have been the whole-time coroner for the Essex and Thurrock District since 2000. I also sit as a president of Mental Health Review Tribunals and am a former lay magistrate.

The Essex and Thurrock district comprises all of the county of Essex, excluding the unitary authority of Southend, and has a population in excess of a million. Within this jurisdiction are Stansted Airport, Chelmsford Prison and Young Offenders Institution, an Army garrison, four large hospital trusts, many large industrial areas, an extensive coastline, part of the M25 motorway and other major roads, rural areas etc.

Around 4,500 deaths are reported to me annually. This jurisdiction would appear to be of a similar size to that envisaged in the new coroners service.

I am fully committed to the future of the coroners service and wish to strive for and work within an improved and reformed service.

Specific coroner areas of expertise and interest:

— Member of the Law Review and General Purpose Committee of the Coroners Society.
— Member of the Coroners Study Committee (joint Department of Constitutional Affairs/coroners membership) which is responsible for delivery of training for coroners.
— Director of induction courses for newly appointed coroners.
— In July 2005 sent by the Department of Constitutional Affairs and the Foreign and Commonwealth Office to Sharm-el-sheikh as “lead” coroner to oversee the identification of the eleven UK victims of the bombings.
— Past President, South East England Coroners Society.

EXECUTIVE SUMMARY

Purpose of submission:

— to express thoughts upon the reform proposals;
— to draw attention to areas of particular concern; and
— to suggest certain recommendations for action by the government which might be included in the Select Committee’s report to the House.

Any views expressed are entirely my own.

GENERAL RESPONSE TO REFORM PROPOSALS

I broadly welcome the way forward which has been outlined by the government. The six key reforms should provide a coroner service more fit for the twenty first century.

— Recent events and the two reports have clearly shown the importance of facilitating more involvement by bereaved people in coroners’ investigations. It is my view that there should be more opportunities for involvement by bereaved families in the investigation and inquest process. Presently charters are produced at local level—a nationally validated coroners’ charter will be helpful.
— I am of the opinion that national leadership is sorely needed and it is to be hoped that this national leadership will put in place solid mechanisms for disseminating national standards and values to local councils.
— I welcome the creation of a body of full-time coroners in conjunction with the formation of a smaller number of coroner jurisdictions. This should result in enhanced professionalism and the delivery of an improved service.
— I consider that the modernisation of investigation and inquest processes is long overdue, as is also the ending of archaic boundary restrictions which hamper coordinated action, for instance, in mass fatalities incidents. My experience of the practical application of s14 Coroners Act 1988, whereby jurisdiction can be transferred between coroners with ultimate recourse to the Secretary of State, is that it does not always work smoothly. Modern legislation is needed to meet the challenges of mass fatalities in the UK and abroad.
— I have long been of the view that a discretion for coroners to complete their investigations and decide upon the facts without holding inquests in certain circumstances would be beneficial. This situation would be akin to the practice in the State of Victoria, Australia, of concluding certain
investigations by way of “chambers findings”. The present regime which dictates that all inquests are held in open court with the attendant presence of the press can intrude unnecessarily into private grief. I am aware that this is not a stance taken by all my colleagues.

— I welcome the provision of better medical advice and support at local and national level. I do this in the light of having seen in action the Clinical Review Liaison Service which is part of the Victorian coroner service (incidentally, the State of Victoria has a similar number of reported deaths to my jurisdiction). I also do this having regard to the results of the pilot for a medical examiner scheme carried out in my jurisdiction at the behest of the Home Office in the Autumn of 2004. (Copies of the report can be supplied to the committee upon request.) There is no doubt that input of medical expertise and support would be of great value for coroners at each stage of the investigation and inquest process.

Areas of concern

1. Resources

I am concerned that local authorities may not be able to fund the coroner service to the extent that the reformed system will require. Essex County Council, for instance, is extremely supportive but each year the coroner service budget is exceeded and I presume that this situation exists in many other local authorities. The demands upon the service are unlikely to lessen, not least as a result of their lordships’ decisions in Regina v. Her Majesty’s Coroner for the Western District of Somerset (Respondent) and other (Appellant) ex parte Middleton (FC) (Respondent) and Regina v. Her Majesty’s Coroner for the County of West Yorkshire (Appellant) ex parte Sacker (FC) (Respondent) which broadened the scope of inquests in which Article 2 is engaged, so that the inquest forms part of the state’s obligation to investigate deaths at the hands of or in the care of the state.

For some time the police have tended to regard their responsibility for the funding of coroners officers as a short term situation, but now that the government has clarified the way forward I fear that there may still be reluctance to provide the necessary resources to meet a reformed service under ever increasing pressures. During my five years in post I have had constantly to ask Essex Police to provide the necessary resources for a coroner officers’ establishment which has lacked resilience. For example, Essex Police has withdrawn the provision of deputy coroner officers with a resulting detrimental effect upon the standard of service for the bereaved.

Suggested recommendation

— That the Government ensures that there is sufficient funding, both from local government and police authorities, for the reformed coroners service as envisaged.

2. Medical input and support

I hope that there will be clear guidance as to how this will be provided and by whom it will be funded. My experience with the medical examiner pilot scheme demonstrated that a great deal of inter-agency work was needed at local level—for instance, I liaised with the local Primary Care Trusts, with Hospital Trusts, with general practitioners, with the Strategic Health Authority and with the local registrars. There has to be a well financed, structured mechanism for the delivery of this much needed medical assistance.

Suggested recommendations

— That the Government puts in place efficient, well resourced structures nationally and locally to deliver medical input and support for coroners.

— That the Government considers piloting such schemes locally in the near future.

3. Training

The Fundamental Review carried out by Tom Luce emphasised the importance of compulsory training at both induction and continuation level for coroners. Over the last few years, great strides have been made in the area of coroner training—for instance, whereas induction training used to comprise of a few hours training prior to another course, there is now provided four days of induction training which compares favourably with the amount required of newly appointed members of the judiciary. Over the last few years, we have reaped the benefit of increasing input from the Judicial Studies Board in the area of coroner training. It is to be hoped that as a result of the responsibility for the funding of the coroner service not moving to the Department of Constitutional Affairs but remaining with local authorities, all this progress will not be lost. It would be helpful if the government were to make it clear that these links with the Judicial Studies Board will be maintained and developed.
Suggested recommendations

— That the Government acknowledges the improvements which have been made over the last few years in the provision of training for coroners

— That the Government ensures that there continues to be increasing input from the Judicial Studies Board into the delivery of training for coroners.

— That the Government puts in place a mandatory scheme of continuing professional development for coroners

4. Court accommodation

Very few coroners have purpose-built court accommodation and many have difficulty in obtaining accommodation for inquests. When Tom Luce presented his Fundamental Review at a press conference, as an illustration of how lacking in facilities the present coroner service is, he referred to his shock at discovering when he visited me that, as a whole-time coroner with one of the largest jurisdictions in the country, I worked from an office in my own home and held inquests in a room in Shire Hall with a small kitchen as a retiring room. I currently hold most inquests in the Essex County Council Chamber, but this is not available on days when citizenship ceremonies are taking place and it has other drawbacks too. I have campaigned successfully for a purpose-built coroners court and, with the support of my local member of parliament, Mr Simon Burns, the member for West Chelmsford, I have been able to get coroner court accommodation within a Public Finance Initiative Magistrates’ Court scheme. This new build, however, has been delayed for various reasons and there now seems to be uncertainty about the funding for the coroners court. My fear is that this uncertainty will continue now that it is known that funding for the coroner service will not come from the Department of Constitutional Affairs but will remain the responsibility of local government. When the Lord Chancellor attended the annual conference of the Coroners Society in York last September, in answer to a question from the floor from me on the subject of coroner court accommodation, he assured us that local HM Court Services were encouraged to assist where there are accommodation problems. This was reiterated by the Minister in the House on 6 February 2006. However many magistrates’ courts are being closed and the serious problem of the lack of facilities for coroners courts is not being addressed.

Suggested recommendations

— That the Government recognises that the poor accommodation provided for coroner courts is a real barrier to the delivery of a modern coroners service

— That the Government takes steps towards the provision of appropriate coroners court facilities

5. Criticisms of coroners

Over the last few years, coroners have received a bad press and Hansard columns 608 to 619 for 6 February 2006 when coroner service reform was debated in the House does not make happy reading because it was clear that many people are unhappy with the performance of the coroner service and of individual coroners in particular.

There may be some of my colleagues who present as “arrogant, unreformed relics of feudalism” and that is most unfortunate. However I would like to assure the committee that there are many of my colleagues who carry out their duties as independent judicial officers with the utmost professionalism, courtesy and sensitivity and this they do often in spite of inadequate resources and facilities.

Another criticism which is levelled against coroners is that of delay between the date of the death and the matter coming to inquest. I would like to point out that there are often many reasons for delay which are beyond the control of the coroner concerned.

6. Timescale

I am sure that I speak in unison with my colleagues when I say that it is of grave concern that reform of the coroner service has been so slow in coming to fruition. As the Secretary of the Coroners Society observed when the government plans were announced, the coroner service has for too long suffered from blight.

Suggested recommendation

— That the Government publish a Bill promptly and use its best endeavours to ensure that this piece of legislation is on the statute book with expedition.

Caroline Beasley-Murray
HM Coroner for Essex & Thurrock

March 2006
Evidence submitted by The Law Society

REFORMING THE CORONER AND DEATH CERTIFICATION SERVICE

The Law Society has been actively involved in the reform of the inquest system. The Society, through its Coroners Courts and Inquest Working Party has prepared written submissions to the Shipman Inquiry and to the Coroners Review. In addition, the Society has provided written evidence to the Constitutional Affairs Committee and has two members of its working party serving as Special Advisers to the Committee throughout the inquiry.

Although it is impossible to fully comment on the reforms until the detail of the new proposals are published, in light of the recent Government briefing note Coroner Service Reform I write to share the Society’s current views.

We support statements by the Government to create a system based on coroners with legal qualifications and to give coroners increased powers to investigate deaths. However, we remain concerned about the provision of public funding for inquests and fear that financial constraints may make adopting effective reforms extremely challenging.

As the attached paper outlines, we are confident that a new independent, consistent and transparent system is within reach and the Society eagerly awaits the publication of the draft Bill.

I. INTRODUCTION

1.1 The Law Society is the professional body for solicitors in England and Wales. The Society regulates and represents the solicitors’ profession, and has a public interest role in working for reform of the law.

1.2 The Law Society’s Coroners Courts and Inquest Working Party brings together individuals with expertise in the area of coronial law. The working party is comprised of solicitors and barristers who regularly act for families at inquests as well as coroners and deputy coroners with several years experience presiding over inquests.

1.3 The Law Society recognises the need and the importance of reform of the current system. Outlined below are the Society’s views on proposals for an improved inquest system. The recommendations are taken from the Coroners Report, the Third Report of the Shipman Inquiry and the Government’s recent Briefing Note.

1.4 One of the overarching concerns the Law Society has with the proposed reforms is the suggestion that there will be no additional resources available to carry out the various services outlined in the proposals. Additional funding is paramount to the effective delivery of service.

II. THE BEREAVED

2.1 In our response to the Government position paper Reforming the Coroner and Death Certification Service we stated our support for proposals made by both the Coroners Report and the Shipman Inquiry that a more involved role for the family of the deceased was necessary.

2.2 In that response, we also supported a coroners’ charter (then entitled a family charter) outlining what families can expect from the service. The Society has always strongly supported greater involvement of families in the inquest process and supports the extension of such involvement to other non-family members closely involved with the deceased. However, it is important to ensure proper balance in judicial proceedings amongst all parties to the inquest.

2.3 We support the establishment of a charter outlining essential and timely information to families, their rights of access to key people and material, the processes for obtaining bereavement help, the likely timing of developments in their case and the arrangements for giving practical help at the inquest where necessary.

2.4 The Government’s Briefing Note states that there will be easy access rights to seek a review of coroners’ decisions. In principle, we support a more readily available appeal process on decisions made by the coroner. This could eliminate the over-use of judicial review and be the mechanism by which individuals can challenge procedures, for example, the failure to hold an inquest, issues around disclosure of information or to challenge proposed failure to summon a jury where discretion to do so exists.

2.5 However, this could raise difficulties. For example, if a coroner needs to make a decision on whether or not to order a post-mortem on a suspicious case, the post-mortem must take place within hours of the death, often in the middle of the night.

2.6 In addition, we have concerns that an open invitation for appeal could stifle a system already strapped for resources. Nonetheless, it is vital that all appeals should be heard before individuals with substantial coronial experience.
III. AVOIDING UNNECESSARY INQUESTS

3.1 The Society supports the tradition of public hearings into the circumstances of violent or unnatural deaths. We were pleased to note that the Government Briefing Note allows for coroner investigations into “all traffic deaths, workplace deaths, deaths apparently from self-harm, from injury . . . operations of the law and order services and any death in which occupational disease may have played a part”.

3.2 The Society is worried that adopting a provision for not holding a public inquest may lead to problems. However, if the Government adopts this provision, the Society advocates that there must be adequate appeal mechanisms in place within the system to challenge a decision not to hold an inquest.

3.3 We have concerns about including a discretion which may lead to a great number of appeals and which could be time consuming and expensive. However, we note that, should a discretion exist, decisions should not be made merely on the issue of the cost of holding an inquest.

IV. NATIONAL LEADERSHIP, NATIONAL STANDARDS

4.1 We support the establishment of a Chief Coroner and are aware that such a position would need to have proper funding and resources and candidates would have to be selected from the very best with skill, experience and a broad depth of knowledge.

4.2 The role could include establishing practice direction, like the Lord Chief Justice does in criminal cases, or the Master of the Rolls in civil cases. These practice directions and guidelines may be a useful way of speeding up the process of law reform without the need to fight cases through the courts.

4.3 We support proposals for the Chief Coroner to be responsible for the charter and suggest that s/he receive representations on poor and good practice directly from interested persons.

4.4 The Society approves in principle the adoption of the Coronial Council with powers to monitor the general performance of the new structures and give guidance on issues of policy and process. However, if funding is an issue, this recommendation should not be among the most important priorities for reform.

V. FULL TIME CORONERS

5.1 We support proposals for a national coroner and around 60 coroner areas in principle. However, we are concerned by the prospect of insufficient resources to make such a model work effectively.

5.2 Part-time coroners partially fund the current system. Doing away with these posts will not only eliminate flexibility of staffing, but may potentially do away with important financial resources the system depends on.

VI. LOCAL AS WELL AS NATIONAL ACCOUNTABILITY

6.1 The Society endorses proposals to mandate all coroners have a legal qualification. We advocate that the requirements for coroners should be consistent with the requirements for the rest of the judiciary, and be consistent with any changes to the judicial appointments system.

6.2 Regarding appointments, we are concerned that coroners appointed at a national level but functioning at a local level may have implications on the local authorities.

VII. IMPROVED INVESTIGATIONS AND INQUESTS

7.1 The Society supports recommendations made by the Coroners Report to provide coroners with increased powers. Such powers include:

— to investigate and find the causes and circumstances of any death reported to them;
— to determine the scope and scale of the investigation;
— to obtain any document or material needed for such investigations;
— to investigate any death or group of deaths; and
— to require for any specified time that all deaths occurring in particular facilities or locations be reported to him/her.

7.2 It is important to note that whilst additional functions are welcome, coroners must be given the necessary resources to carry out such functions.
VIII. IMPROVED MEDICAL CAPACITY

8.1 The Society supports the appointment of a Medical Advisor to the Chief Coroner to maintain medical standards. We believe that such appointments will yield better consistency within the system.

8.2 The Society also supports previous proposals to adopt a Medical Examiner to provide the checks and balances that were missing in the system when Dr Shipman was practising.

IX. OTHER ISSUES

9.1 Pre-inquest hearings

The Society supports a statutory footing for pre-inquest hearings and the instruction of counsel for appropriate cases. Their adoption will provide an opportunity to discuss and explore medical evidence, experts, disclosure and general case management.

9.2 Counsel to the inquest

The Society is generally supportive of the adoption of counsel to the inquest. However, we are concerned that the appointment of counsel to the inquest should not be viewed as a replacement for legal representation for the family as they serve different purposes.

9.3 Juries

The Society supports recommendations in the Coroners Report that juries should be empanelled where someone compulsorily in the care of the state has died in unclear circumstances, or where a death may have been caused by agents of the state, and in other cases which fall within Art 2 of the ECHR. However, we believe that the criteria for the use of juries should be slightly extended to include voluntary patients in mental health institutions and to include deaths where health and safety issues arise including workplace deaths and railway deaths. We are concerned that providing the coroner with discretion to summon a jury could be problematic in practice.

9.4 Conclusions

The Society supports the introduction of a narrative conclusion as recommended in the Government’s position paper. We agree that more emphasis needs to be placed upon the overall findings of the inquest procedures rather than the conclusion alone. We support proposals in the Coroners Report that the outcome of the inquest should be “primarily a factual account of the cause and circumstances of the death, an analysis of whether there were systemic failings which had they not existed might have prevented it, and of how the activities of individuals bore on the death. The analysis should in suitable cases examine whether there was a real and immediate risk to life and whether the authorities took, or failed to take, reasonable steps to prevent it”.

9.5 The House of Lords has made clear in Middleton that in order to comply with the procedural obligations under Article 2, an inquest conducting an investigation into a death should culminate in an expression of the jury’s conclusion on the disputed factual issues at the heart of the case. The inquest’s remit should not be limited to “how” the death happened; it should be more wide ranging, assessing “by what means and in what circumstances”. It is interesting to note that the Form of Inquisition used by coroners for many years, whilst not statutory, has always included a question as to the circumstances of the death.

9.6 The Society supports enhanced communication between relevant bodies concerned in an inquest and advocates that coroners’ reports should be sent to the Health and Safety Executive and to any relevant inspectorate of Directors of Public Health as well as to any individual or organisation directly responsible for the circumstances of the death.

9.7 Where possible, reports should contain practical recommendations or suggestions for the relevant body to act upon within a particular timescale and report back to the coroner that the suggested action has been considered and dealt with. If not dealt with reasons should be provided as to why this has not been possible.

9.8 Funding

The Government’s Briefing Note does not address the issue of funding for representation at inquests.

9.9 Despite welcome reforms to the funding regime, we are concerned by the inconsistent approach to funding currently experienced by practitioners working within this area. Inquests are complex proceedings which require lawyers with specific skill set and experience. Public funding should be available so that families are able to instruct lawyers who are well-versed in the proceedings of coronial law.
X. Conclusion

10.1 The Law Society looks forward to further involvement as the Government moves ahead with recommendations to reform the inquest system. We await the publication of the draft Bill and will be looking at reform of the service with great care.

The Law Society

June 2006

Evidence submitted by Victor Round, Honorary Secretary, The Coroners’ Society of England and Wales

Initial response to the Draft Coroners Bill 2006

We welcome the publication of the draft Coroners’ Bill. We believe that this provides a foundation upon which to develop a modern coroners’ service. The draft Bill, which has taken on board many of our concerns, gives us a framework to work with. On the credit side it recognises that coroners need adequate powers to carry out investigations, and to obtain evidence.

Coroners have served our society since 1194. The last major reform of the coroners jurisdiction was in 1887 (there was some reform in 1926). There has been much analysis of the coroners system over the years, but even so the system has been neglected. Nevertheless we do whatever we can to provide a personal, sympathetic and independent service in our neighbourhoods. Our jurisdictions are local judicial services, relying on the infrastructure and resources available from the local authority. There has been little national guidance and support.

Over many years, but particularly in the past six years or so, the coroners’ services have become blighted. Some local authorities and police authorities have not made adequate provision for a coroner’s service and as a result many coroners are working with inadequate court facilities, offices and support. Some authorities have, however fully recognised their responsibility and the importance of the coroner’s work to the local community. It is not surprising that there is a perception of a postcode lottery as to resources available to coroners: effectively it exists.

The importance of the coroners’ work is that we support the bereaved and all affected by sudden or unnatural death by searching for the true circumstances of what has happened. This is for the benefit of society and the bereaved.

The draft Bill retains local ties in that local authorities will still fund the service, and will have to provide accommodation. Nevertheless it must be recognized that the reduced number of jurisdictions will reduce the present local nature of the service delivery.

We welcome national leadership through a Chief Coroner.

The regulations and practice directions under the future Act will be informed through advice from the Coronial Advisory Council. This is most helpful, as it will build on experience and keep moving the service forwards.

The Bill provides for a right of appeal to the Chief Coroner. It was always unfair that challenge could only be made through expensive applications to the High Court but the new appeal system must be efficient, affordable and expeditious. The fast track appeals system has merits but we worry that it has not been thought through fully and may have immense resource implications that have not been accounted for.

Under the present system most coroners are part-time. Whilst they are available to carry out coronial duties at all times, in between the demands of the coroners responsibility, they work (mainly) as solicitors. In many jurisdictions their legal practices subsidise the coroner’s service. Part-time coroners have provided excellent public service over many centuries. The Bill enables us to retain their invaluable experience and expertise.

Careful transitional arrangements will be very important to ensure that a service continues while the new infrastructure is developed. These arrangements must ensure that the experienced coroners and their staff are encouraged to remain at their posts rather than seeking work elsewhere. The service has been neglected and blighted for too long and now is the time to invest and build.

The Importance of Coroners’ Officers in all this is still not adequately recognised. They are at the front line of bereavement care; they must have a proper career structure and access to training and continuing education. The new powers of investigation will be of little use if the investigators are not trained. The Chief Coroner will set standards but it is for local authorities and police authorities to ensure those standards are achievable, by preceding to resource them.

The Society would like to acknowledge the enthusiasm and hard, work of Paul Goggins MP, Robert Clifford and Judith Cooke and their staff at the Home Office before the transfer to the DCA. The work they oversaw has underpinned the recent work of the DCA.
This draft Bill has been long awaited and now it has arrived the work starts. The crucial workings and plans will be detailed in the Rules, Regulations and Practice directions but we congratulate the Minister and the team in the DCA Coroners Division for laying these foundations for the future.

The fine details still have to be decided. The Bill’s broad brush approach gives us something to work with and we will do our best to achieve an efficient, effective and humane system, which seeks the truth, and allays fears.

*But everything will depend on resources, It is a big but . . .*

Victor Round
Hon Secretary
The Coroners’ Society of England and Wales

*June 2006*

Evidence submitted by the Coroners Services Public Accountability Action Group (CSPAAG)

1. **WHO IS THE CORONERS SERVICES PUBLIC ACCOUNTABILITY ACTION GROUP (CSPAAG)**

The CSPAAG was formed in December 2005 by a group of bereaved persons living in the London area who have all had similar bad experiences of the Coroners Services. We are affiliated to the Marchioness Disaster Action Group. As bereaved families we have first hand experience of the violations and flaws of the current practice in Coroners Services. We see the laws that have been in place for a number of years, particularly the Human Rights Act of 2000 and which have now been incorporated into British domestic law are being broken. Our contacts with families from the Marchioness Action Group, The Alder Hay Enquiry and the Shipman Enquiry and four mothers whose sons were killed give us clear evidence that serious violations continue.

Our conversations with members of other organisations ie Road Peace, Victims Voice, Deaths Abroad and SAMM suggest that our cases represent what is the tip of the iceberg and that our concerns spread nation wide.

2. **THE AIMS**

— We find that the Coroners service needs a complete overhaul as it is marred by many serious and wide reaching faults.

— *We wish to raise serious concerns about how the Inquest procedures can be made an adequate investigative mechanism for examining the circumstances surrounding a death and whether these services can succeed the “most careful public scrutiny test”.*¹

— For that we want to achieve public accountability of the Coroner’s Services.

— Our experiences show that the Amendments since 1989 to the Coroners Act made no real changes in delivery of services. We wish to see action taken to ensure that the Human Rights Act and other existing laws and International protocols that have been in existence for some time, are incorporated without breach into current practice.², ³

— We wish to ensure that all citizens are entitled to and receive full and effective investigations in cases of sudden and unnatural death whether at home or abroad.⁴, ⁵

— We need independent supervision of the Coroner and effective right of appeal against his decisions and full access to Justice for the Bereaved.

— To assist the authorities to ensure that new legislation will bring about good practice.

3. **COMPLAINTS AGAINST CORONERS SERVICE WITH EXAMPLES**

— Lack of transparency.

— An atmosphere of secrecy. Much is hidden behind too wide discretionary powers which are unregulated and unaccountable to ANYONE!!

— Failure to carry out full and fearless investigation into causes of suspicious and sudden death here and abroad. The coroner does “as I see fit” !!

— Failure to carry out identification procedures.

— Failure to make adequate investigation of circumstances surrounding the death.⁶

— The Coroner frequently closes down cases without involving the police.

— Failure to keep proper records or to disclose to the next of kin.⁷

— Failure to acquire medical/dental records prior to post-mortem/specialist investigations.
— No matter whether the Inquest proceedings are recorded by professionals or not the Coroner uses his wide discretionary powers to make changes and so there is not a valid record.
— Coroner delegates decision to officers who have no or poor investigative skills and no training.
— Inadequate involvement of the next of kin.
— False excuses given for violations and for providing wrong information.
— Failure to inform families of their legal rights, of the kind of post mortem to be carried out and the Inquest process.
— Failure to issue Home Office pamphlets on Coroners Procedures on Sudden Deaths as soon as possible and importantly before the post mortem/specialist examination.
— Families are not consulted about retention or disposal of removed organs.
— Illegal secret removal of body parts.
— Post mortems are ordered and carried out unnecessarily in unequipped public mortuaries with no facilities for forensic work.
— Medical Officers delegate the work to Mortuary technicians who are unregulated, unmonitored and untrained for forensic work.
— Medical officers used who are unsuitable, untrained in forensics and not part of mainstream medical practice.
— There is no inspection of the Mortuary personnel or facilities.
— Post mortems/specialist examinations are not undertaken to a common standard nor do they conform to best practice.
— The remains of the Deceased are treated with no dignity or care.
— The coroner is not part of the Justice system. This quasi—legal process as it exists undermines the rule of law and British Judiciary. It is a violation as inadequate Inquests can do permanent damage to a possible criminal or civil case. We the Bereaved then feel exploited, betrayed and deceived. For example: The coroner has too much power and can use this to shut down police enquiries rather than to open them. Bad practice post mortems having vital evidence which is then destroyed for ever. The coroner frequently holds Inquests based on hearsay evidence. The coroner has the power to summon people but no power to require them to answer questions.
— The Bereaved have no fair or full access to Justice. 8

4. THE STATE OF THE LAW AND THE HUMAN RIGHTS ACT (HRA)

Compliance with the obligations of the HRA ranks among the highest priorities of a modern democratic state governed by the rule of law. Any violation or potential violation must be treated with great seriousness. 9

(i) The Human Rights Act became British Domestic Law on 2 October 2000. All public bodies are bound by these laws and should be implementing them. 10
(ii) The Coroners Court is a Public Body and is bound by these laws.
(iii) Section 6 of the HRA makes it unlawful for a public authority to act in a manner incompatible with a HRA . . . This is part of British Domestic Law. 11
(iv) The Right to Life is a substantive entitlement under the European Court of Human Rights. All citizens are entitled to an effective investigation into a sudden or unnatural death. The coroner is duty bound to conduct basic Jordan type investigations. 12
(v) Section 2 (Human Rights) requires any Court or Tribunal to determine the connection with a Convention Right which must be taken into account. It is also necessary for all Courts and signatory countries to take account of Strasbourg decisions. 13
(vi) All state institutions have a duty to disclose material in order to assist proper and effective examination of Article 2 issues. 14
(vii) “Public scrutiny” is all given great importance under the Convention as being a way of underpinning the positive obligation to protect the right to life. Following on the HRA key changes must inform the conduct of every inquest. 15
(viii) (iv) Section 3 of the HRA allows for active involvement in the investigation by the next of kin, should it be so desired by the family, respect for family life etc, enables the family respect for human dignity in the course of their grief. 16, 17, 18
5. VIOLATIONS OF THE LAW

Our experiences are that Coroners are in violation of the Human Rights Act even though it has been in force for five years. They are in breach of a number of United Nations Protocols and Strasbourg Decided Case Law, in particular Jordan v United Kingdom (2001 11BHRC 1) where the Government’s failure to disclose relevant information to the family coupled with the lack of legal aid for their representation was alleged to be a violation.

United Nations Protocols are binding law and they have been violated in the Coroners system which has far reaching effects on other State Departments.

When the Coroner denies his legal Right to call witnesses at home and from abroad he/she prevents full investigation into cause of death. An early primary decision is supposed to be made regarding investigation, post mortem/special examinations. This Law is disregarded.

According to HRA Section 6(3) The Coroner is a public servant paid by public funds and according to Human Rights Law and Strasbourg Case Law the Freedom of Information Act extends to him. However families are being misinformed and denied access to Coroners records.

Our evidence shows that the Coroner is in violation of Section 7 of HRA in which there is an explicit Right for a person to claim that a public authority has acted or proposes to act in a manner which is incompatible with a Convention Right and for that person to be enabled to challenge such a decision. At the moment all disputes about the Coroners actions are referred back to the Coroner or to the Police who in turn refer them back to the Coroner so in effect the family have no redress.

To engage in the Judicial Review system with coroners has been for many of us a process fraught with corruption and abuse. There are a number of cases known to us that substantiate this claim. The coroner repeatedly refused to open the inquest into the son of Christian Hurst stating that the issues had been raised at the criminal trial. Then the Coroner tainted the case by speaking about it with other coroners who would not then take it on. Legal action had to be taken to find a Coroner to re-open the Inquest. Three court cases ensued and the case went to the House of Lords. This cost a great deal and is still not resolved.

6. POST MORTEMS SITUATION/SPECIAL EXAMINATIONS

The body of the deceased is the most vital piece of evidence in respect of investigating cause of death. Of major concern is how unlawful post mortems are being conducted on a daily basis.

This issue was addressed in Strasbourg in Tanli v Turkey (ref 10. 4.2001 ) re: a post mortem. A deficient post mortem constitutes an abuse of power when the next of kin is denied effective action to establish the cause of death. A post mortem must be in accordance with Article 2. HRA . . . It is a violation of HRA Article 13 when a Coroner imposes a compulsory non forensic post mortem in cases of suspicious death. Other violations are Article 8 a Right to family life and grieving and Article 9 referring to religious and non invasive post mortems.

“We of the CSPAAG state that from our own experience gross violations continue to take place behind closed doors. Those who are charged with upholding the law are guilty of violating these laws on a regular basis.”

We wish to make clear that we do not object to postmortems if they follow the International and European guidelines of good practice. But we want to be sure that the cause of death is fully and fearlessly established.

Local authorities and the public are uninformed about what is meant by a post mortem. They assume that because it is compulsory and that it will be a full investigation into cause of death. They also assume that postmortem refers to specialized examinations to ascertain means of death. In practice this does not happen. There are a high number of illegal and sub-standard postmortems performed in mortuaries which are not equipped for forensic examination. There are no X-ray machines, scanners, testing equipment, microscopes, lighting, video or photographic recording to make proper examinations and there are no records kept.

95% of these routine postmortems are in violation of International Treaties and Protocols because they do not satisfy the conditions needed to conduct to an investigation that will fully establish the cause of death. They appear to be used to “rubber stamp” or confirm the cause that has already been established.

Why are there so many of these post mortems? There are stores of body parts throughout the country. We have no way of investigating and if there is no public accountability and no records kept, there is no way of feeling confident in a system that fails to disclose.
7. **Deaths abroad with examples**

   The families are placed in the most vulnerable position. Often they do not know the language, the customs or the laws of the foreign country. They do not get diplomatic support from the FCO who repeatedly state “we cannot interfere in the legal process of another country.” The bereaved are treated as individuals with “expectations to be managed” rather than British subjects with Human Rights to be protected.\(^{34,35}\)

   *(In the case of a sudden, unnatural and suspicious death here or abroad, the cause of death, the right to justice, the right to a fair hearing and the right to family life must be observed)*

   In two cases of suspicious deaths abroad there is evidence that there was no British investigation before the postmortem into the cause of death.\(^{36}\)

   The Coroner held an Inquest without having the full information needed to carry out such a hearing. He had no medical or dental records but he authorized a routine, not a forensic postmortem even though the body was the main evidence of the cause of death. He took no account of the foreign postmortem report or the foreign police photographs of the body and of the scene of the accident.

   The Coroner used his discretionary powers to prevent a full investigation by the police and the Foreign Office and he denied his power to request a further investigation from a foreign country. He merely worked with the verdict of the foreign police.

8. **The present situation**

   The Coroner seems to be without any supervision or outside control or accountability.\(^{37}\) He is bound by no rules or regulations as are other professionals such as doctors or solicitors, he has wide discretionary powers which cover many aspects of dealing with deaths. He directs the Police, the mortuary services and the FCO and what he says goes. If the families have complaints they may be told to go to the police who will not accept complaints against the Coroner. The police may advise the complainant to go to law but this is beyond the resources of many people while the Coroner can draw on limitless public funds and influences to defend himself. There are legal firms who will not take on such cases when it means confronting the Coroner. Even when the Coroner has been found at fault by the Courts he is not removed from his position. At the present time the Coroner seems to be above the law which inevitably leads to corruption, abuse of power, misconduct and injustice.\(^{38}\)

   It is a matter for concern that the Rt Hon Harriet Harman of the Constitutional Affairs Department continues to assert that the Coroner is and should be an independent Judicial Officer.

   Past actions of the FCO have in some cases served to block investigation in foreign States which could amount to “cover up” and complicity in possible crimes. Unfortunately the lack of supervision over the repatriation process which also is under the aegis of the Coroner, gives opportunities for international crime and abuse of power which can only grow if the FCO does not accept its responsibility to support the victims of crimes committed abroad.\(^{39}\)

   The problem of uninvestigated suspicious deaths abroad will result in all British subjects traveling abroad being placed in a vulnerable and dangerous situation.

   It is only a matter time before the lucrative international trade in body parts increases giving opportunities for acts of violence against Britons without redress. The lack of accountability at every level of the service leaves bereaved families at the mercy of unregulated funeral directors and other companies involved in the transport of bodies, placing insurmountable obstacles in their way when trying to get effective investigation.

   Citizens are left without access to legal advice, police assistance or diplomatic influence.\(^{40}\)

   It is a shameful fact that in one case a young man was murdered abroad and when his body came home his heart and other body parts were missing. Far from the British Coroner, the police or the FCO assisting the mother to find out where her son’s body parts were, they put many obstacles in the way of her finding the truth. Why did the Coroner use his discretion to withhold information that could have helped the mother to find out where the young man’s heart went? In other cases the families informed the Coroner about the dangers surrounding a suspicious death and yet the Coroner shut down necessary enquiries which is essential in order to prevent future possible threats to life.

   The failure of the Coroners system has taken a huge toil mental, physical and financial on the families, and our question is why has this widespread abuse of power and position escapes the notice of the Government?

9. **Proposals**

   (a) Reform failures

   — There is little or no understanding of the existing legislation and the Bill of Human Rights.

   — There is a lack of willingness to apply the law.
— Local Government officials need more training and support so that they can provide a service that takes account of the content of the Human Rights Act and relevant rules. This needs to be implemented in their duties in regard to the provision they finance and administer in relation to the Coroner Services.41

(b) Suggestions for Reform

— Coroners Reform Bill (CRB) must include the Human Right Law that already exists.
— CRB Must comply with European Protocols.
— Ensure that Coroners Statute and Rules are followed.42
— Solutions must be found to curb the discretionary powers of the Coroner.
— CRB must incorporate the European Council of Legal Medicine and the UN Minnesota Protocol on Autopsies.
— All citizens must have the right of effective investigations into sudden and unnatural death.
— The Human Tissue Commission and the Freedom of Information Commission, the Foreign Office and the Dept, of Constitutional Affairs must act in accordance with the Human Rights Act. They must cover the Coroners Services.
— All advisors working on new reforms or new codes of practice must be fully informed on international agreements and Human Rights law.
— The Department of Health should have direct supervisory powers over the Coroner’s postmortem services.
— There should be no more postmortems carried out in public mortuaries as these are in violation of the Coroners law.
— Regular inspections should take place to ensure all rules about removal and retrieval of body parts and tissues are followed.
— Forensic Pathologists should work as part of teams in the NHS Hospitals so that Coroners post mortems should have more recognition and be able to use up-to-date scanning and the Hospital facilities.
— The next of kin should be kept fully informed and involved in what transpires with respect of post mortem procedures. No body parts should be removed without full documentation and disclosure to the next of kin.
— The examination of the body is a crucial part of the Coroners investigation. Failure to carry out the guidelines must be met with immediate censure.
— No coroner’s postmortems should be performed unless as part of a necessary investigation into a suspicious death.
— The bereaved must be fully involved in all stages of the investigation process.
— Confidence can only be restored in the system if the post mortems are made fully publicly accountable, with inspections taking place regularly and unexpectedly.
— An immediate action plan must be put into place by the FCO—with full consultation with the relevant Victim Groups.
— The FCO method of “managing expectations” must be replaced with the imperative to protect and safeguard the Human Rights of the citizen.

It is with great anxiety and hope that we submit this document.

We hope that this document will assist in bringing about good practice.

Margaret Lockwood-Croft
Spokesperson
Bereaved Parents for the Coroners Services Public Accountability Action Group (CSPAAG)
Group affiliated to Marchioness Action Group

June 2006

Notes:

1 Articles

Article 1. The inter-relationship between article 2 and article 1 “to secure to everyone in the jurisdiction the rights and freedoms contained” within it.

Article 2: The right to life. This refers to a Free standing Right to conduct an investigation. There is a procedural obligation to investigate when there has been a violation of the right to life of the deceased and it falls upon the State to conduct an inquiry, whether the family instigated it or not (Jordan v UK Paragraph
105) The provision of active involvement in the investigation, is central to enable a family to grieve and facilitates the bereavement process where the human dignity of each of it members is valued. Thus Under article 2 read in conjunction with article 8 there is an obligation on the coroner to put the interest of private and family life in primary positions.

Article 8 The right and respect for private and family life; that includes grieving. The basic pre-requisite of any grieving process involves enabling the bereaved to be in possession of the full facts of the death.

Article 9 This refers to religious concerns and non-evasive mortems.

Article 10. The right to receive information.

Article 13 “Everyone whose rights and freedoms as set forth in this Convention are violated shall have an effective remedy before a national authority notwithstanding that this violation has been committed by persons acting in an official capacity.”

2 Coroners Rules

“Jervis on Coroners” paragraph 107

“The functions of an inquest on a dead body at the present day are really to determine certain facts about the deceased: identity, the cause of death, and the circumstances surrounding both death and that cause. 11th edition:

“The question of how the deceased came by his death is of course wider than merely finding the medical cause of death and it is therefore right and proper that the coroner should inquire into acts and omissions which are directly responsible for the death.”


4 The Case of Helen Smith
Div Ct Ref No DC/667/81

Lord Chief Justice Lord Lane in the case of HM Coroner For the Eastern District of The Metropolitan County of West Yorkshire v Ex parte Ronald Smith (Supreme Court of Justice Court of Appeal. 30 July 1982) concluded that if the Right to an effective investigation is left to the discretion of the Coroner then Section 3 of the HRA and UN protocol are violated.

Paragraph 1c13 reads “Deaths abroad. Where a death has occurred abroad and the body has been brought into England or Wales for disposal, the coroner for the district in which it is lying has jurisdiction . . If there seems to be good reason for inquiring into the death, such as suspicion of homicide, complaint by relatives or apparent failure to make full investigation, the coroner may assume jurisdiction.” Further refers to:

“ Where the relatives of the deceased were of opinion that his death had not been properly investigated abroad or where they had not been informed of the results of the investigated or the coroner was of the opinion that the cause of death should be investigated then the same procedure should be followed as if the death had taken place in this area.”

5 Home Office Circular No 79. 1983

Deaths Occurring Outside England and Wales.

1. Following the judgment of the Court of Appeal in the case of Helen Smith. The coroner’s contention upheld by the Divisional Court, was not confirmed by the Court of Appeal.

2. The Court of Appeal took the view that where a coroner is informed that a dead body is lying within his area, he must hold an inquest if the death is one which requires an inquest to be held under Section 3 of the Coroners Act 1887, even though the death occurred abroad.

6 McCann v UK

This case identified the inter-relationship of Article 2 and Article 1. Outlines that there should be an effective investigation when individuals have been killed as a result of force.

Paragraphs 200–201. The investigation must focus on the context in which the death took place. The circumstances in so far as they have a causal nexus to the death.

Streletz v Germany (2002) 33 ECHR 31 (paras 92–94) “it indicates that the right to life is an inalienable attribute of human beings and forms the supreme value in the hierarchy of human rights.”

Case of McKerr:

The obligation to hold an investigation is an obligation triggered by the occurrence of a violent death.

7 Disclosure of documents There was no requirement prior to 1999 for the families at inquests to receive copies of the written statements or documents submitted to the Coroner during the inquest. Coroners generally adopted the practice of disclosing the statements or documents during the inquest proceedings, as the relevant witness came forward to give evidence.

Following the recommendation of the Stephen Lawrence Inquiry, Home Office Circular No 20/99 (concerning deaths in custody or deaths resulting from the actions of a police officer in purported execution of his duty) advised Chief Constables of police forces in England and Wales to make arrangements in such cases for the pre-inquest disclosure of documentary evidence to interested parties. This was to “help provide reassurance to the family of the deceased and other interested persons that a full and open police investigation has been conducted, and that they and their legal representatives will not be disadvantaged at the inquest”. Such disclosure was recommended to take place 28 days before the inquest.

Note 6(3) refers to in cases of sudden occurrence of death a more comprehensive investigative scheme is essential.

International Association of Prosecutors Mutual Legal Assistance, Best Practice Series No 4 International Co-operation, Basic Guide to Prosecutors in obtaining Mutual Legal Assistance in Criminal Matters
http://www.iap.nl.com/mutual_legal_assistance_bps4.html

9 The Human Rights Act became part of British domestic law on 2 October 2000. This has implications for more extensive investigation of the circumstances of the death as the scope of the Inquest process needs to meet the obligations of the Act and the Convention.
Section 2 (Human Rights) requires that any Court or tribunal determines the connection with a convention right must take into account inter alia judgment/decisions/advisory decisions of the Advisory opinions of the Court of Human Rights. This requires Courts to take account of Strasbourg decisions regardless of the identity of the respondent state.
When a coroner was conducting an inquest in to a death which occurred before the Human Rights Act 1998 came into force the test to be applied to the question of “how . . . the deceased came by his death within s 11(5)(b)(ii) of the Coroners Act 1988 was the narrower test of “by what means” but after 2000 it is rather the broader test of “by what means” and “in what circumstances” applicable to deaths after 2 October 2000 to comply with art 2 HRA . . .
Section 3 (Human Rights Act) states as far as it is possible to do so primary legislation and subordinate legislation must be read and given affect in a way that is compatible with the Convention rights.

The Coroner Services are paid for by Local Authorities. The pathologists instructed by the Coroner do so as private contractors.
This document offers guidance to local authorities: “Public authorities should also consider the broader legal framework applicable to support them in meeting requirements under the HRA.
“Specifications could require suppliers to perform certain tasks as part of the delivery of relevant parts of service to ensure that relevant human rights considerations have been taken into consideration.”
Issue: “Where a provider that is not a public authority provides a service to the public under contract to a public authority, that service needs to be provided in a way that takes account of the content of the Human Rights Act 1998 (“the HRA”) relevant to that contract. Providing a service in the manner indicated above will assist in the provision of an optimized service. Not to do so may expose the public authority to legal liability and, furthermore, may infringe the legal rights of service users.”
This document outlines an approach based on contract specifications. In this way the public authority should detail in the specification the activities which id considers will be required to be performed by the supplier. This provides transparency as to the way in which the public authority has sought to secure the discharge of the HRA obligations it has. Flowing from this, it assists the public authority in monitoring and enforcement of those obligations (and auditing bodies similarly).

11 Section 6 (3) The Human Rights Act 1998 defines public authority as including a court, or tribunal and any other persons whose function are of a public nature. The coroner is therefore a public authority. Coroners themselves are public authorities for the purpose of section 6.1 of the Human Rights Act 1998 and are therefore now required under domestic law not to act in a way which is not incompatible with a convention right subject to section 6.2.

In the case of Jordan v UK it is clear that the right to an effective investigation is a substantive entitlement under the ECHR. The absence of an effective investigation constitutes a violation of Article 2. Moreover this entitlement to an effective investigation is not limited to death that occurs as a result of the use of force by agents of the State. The minimum requirement in Strasbourg terms is that the inquiry must have “taken the reasonable steps” to secure the evidence concerning the incident, including inter alia eye witness testimony, forensic evidence and where appropriate, an autopsy which provides a complete and accurate record of injury and an objective analysis of clinical findings, including cause of death*. paragraph 107.
Extract:
1. General principles The decision to conduct an effective investigation cannot be left to the initiative of the next of kin either to lodge a formal complaint or to take responsibility for the conduct of any investigative procedures (see, for example, mutuais mutandis. Ilhan v Turkey [GC] no 22277/93, ECHR 2000-VII, § 65).*
2. For the same reasons, there must be a sufficient element of public scrutiny of the investigation or its results to secure accountability in practice as well as in theory.
So called Jordan criteria are that the investigation must be (1) prompt, (2) independent and impartial, (3) effective, (4) public and (5) sufficiently inclusive of the next of kin in order to protect the interests of the deceased.
Thus no (5) gives emphasis to the importance to the obligation that the next of kin must be involved in the investigation procedures to the extent necessary to safeguard his or her legitimate interest.
“Involvement of the next of kin” in an investigation will generally raise the quality of “public scrutiny” because the next of kin by virtue of their interest in the true fate of the deceased will be more exacting in their analysis of “official versions” (see Glu¨leç v Turkey, cited above, p 1733, § 82, where the father of the victim was not informed of the decisions not to prosecute; Ö¨gˇur v Turkey, cited above, § 92, where the family of the victim had no access to the investigation and court documents; G¨ul v Turkey judgment, cited above, § 93).”

Although the rights of the family are not explicitly referred to in the text of Article 2, respect for private and family life (article 8) and the right to receive information (article 10) must fall within this aspect of the Jordan criteria.

13 The Amin, Khan and Middleton cases recognises that the coroner is the key public authority responsible for fulfilling the States obligation to carry out an effective investigation into a possible violation of the right of life.

14 Witnesses and Disclosure of Documents. All state institutions have a duty to disclose material in order to assist “a proper and effective examination” of Article 2 issues. Gaskin v UK (1990) 12 EHR 36 Paragraph 36 recently applied in MG v UK 2002: This relates to the distress and anguish suffered as a result of how the authorities behaved in reaction to her enquiries. There is an interrelationship between human dignity and the right to private and family life. The Court recognises a right to be assisted in the grieving process, through access to information.

Case of Edwards
Court found that the inquiry was inadequate for two reasons: First by failing to compel the attendance of key witnesses and secondly by failing to hold the inquiry in public where the family could enjoy effective access and cross-examine witnesses. (Paragraph 83804)
The public's safety was breached because they could not receive information when the proceedings remained private. If life is in danger the evidence can be given behind screens or anonymously.

15 There must be a sufficient element of public scrutiny of the investigation or its results to secure accountability in practice. In all cases the next of kin must be involved.

Case of Jamieson R v HM Coroner for North Humberside and Scunthorpe, ex Parte Jamieson (1995) OB1. (Pg 26B) The need for full, fair and fearless investigation and the exposure of relevant facts to public scrutiny.

“it is the duty of the Coroner as the public official responsible for the conduct of inquest . . . to ensure that the relevant facts are fully, fairly and fearlessly investigated . . . He must ensure that the relevant facts are exposed to public scrutiny, particularly if there is evidence of foul play, abuse or inhumanity. He fails in his duty if his investigation is superficial, slipshod or perfunctory. But the responsibility is his.”

16 R (Middleton) V West Somerset Coroner and (Sacker) v West Yorkshire Coroner (both February 2004) make clear that Article 2 ECHR requires that an inquest jury should be permitted to issue conclusions on the surrounding facts of a case. The word “how” in section 11(5)(ii) of the 1988 Act and rule 36(1)(b) of the 1984 Rules is open to the interpretation that it means not simply “by what means” and in what circumstances.” The provisions of section 3 of the Human Rights Act 1998 indicate that it should now be given the broader meaning.

17 Involvement of the Next of Kin:
A number of other cases relate to how the investigation must allow the family to have effective access to the investigation process in order to safeguard their interest: Case of Jordan v UK (2001), Assenov v Bulgaria 28 EHR 652 Paragraph 117; Aydin v Turkey 25 EHR 251 Paragraph 103; Ergi v Turkey, judgment of 28 July 998 Paragraph 96; Rv DPP ex p Manning and Melbourne (2000) 3 WLR 463; R (Weight and

18 Abuse of power by authorities. The investigation must allow the next of kin to have effective access to the investigation and the p/m process. See cases: Assenov v Bulgaria 28 EHR 652 parap 117
Aydin v Turkey 25 EHR 251 Paragraph 103
Amin and Middleton v SSHD (2002) 2 WLR 505

19 Review of Coroners: Consultation Document. 2002. RCGP Summary Paper. Royal College of General Practitioners. This review is independent of the Gvt Financed by the Home Office and the North Ireland Courts. Three further surveys have been carried out.

(D) Critical Defects:
Fragmentation: The certification and investigatory processes focus on individual deaths and will therefore overlook trends and patterns. The certification process is separate from the coronial process and therefore the coroner has no responsibility towards deaths not reported to him. No public authority is responsible for policing the certification process or for checking that deaths, which should be investigated further, are appropriately referred.

Public participation: the bereaved are excluded from the certification process and are under-informed about post mortem processes and inquests.

Minority Groups: There is a lack of a reliable response to traditions for disposal of the dead in minority communities.

Certification: Medical skills to support and audit the death certification process are inadequate.

Quality: Inadequate quality assurance and professional support processes.
Legal Base: There is a lack of clear modern legal base, and of mechanisms to monitor the effectiveness of the services and help them adapt to future change without infringing professional and judicial independence.

Recommendations:
The aim is the review is to make recommendation that will create efficient death certification and investigation services; meet public safety, health and confidence requirements; to ensure information on preventable deaths is available and effective and to respect individual, Community and family wishes, as well as encouraging their participation in certifying and investigating deaths. These new structures must be suitably staffed to deal with medical, legal and judicial responsibilities; have full independence and proper accountability; And, work to known and auditable standards.

20 The United Nations Prevention and Investigation of Extra-Legal, Arbitrary and Summary Executions adopted on 24 May 1989 by the Economic and Social Council Resolution 1989/65, (UN Principles on Extra-Legal Executions) provides, inter alia, that: “There shall be a thorough, prompt and impartial investigation of all suspected cases of extra legal, arbitrary and summary executions, including cases where complaints by relatives or other reliable reports suggest unnatural death in the above circumstances . . .” Paragraphs 10 to 17 of the UN Principles on Extra-Legal Executions contain a series of detailed requirements that should be observed by investigative procedures into such deaths. Paragraph 10 states, inter alia:
“The investigative authority shall have the power to obtain all the information necessary to the inquiry. Those persons conducting the inquiry . . . shall also have the authority to oblige officials allegedly involved in any such executions to appear and testify . . .” Paragraph 11 specifies:
“In cases in which the established investigative procedures are inadequate because of a lack of expertise or impartiality, because of the importance of the matter or because of the apparent existence of a pattern of abuse, and in cases where there are complaints from the family of the victim about these inadequacies or other substantial reasons, Governments shall pursue investigations through an independent commission of inquiry or similar procedure. Members of such a commission shall be chosen for their recognised impartiality, competence and independence as individuals. In particular, they shall be independent of any institution, agency or person that may be the subject of the inquiry. The commission shall have the authority to obtain all information necessary to the inquiry and shall conduct the inquiry as provided in these principles.” Paragraph 16 provides, inter alia:
“Families of the deceased and their legal representatives shall be informed of, and have access to, any hearing as well as all information relevant to the investigation and shall be entitled to present other evidence . . .”

21 Finucane vs United Kingdom Strasbourg Case Final 01/10/2003 Addresses the issue how the inquest is a fact finding exercise and that where there has been a violation of the right to life then there must be a prompt and effective investigation into circumstances. The Court held unanimously that there had been a violation of Article 2 of the Convention as there had been collusion of the security forces with the person’s killers.

22 Case of Kathleen Mary Neal. Section 13 application. High Court of Justice. Recommendations from the Coroners Society 17 November 1995 Coroners give misleading information when they state that they have no powers to summon witnesses from about because case law states otherwise.

“. . . the broad purpose of an inquiry is to discover the truth about the events leading to the suspicious death of a victim. To fulfill that purpose, those conducting the inquiry shall, at a minimum, seek:
(a) to identify the victim;
(b) to recover and preserve evidentiary material related to the death to aid in any potential prosecution of those responsible;
(c) to identify possible witnesses and obtain statements from them concerning the death;
(d) to determine the cause, manner, location and time of death, as well as any pattern or practice that may have brought about the death;
(e) to distinguish between natural death, accidental death, suicide and homicide;
(f) to identify and apprehend the person(s) involved in the death;
(g) to bring the suspected perpetrator(s) before a competent court established by law.”
In section D, it is stated that “In cases where government involvement is suspected, an objective and impartial investigation may not be possible unless a special commission of inquiry is established . . .”:
(a) in defense 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."

24 Rule 20.2
Statements of witnesses can only be admitted if that person cannot attend and there is no objection. If the there is an objection then the coroner has a duty to ensure what arrangements can be made to enable the defendant to cross examine whoever made that statement. If not then that evidence is not admissible. Coroners Rules 1984 rule 22. At the moment coroners warn witnesses that they need not answer questions that would cause them to incriminate themselves.

25 Tanli v Turkey 26129/95 Breach of article 2 as the post mortem was defective, inadequate and failed to provide explanation for cause of death. Given the inadequacy of the post mortem examinations, the Court found that the applicant had been denied an effective remedy The failures to carry out an effective forensic investigation related to:
No records of marks, injuries on the body. No medical substantiation concerning how injuries sustained. This case shows that there is a duty to carry out a specialist postmortem to ascertain precisely how a death occurred. Also add here Article 13
The Court found given the inadequacy of the p/m that the applicant had been denied the right to a full investigation and as a result the family had been denied an effective remedy.


27 Case of Regina v Kelly. 14 May 1998, The appellants were convicted of Theft (Theft Act 1968) of body parts from the Royal College of Surgeons contrary to section 1 of the Theft Act 1968. The judge ruled, in favour of the Crown, that the specimens were property.


29 European Council of Legal Medicine—ECLM. 1994–95
Harmonization of the Performance of the Medico-Legal Autopsy.
Includes:
Identification of the deceased has to be checked carefully and documented. Circumstantial factors such as clothing, etc should be a basic and regular component of the procedure as well as inspection of the scene of the crime and the distribution of biological stains given extreme importance. Guidance is stated for examination of clothing and description of the corpse. In the cases where there is either nil or minimal findings to explain the occurrence of a sudden death then much more comprehensive investigative scheme is essential.
There should be a thorough documentation of external and internal examinations, previous history, police report, scene findings, evaluation of all relevant findings including autopsy diagnosis and cause of death. Matters http://www.iap.nl.com/mutual_legal_assistance_bps4.html

30 Tanli v Turkey 26129/95 Breach of article 2 as the post mortem was defective, inadequate and failed to provide explanation for cause of death. Given the inadequacy of the post mortem examinations, the Court found that the applicant had been denied an effective remedy The failures to carry out an effective forensic investigation related to:
No records of marks, injuries on the body. No medical substantiation concerning how injuries sustained. This case shows that there is a duty to carry out a specialist postmortem to ascertain precisely how a death occurred. Also add here Article 13.
The Court found given the inadequacy of the p/m that the applicant had been denied the right to a full investigation and as a result the family had been denied an effective remedy.

31 The full report will study the implications to be drawn from the 30% or more error rates in death certification causes of death that have been found in various studies comparing them with findings after post-mortem examinations.

32 Human Tissue Acts
It is a criminal offence to take body parts without consent and falls under the theft Act 1968.

33 Schedule 2, rule 10
A coroner has a duty to state on the post mortem form where and what time and what place the death happened.
A coroner must in writing instruct a pathologist namely the pathologist and what he requires of him. Where the causes of a death which is sudden and unnatural are unknown a coroner cannot use his discretion not to comply with s 19 and 20 and order a basic or “routine post mortem” It is a mandatory requirement that any body parts tissue or blood taken must be specified and parents consulted.

“There are however, various circumstances where the British Police Service may become involved either in an investigative capacity or by assisting an English or Welsh Coroner.
Death Abroad can come to the attention of the Police Service in a number of ways, some examples are:
On direction of the Coroner
ON return of a body/bodies to this country:
Dissatisfaction of a family in the investigation by the appropriate country
Where there has been no investigation
And more.

35 HM Coroner For Surrey. 2004 Openings of the Inquests into the deaths of Diana, Princess of Wales and of Dodi Al Fayed.
Deaths Abroad—The law is clear; when a death occurs outside England and Wales, a coroner will become involved if the body is brought into his district and he “... has reason to suspect that the deceased has died a violent or unnatural death, [or] has died a sudden death of which the cause is unknown” (Coroner’s Act S)
The Inquest process
36 Two known recent cases of Illegal Post Mortem. Violation of Family Life . . . If a death is unnatural and sudden then the post-mortem must be a specialist forensic post mortem and must only be carried out if it will reveal further information about the cause of death. The coroner has a legal obligation to conduct a forensic post mortem to ascertain cause of death for which consent by the next of kin is not required. In the two cases reported to us it can be shown that the Coroner breached the law because only a basic post mortem was conducted and that in this form it was not able to sufficiently examine and show the cause of death. Such a basic p/m reveals nothing about the cause of death and it becomes solely a serious breach of human rights. These two families consider this form of P/m a mutilation of the body and an infliction of huge upset to the family’s rights that are then violated.
The fact that in both these cases the Mortuary staff “prepared the body” This refers to cutting up the body and many other work concerning removal of body parts and this took place prior to the arrival of the Medical Officer. This is a serious offence to mishandle a dead body and does not meet the legal requirements.

37 Independent and Impartiality regarded as necessary under the Act.
Ergi v Turkey, July 1998 paras 83–84
R Wright and Bennett v SSHD (2002) HRLR 1 at paragraph 60(2) coroner made a decision to rely solely on evidence of chief medical officer of the prison in which the death occurred without recourse to further independent expertise, did amount not amount to sufficiently independent inquiry.
R (Nicholls) b HM Coroner for Liverpool (2001) EWHC 922 refusal of Coroner to call other medical witnesses.

Non State Agents
Entitlement is not limited to death that occurs as a result of the use of direct force by only agents of the state.
Non state agents admissibility: See the following cases:
McShane v UK (2002) 34 EHRR
Keenan v UK (2001) 33 EHRR
Edwards v UK (2002) 35 EHRR
A number of admissibility decisions recognise the procedural right to a public investigation extends to potential negligence cases in public hospitals:
Erikson v Italy, App No 37900/97
Siemiska v Poland 37602/97
Velasquez Rodriguez v Honduras in the Inter America Court.
This is still a citable case despite being from a different jurisdiction which puts a responsibility to investigate in the case of non state agents involvement.
38 Case of O Reilly.
If an enquiry leaves too many questions unanswered, and does no allay rumours and fears of the Bereaved, then it is not a sufficient enquiry.

THIRD SECTION CASE OF SHANAGHAN v THE UNITED KINGDOM
(Application no 37715/97)
JUDGMENT STRASBOURG 4 May 2001 Final 04/08/2001
The European Court of Human Rights (Third Section Conclusions: No prompt or effective investigation into the allegations of collusion in the death of Patrick Shanaghan has been shown. It is a violation where there was a lack of independence of the police officers investigating the incident from the security force personnel alleged to have been implicated in collusion with the loyalist paramilitaries who carried out the shooting:
Case of Finucane v UK. Strasbourg Case 29178/95
Ex territorial powers—extra-territorial
The authorities must carry out an effective investigation and not leave the initiative to the next of kin to investigate or lodge complaints. Any deficiency in the investigation which undermines its ability to establish the cause of death or the person or persons responsible will risk falling foul of this standard.
Those carrying out the investigations must be independent from those implicated in the events. Fell short of the requirements of Article 2 because it did not provide an investigation into the incident or a means of identifying or leading to the prosecution of those responsible. Not prompt. Failure to comply with the procedural obligation imposed by Article 2 of the Convention.
The authorities must have taken the reasonable steps available to them to secure the evidence concerning the incident, including, inter alia eyewitness testimony, forensic evidence and where appropriate, an autopsy which provides a complete and accurate record of injury and an objective analysis of clinical findings, including the cause of death.
A requirement of promptness and reasonable expedition is implicit in this context.

39 Application/Requete No 7547/76 X v / The United Kingdom
From the constant cases of the jurisprudence of the Commission that authorized agents of a State, including diplomatic or consular agents bring other persons or property within the jurisdiction of the State to the extent that they affect such persons or property by their acts or omissions, the responsibility of the State is engaged (also Cyprus v Turkey 1611/62) for the purposes of the European Convention of Human Rights.

40 Home Office Circular No 43/1999
Access to Justice Act 1999

41 Death Certification. Public Health Issues
“Article 2 imposes three obligations upon the State. First, the State is under a negative duty not intentionally to deprive a person of his/her life, save in the limited circumstances outlined in Article 2(2) Second the State is under a positive duty to take reasonable steps to safeguard the lives of individuals, especially in circumstances where there is a known real and immediate risk to their lives. Third the State has a procedural duty to investigate a death where it is arguable that either the negative or the positive duty to protect life has been breached. It is the procedural obligation that principally interest the Review Team.
The fact that Article 2 imposes such a free standing obligation has been the subject of clear and unequivocal ruling of the European Court in the last six years.
Three results come from the procedural obligation to identify how the death was caused: (1) The inquiry may enable the examination of evidence that would assist in the possible initiation of criminal or civil proceedings. (2) The inquiry may enable the family to understand the fate of the deceased and assist them in the grieving process. (3) Help to prevent similar fatalities.

42 11th edition of Jervis on Coroners states: “The question of how the deceased came by his death is of course wider than merely finding the principal cause of death, and it is therefore right and proper that the coroner should inquire into acts and omissions which are directly responsible for the death.”

Evidence submitted by Mrs L H Lewy, Rigorous Analysis of Iatrogenic Death (RAID)

The undersigned was greatly perturbed to hear Dame Janet Smith’s remarks on the subject of compulsory post mortem examinations of all persons dying less than 24 hours after admission to hospital.

Were such post mortems to be carefully and conscientiously performed by highly qualified Pathologists there would be little or no objection except possibly for Religious reasons.

But as is generally known and accepted in Mortuaries out of sight of the bereaved public, these are carried out by Mortuary Attendants (or, as they are now called, Assistant Pathology Technicians) whose professional organisation has a website, but does not reply to questions The ensuing “Report”—although the body has NOT been examined either according to Medical or Forensic criteria—may be (and frequently is) signed by a Pathologist who may never have come within touching distance of the Deceased.

Where such a “Report” purports to state that Death was due to Natural Causes, the Family is adamantly denied a proper Inquest.

It is a matter of great concern that only a very few of the recommendations made in the Wassermann and Brodrick Reports have ever been put into practice.

1. CORONERS HAVE POWERS WHICH THEY EXERCISE WITH IMPUNITY

1.1 No one calls coroners to account or scrutinises their behaviour. In many cases Coroners breach the Human Rights of both the Deceased and the Next of Kin, yet their decisions can only be challenged (usually without success) in the High Court at enormous and disproportionate expense to the bereaved Families.

1.2 They have the power to seize the bodies of deceased people whether the body is lying or has arrived in the area over which they exercise “jurisdiction.”

1.3 They have the power to order post mortems to be performed by mortuary attendants, and the power to accept the ensuing reports even when signed by unqualified and even disqualified “experts.”

1.4 They have the power to make arbitrary decisions, eg “natural causes” or “accidental death,” which are often contrary to the experience and knowledge of the Next of Kin, and the power to refuse to hold an Inquest when requested.
2. **POWER WITHOUT RESPONSIBILITY**

2.1 Coroners proclaim themselves to be entirely “independent.” In fact they are local authority employees in everything but name.

2.2 The erstwhile Lord Chancellor’s Department never exercised any jurisdiction over unsatisfactory coroners; the Coroners Unit at the Home Office issues occasional Circulars to Coroners but does not intervene in disputes between Coroners and Families.

2.3 The “Luce Review” some years ago made recommendations proposing various reforms. Not one of them has yet been effectively implemented.

2.4 Another body under the aegis of the Dept for Constitutional Affairs is currently reviewing Coroners again, apparently intending to draft a Bill which may eventually result in a new Coroners’ Act (the current one being dated 1988).

3. **WHO PAYS FOR ALL THIS?**

3.1 Anyone asking about this will be given only conflicting and inaccurate answers: The answer is the Law-Abiding Citizen and Council-tax Payer, that is, all of us!

3.2 Until very recently, no one fully appreciated that local Authorities (Borough or Council) pay all the Coroners’ bills, and moreover pay them on request/demand: they are not examined for justification, value-for-money or anything else.

3.3 One local authority’s own Auditor told a member of the public that such auditors “never looked at any figure below a million pounds.”

3.4 The District Auditor who was appointed by the Audit Commission to Certify another Borough’s accounts informed a member of the public that the District Auditor is willing to respond to “How Much?” type questions, but not to “Why?”: he did not even mention “To Whom?”

Many people will consider that these questions must ALL be asked, and asked EVERY TIME a single cheque is issued for even the most trivial amount.

4. **PROBLEMS WITH CORONERS’ OFFICERS**

These individuals very often represent the recently-bereaved Family’s first contact with the Coronial system.

4.1 They are usually untrained and inexperienced and ignorant not only of their duties but of the Human Rights of the Deceased and of the Next of Kin.

4.2 The undersigned has had a prolonged but unsatisfactory and inconclusive correspondence with the Judicial Studies Board on this subject and will submit documentation on the questions that have been repeatedly raised, and raised in vain, by the undersigned.

*Mrs L H Lewy*  
*February 2006*

**Evidence submitted by Margaret Lockwood Croft, Chair, Marchioness Action Group (MAG)**

**BACKGROUND INFORMATION**

The Marchioness Action Group over the past seventeen years with the support of others has campaigned to change attitudes procedures and where necessary law for improvements in how the suddenly bereaved are dealt with.

Achieved through this campaigning an Inquest three Inquiries relevant to the Marchioness Disaster and the River Thames Rescue Service which we continue to support annually by fund raising. We continue to monitor river safety. These reports are often quoted from for training seminars.

1. The Hayes Report.


The edict behaviour of the present Coroners system causes disenfranchisement of the bereaved next of kin who are subjected to unreasonable burdens and in some cases abuse in addition to the loss of a loved one.
The system in place consist of arcane procedures unfair rules is inadequate investigating sudden and controversial deaths which is presided over by Coroners with "wide discretionary powers" and "with juries that are hand picked". It is not consider a viable humane cost effective service to the community for the 21st century.

There is no pre-training or exams for the post. No accountability.

No formal set terms of employment. No accountability.

No formal procedures for complaint or dismissal. No accountability.

No formal body scrutinising costs of the Coroner service accounts which are paid by the local rate payers. No accountability. Inadequate Mortuaries with out the necessary modern day equipment or record systems or pre-trained staff to manage them and with no formal body to inspect them. No accountability.

There is no independent formal oversight body checking the Coroners System and failure to comply with Coroners Law, Human Tissue Law, Other British Law, Human Rights Law, European Laws United Nation Laws and protocols. No accountability.

Coroners who have failed to comply with existing laws or have abused the bereaved in one form or another even after written complaints and evidence sent to the Lord Chancellors Department are not being dismissed and continue the same bad practices. No accountability.

No individual statistical records of how often annually Coroners are judicially taken to court by the Bereaved!! No records of costs to local bodies that pay for the Coroners legal representation No record of what such action costs the bereaved emotionally physically and financially. No accountability.

RECOMMENDATIONS FOR CASC CONSIDERATION

One of the recommendations adopted from the Marchioness NSI was that the Coroners System should be reviewed. The committee Chaired by Mr Luce comprised of people with out any knowledge or experience of the Coroners system. Interviews were conducted on a voluntary bases only and written submissions. The remit for the review was limited. The bereaved had no representative invited to be a member of the committee. Although the report was a positive step forward in highlighting some of the many failings of the current system.

There has been no formal proper in-depth research with structured varying questionnaire papers covering each of the agencies that would be involved with sudden death. No compulsory interviews of all Coroners, Deputy Coroners, or Coroners Officers covering the whole of the service. This also includes police, pathologists who carry out the post mortems, mortuary technicians/managers, funeral director’s FCO and the enforced unwilling user of the service the Bereaved. No investigation or collection of evidence covering the different types of sudden death for example—Road Deaths, Murders, Disaster Deaths, Suicides, Deaths at Home Deaths in Education, Deaths at Work, Deaths in Hospital, Deaths in Custody/Prison, Deaths Abroad, were they satisfied with the Coroners Service. No research on how often and which Coroners have had legal action taken against them and what each case cost the local rate payers. No research into the costs of maintaining a Coroner by each authority.

To have more reforms or amendments to the existing service would not eliminate the problems that prevail.

It is urged that a completely New Statutory Code of Practice for Sudden Death be devised and that the existing Coroners System be disbanded.

Taking in to account time element practicalities and cost perhaps at this time Judges with specialist training in dealing with the bereaved needs and who have had a psychological screening to determine suitability for the post should preside over Sudden Deaths.

They have the experience of the main stream judicial system an court procedures and would be able if the evidence presented showed a need for further action pass the case onto the next legal avenue or court list.

Consideration could be given that the specially trained Judges could preside over the whole saving time and cost. This would provide continuity for the bereaved lessen the additional heavy burdens inflicted on them by this present erroneous Coroners system.

Brining Sudden Deaths into the main stream judicial system would allow those not in a position to pay for legal representation to apply for full legal aid. They would have the right to see evidence witness statements and have relevant witnesses called which the Coroners system denies them.

The Judge would need to have support with in the court by having specially trained clerks to over see the necessary documents and make sure the bereaved have received the right information leaflets on their rights well before court proceedings (although this should have been carried out by the person who informed them of the death perhaps a trained police FLO) but this would depend on the circumstances, time, place or type of Sudden Death. Note: FLO’s are not deployed to all Sudden Deaths. Mainly Road Deaths, Murders, and Disaster Deaths. Note: not all of the 43 police services have trained FLO’s. The training across the country and resources are different, including there special codes.
Investigation of sudden deaths should be carried out by the Police with a trained police FLO to support and guide the bereaved family through the different processes of the proceedings. The police should hold an open honest non judgemental investigation and keep the next of kin family fully informed at every stage of the proceedings. In an appropriate partnership with the deceased’s family, with respect of religious/social beliefs.

Post Mortems should not be gratuitously granted but should only take place if the cause of death is in doubt (ref: Marchioness victims drowning) after identity has been established and the next of kin notified. Post mortems should only be carried out at a hospital or specialist unit with modern equipment (example MRI scans) reducing the need for invasive procedures.

Only one post mortem should occur with each relevant party being represented by there own medical examiner.

“Ownership” of the deceased should reside with next of kin family not the court/state. The need and requirement of establishing cause of death can be adhered to without encroaching on the desires or wishes of the deceased next of kin family.

To ensure uniformity of implementation in England, Wales and Northern Ireland, Statutory Codes of Practice and Designated Oversight should be established for 1. Identification Procedures. 2. Post Mortem Procedures. 3. Special Examinations Procedures. 4. Mortuary Procedures. 5. Police Procedures. 6. Coroner/Judge Procedures. Note: since these activities are not done in isolation in any Sudden Death there should be only one oversight body. All practitioners involved with Sudden Deaths must have compulsory pre-training for the post and to ensure accountability all need to have full terms of reference for the appointment of employment including complaints and dismissal procedures. Aiming for a humane “seamless service”.

It is recommended that CASC co-opt two or three bereaved who have experienced personally the whole Coroner System and who also have experience of the judicial review system of a Coroner.

This is a very short position paper that does not or is intended to cover in depth all the required aspects that need to be studied and debated. My continued concerns are for the bereaved as annually I am contacted by other organisations and individuals requesting assistance information because the Coroners service has failed to apply its self to the needs and rights of the bereaved.

Margaret Lockwood Croft
Chair
Marchioness Action Group
June 2006

Evidence submitted by the Independent Police Complaints Commission (IPCC)

SUMMARY

(1) Where a death follows contact with the police and there is reason to believe that the contact may have caused or contributed to the death, the IPCC is responsible for ensuring the death is properly investigated (either by itself or by the police). It takes the place of the police at inquests where the IPCC has conducted the investigation itself or managed the investigation by the police.

(2) The IPCC also has a duty to advise on changes needed to police practice in the light of its experience.

(3) It would help the IPCC in performing these functions to have the right to play a part in inquests where the IPCC has carried out or instigated an independent or managed investigation.

(4) Where the IPCC has carried out the investigation into the death in question coroners need to be sufficiently resourced to undertake responsibility for provision of documents to properly interested persons and storage of documents and exhibits.

(5) Coroners should have the same right as a relevant judge to order disclosure to themselves of intercept material.

INTRODUCTION

1. This submission outlines the role and responsibilities of the Independent Police Complaints Commission (IPCC) in relation to deaths and highlights areas where changes to the existing coroners system would assist the IPPC in performing its functions.

2. The IPCC was established under Part 2 of the Police Reform Act 2002 with a broad remit in relation to police misconduct and complaints about the police. It has a general duty to secure, and maintain public confidence in, the proper handling of complaints about the police and, in doing so, to contribute to increasing confidence in policing as a whole.
3. More specifically, its functions include investigating certain conduct matters of a serious nature. Any death following some form of direct or indirect contact with the police where there is reason to believe that the contact may have caused or contributed to the death must be referred to the IPCC, regardless of whether there has been a complaint.

4. The IPCC must then determine how the death is to be investigated. An investigation may be independent (conducted by the IPCC itself), managed (conducted by the same or a different police force but managed by the IPCC), supervised (conducted by the same or a different police force but supervised by the IPCC) or conducted by the police force itself.

5. Where an investigation into a death is conducted or instigated by the IPCC, the coroner will normally adjourn the inquest until the investigation has been completed. If the IPCC concludes as a result of the investigation that anyone serving with the police may have committed a criminal offence, it will refer the matter to the Crown Prosecution Service. The IPCC also has the power to recommend, and ultimately direct, that disciplinary proceedings be undertaken.

6. Where the investigation is carried out by the IPCC independently, or conducted by the police but managed by the IPCC, the IPCC in effect replaces the police as the body charged with investigating the death for the benefit of the coroner. Consequently, at the inquest it performs the function which would otherwise be undertaken by the police.

7. Since assuming this responsibility, the IPCC has developed a good working relationship with coroners. On specific inquests and more generally through the medium of the Coroners Society the IPCC collaborates with coroners and consults and assists where necessary. The IPCC and the Coroners Society have recently agreed a Memorandum of Understanding that covers issues of common concern.

8. The IPCC also has a wider responsibility to recommend and advise on changes needed, in the light of its experience, to police practice and to the arrangements for handling and investigating complaints and conduct matters. It is a prime function of the IPCC’s broad guardianship role in respect of complaints to identify and spread best practice and ensure the appropriate lessons are learnt at both a national and local level when mistakes are made.

9. The IPCC is developing considerable expertise into deaths following contact with the police. This is particularly the case in respect of fatal shootings, where the IPCC as a matter of course carries out the investigation itself. Since the IPCC started on 1 April 2004 there have been eight fatal shootings and through its investigations the IPCC is accumulating a body of advice as to the policies and practices to be followed by the police that can be of relevance in inquests.

10. The IPCC welcomes the changes proposed in the Briefing Note on Coroners Service Reform recently issued by the Department of Constitutional Affairs and anticipates that they will lead to a significant improvement in the service.

PROPERLY INTERESTED PERSON

11. There are occasions when the IPCC needs an opportunity to examine witnesses at an inquest. For example:
   — The IPCC, through its developing expertise, can assist coroners to satisfy their obligation under Article 2 of the European Convention on Human Rights to investigate effectively where a death has occurred from contact with state employees.
   — The IPCC as the investigating body may need to be able to question witnesses in order to deal with issues that have arisen in the course of questioning by others.
   — IPCC involvement can provide the necessary balance in the context of proceedings that are adversarial in nature, particularly where the family does not have legal representation.
   — Where procedures and policies followed by the police are at issue, the IPCC can use its questioning to ensure that the lessons learnt during its investigation are being applied and any recommendations implemented. In this way, the IPCC can assist the Coroner in identifying where action should be taken by the Coroner under rule 43 of the Coroners Rules in order to prevent similar fatalities.

12. Even in cases of death following contact with the police where the IPCC rather than the police is responsible for the investigation into the death, the IPCC has no automatic right to play a part in the inquest. Rule 20(2)(a) to (g) of the Coroners Rules lists those who have; others can only do so if they are, in the opinion of the coroner, properly interested persons. The chief officer of police is included in the list at Rule 20(2)(g) and thus has an automatic right to be a party to the inquest, whereas the IPCC is dependent on the coroner taking the view that it is a properly interested person. Where the IPCC performs the function of the police at inquests, the IPCC needs to have the same right. This would also assist the IPCC to make a valuable contribution on lessons to be learnt.

13. The IPCC submits that it would be appropriate to change the Coroners Rules to provide that, where the IPCC has conducted or managed an investigation, the IPCC has an automatic right to play this part in the inquest.
APPOMTMENT OF JUDGES

14. Death Certification and Investigation in England, Wales and Northern Ireland, the Report of a Fundamental Review 2003 (Cm 5831) recommended that exceptionally complex or contentious inquests should be taken by suitably trained Circuit Judges and still more complex inquests should be heard by suitably prepared High Court Judges, each sitting as a coroner. This view was endorsed by Leveson J in R (on the application of Sharman) v HM Coroner for Inner North London [2005] EWHC 857 (Admin) who took the view that judicial oversight was needed in such cases at a much higher level than coroners were equipped to provide. We note the Government’s intention to provide for judges, or counsel to inquests, to be appointed in particularly complex cases. The IPCC supports the call for a judge to be appointed to sit as coroner in particularly sensitive or complex inquests.

15. At present, the rules as to appointment of a judge are unclear. We submit that there needs to be a clear system in place for referral of an inquest to a judge with guidance as to when it would be appropriate. Any such system should allow interested parties to make representations as to the need for a judge.

RESOURCES

16. Until 1 April 2004 investigations into deaths arising from or involving contact with the police were investigated by the police themselves, usually by officers from a different force and under the supervision of the Police Complaints Authority. The handling and storage of exhibits was the responsibility of the police service and therefore it was possible for arrangements to be made to store exhibits securely near to the location of any inquest.

17. The Police Reform Act 2002 was designed to increase public confidence by enhancing the independence of investigations into such deaths. In most cases to date the IPCC has undertaken the investigation itself, using trained IPCC investigators working out of five regional offices. The police welcome this development and are already seeing the benefits of an accumulating expertise. Since 1 April 2004, the IPCC has undertaken investigation into eight fatal shootings by the police. Some of those concerned forces where a fatal shooting had not occurred before and which therefore had no experience of such investigations.

18. However, the use of the IPCC has thrown up issues relating to the circulation of documents and the secure and proximate holding of exhibits in relation to inquests. The amount of copying involved can be expensive and time-consuming and storage facilities for documents and exhibits may not be readily available. In a recent case, photocopying costs alone amounted to some £5,000 (not counting the cost of the investigator’s additional time). Storage of the documents and exhibits (which in this case involved a firearm and swords) was equally problematic as the IPCC had no offices within easy reach. Eventually the weapons were stored at local naval facilities and the remaining exhibits shared between CPS offices, the coroner’s personal office and the Lord Mayor’s offices; however, this meant the IPCC could not guarantee the integrity of the exhibits.

19. It would seem inconsistent with the aims of the Police Reform Act 2002 to revert to the previous use of local police stations for storage or to use them for the copying of documents to interested persons. The best way to reconcile independence and public confidence with the efficiency and effectiveness of inquests is to provide for secure holding of exhibits at coroners’ courts and to provide coroners with the resources needed to undertake provision of documents.

20. The IPCC notes the Government’s intention that the coroners system remain local and submits that sufficient funding should be provided at a local level to provide coroners with the support needed to undertake administrative responsibilities of this nature.

INTERCEPT MATERIAL

21. In the interests of justice, it is the IPCC’s practice is to pass to the coroner all documents touching the cause of or circumstances surrounding the death in question. There may, however, be occasions where telephone and other intercepts are relevant to an investigation conducted or managed by the IPCC. It would appear that, in those circumstances, under the Regulation of Investigatory Powers Act 2000 the IPCC would not be able to disclose the intercept material to the coroner or even do or say anything that would suggest the intercept had occurred.

22. Under that Act, a relevant judge can order disclosure of such material to himself/herself if satisfied that the exceptional circumstances of the case make the disclosure essential in the interests of justice. “Relevant judge” includes a High Court, Crown Court and Circuit judge. There is no comparable right for a coroner to order disclosure (to the coroner).

23. In order to avoid misleading the coroner the IPCC must ensure that the investigation report and any evidence presented to the coroner is in accordance with the intercept material in question. However, there may be circumstances where the inability to disclose intercept material leads to injustice nonetheless; for example, there might be a verdict of unlawful killing following investigation into a death at the hands of the police where disclosure of intercept evidence suggesting a real and present threat might have led to a different verdict. If there is no subsequent prosecution, the officer in question would not have an opportunity to clear his name.
24. Moreover, in the absence of full criminal proceedings the inquest will normally be the means by which the state discharges its obligation under Article 2 of the European Convention on Human Rights to initiate an effective and independent public investigation into a death involving agents of the state. If such investigation is flawed because the coroner is not in possession of all the relevant evidence, this may place the state in breach of Article 2.

25. It is submitted that the potential for injustice where intercept material is concerned would be mitigated if the same exceptions that apply to relevant judges were also available to coroners.

John Wadham
Deputy Chair
Independent Police Complaints Commission (IPCC)
February 2006

Evidence submitted by The Oak Tree Surgery

I am writing on behalf of the partners at Oak Tree Surgery. Since 2003, we have been trying to obtain copies of post mortems carried out on our patients but have come up against a brick wall when dealing with [our local coroner].

Doctors report deaths to the coroner if the cause of death is unknown or if the deceased was not seen by the certifying doctor, either after death or within fourteen days prior to death or if there is anything violent, unnatural or suspicious about the death. Death may also be reported if due to an accident, self-neglect, industrial disease or related to the deceased’s employment, in cases of abortion, during an operation or prior to recovery from the effects of an anaesthetic, suicide or during or shortly after detention in police or prison custody.

The main reason we as GPs refer deaths to coroners is where the death is sudden, unexpected or we are not in a position to certify what the cause of death is. If we do not subsequently receive a report from the coroner telling us what the cause of death was, then we cannot learn from the experience and we are not in a position to discuss the cause of death with the deceased’s relatives.

I have written to [the local coroner] on at least three occasions and have not received a single written reply. He did, however, speak to me on the telephone on one occasion and was very pleasant but although he told me that he had no objection to doctors receiving post mortem reports for patients for whom they had been responsible during life, he did not subsequently instruct his pathologists to send copies to the doctors and we have been unable to obtain any post mortem results.

Due to the lack of progress, I wrote to the Home Office and also involved [the Chairman of the Local Medical Committee]. [He], like myself, received no reply to any of his letters.

I know that other General Medical Practitioners in [the area] feel like ourselves about this issue and I am also aware that local hospital consultants are also unable to obtain post mortem results on their patients.

We believe this is a significant clinical governance issue as we cannot find out if we are making the correct diagnosis on patients who die unexpectedly and are therefore not in a position to learn from any errors or oversights we may have made.

It is our belief that a post mortem result is an important part of a patient’s clinical records and must be sent as a matter of routine to the patient’s registered General Medical Practitioner and also to any hospital consultant involved in their care. Apparently coroners are currently a law unto themselves and there is no legislation to make them act in a standard manner. We strongly feel that there is a need for legislation to correct this deficit and help us as doctors provide the best possible care to our patients.

Dr S K Madelin MB BCh
On behalf of the partners of Oak Tree Surgery
February 2006

Evidence submitted by the National Association of Funeral Directors

1. INTRODUCTION

1.1 On behalf of the National Association of Funeral Directors (NAFD), I would like to welcome this inquiry into the “Reform of the Coroner’s System and Death Certification”. This reform is of great significance to Funeral Directors and I am pleased to set out our views on the Position Paper on Reforming the Coroner and Death Certification Service that was published by the Government in March 2004 (Cm 6159).
1.2 The National Association of Funeral Directors is the country’s leading funeral Trade Association and is dedicated to maintaining the highest professional standards. Established in 1905, the NAFD represents the interests of the entire spectrum of funeral directing businesses—including independent businesses, the Co-operatives and major funeral groups—who conduct in excess of 80% of UK funerals.

2. **OUR VIEWS ON THE POSITION PAPER**

   We have four principal concerns about the Position Paper:

   2.1 *Geographic availability of Coroners*

      The Position paper suggests that the 127 coroners jurisdictions in England and Wales are reduced to approximately 60. It would appear that the new coroners boundaries would be set on the basis of population (ie including approximately one million population per coroners region). This would have the effect of huge variations in the geographic size of each coroners region, and for example, would result in only three or four coroners for the entire area of Wales. We are concerned that this could result in an increase in the length of time between death and the deceased’s funeral due to the increased travel times that funeral directors would need to undertake.

   2.2 *Coroners Removals*

      The current system of removals of deceased from the place of death to the coroner’s mortuary is organised on an “ad hoc” basis. There are examples of funeral directors completing this work on a zero or even negative tendering basis, and this is considered inappropriate by the Office of Fair Trading. We believe that there should be a national negotiated rate to put removals on an even and fair basis.

   2.3 *Certification for funerals*

      We are very encouraged to see the proposal for a single system of certification for funerals be they either burials or cremations. We are however concerned that the system of Medical Examiners issuing such certificates may result in a continual delay between the date of death and the date of the funeral.

   2.4 *Funding for the new service*

      We note that one of the specific objectives is to instigate the new procedures from existing funding. Given that the coroners will be full time and the new system would involve the employment of at least 180 qualified Medical Examiners, we are concerned about whether this objective can be met.

   *Nigel Lynn Rose*
   
   National President
   
   *February 2006*

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**Evidence submitted by the Federation of British Cremation Authorities (FBCA)**

1. The FBCA was founded in 1924 and represents 95% of the cremation authorities in the United Kingdom. We welcome the opportunity to submit comments to the Constitutional Affairs Committee’s Inquiry into Reform of the Coroners System and Death Certification in England and Wales.

**SUMMARY**

2. In summary, the FBCA believes that:
   — the Government’s proposals for Reforming the Coroner and Death Certification Service in England, Wales, contained in the Position Paper published in March 2004 should be implemented;
   — a two-tier system for all certification, including cremation, is preferable to the current three-tier system;
   — Coroners should be required to provide additional information to crematorium Medical Referees, including the cause of death and the presence or otherwise of medical implants; and
   — the transition to any new arrangements for death certification will need to be carefully managed.
BACKGROUND

3. In the year 2004 (the last year for which the Federation has statistics), there were 245 crematoria in operation in the United Kingdom. A summary of cremation statistics is set out below*:

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<tr>
<td>Deaths in the UK</td>
<td>599,985</td>
</tr>
<tr>
<td>Total Cremations</td>
<td>424,956</td>
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<tr>
<td>Percentage of Deaths</td>
<td>70.8%</td>
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*Provisional figures at 21 March 2005.

4. In addition to the above statistics, 226 crematoria reported carrying out 28,906 cremations of foetal remains and 98 crematoria reported carrying out 448 cremations of body parts in 2004.

GENERAL COMMENTS

5. We welcome the Committee’s Inquiry into Reform of the Coroners System and Death Certification in England and Wales. It will clearly be important that the Committee’s recommendations should be consistent with those of the Third Report of the Shipman Inquiry (under Dame Janet Smith DBE) and the Report of the Fundamental Review 2003 into Death Certification and Coroner Services (the Luce Committee). We also welcome the Government’s proposals for Reforming the Coroner and Death Certification Service in England, Wales and Northern Ireland contained in the Position Paper published in March 2004 (Reforming the Coroner and Death Certification Service: A Position Paper (CM 6159)).

6. There have been previous attempts at reforming the system, including the recommendations of the Brodrick Committee and the report on the coroner system (Wright 1936), which have not been implemented. Consequently, we are concerned that the necessary parliamentary time may not be made available to bring the proposals into effect.

7. The comments that follow are linked to the issues identified in Press Notice No 12 of Session 2005–06 dated 20 January 2006.

WHAT PROBLEMS THERE ARE WITH THE EXISTING SYSTEM

8. We would endorse the identified shortcomings of the current three-tier cremation certification process as described in the Fundamental Review of Death Certification and Coroner Services and the Shipman Inquiry. We would support a two-tier system for all certification, including cremation.

9. We recognise that the cause of an individual death should, for reasons of confidentiality and the protection of families, be regarded as private information. However, at present the Coroner’s Certificate for Cremation (Form E) does not make provision for a cause of death to be shown, but is given only in those circumstances where a local agreement has been made between the Coroner and a Crematorium Medical Referee. It would be of considerable assistance, if not essential, for the Medical Referee to have this information with the cause of death being given in all instances. Furthermore, in the interest of health and safety of crematorium staff and other personnel involved in the funeral process, the Coroner should be required to provide information where the cause of death is infectious.

10. There have been instances in the past where other risks to crematorium staff have arisen from the explosion of cardiac pacemakers during the cremation process. Other risks arise from the presence within the body of cardiovascular defibrillators, pulse implant generators and radioactive implants. In the absence of information from relatives (who are not always in a position to know), we believe that the Coroner should be required to confirm the absence or removal of such items.

11. Historically, bereaved families opting for cremation have had to bear the additional cost of medical certificates for cremation, that are not otherwise required for burial purposes. From 1 October 2005, fees for the completion of Medical Certificates B and C increased from £55.50 to £62.00, representing an increase of 12%, whilst Medical Referees’ Fees increased from £5.50 to £16.50 with effect from 1 January 2005. The combined effect of these additional fees is to add £139.50 to the basic cost of a cremation.

EXISTING PROPOSALS FOR REFORM

12. In our view, the Government’s proposals effectively address the shortcomings identified in Dame Janet Smith’s report and earlier reviews and herald a long-awaited reform of the death certification system, replacing existing complex machinery with a single medical certification procedure for burials and cremations. We have consistently advocated that the certificates to be completed for death should be the same, regardless of whether burial or cremation follows.

13. We are pleased that the Government places the needs of the bereaved at the centre of the new system and we welcome the proposals for a family charter setting out precisely what the deceased’s family can expect from the service. However, the transition to the new death certification procedure will need to be very carefully managed to avoid disruption to funeral arrangements. In particular, we are concerned that geographical access to coroner services, particularly in rural areas, may be made more difficult owing to the proposed reduction in the number of coroners.
14. We welcome the introduction of the second certification in all cases by qualified Medical Examiners based in the coroner's office and independent from the National Health Service. However, we are concerned that there are no plans to require an independent examination of the body in all cases. This seems to afford a new opportunity for concealed homicide. We trust that, in the longer term, the new medical examiner service will be adequately resourced to avoid delays between death and disposal, which will be distressing for the bereaved. This, we suggest, will require rigorous performance management measures to be in place from the outset.

15. Clearly, the secure electronic transfer of confidential patient information will be of value to the reformed system. This raises issues of ownership of information, the legal restrictions under which different agencies operate, identification, authentication, security and the sharing of information between local and central government agencies: all of which will need to be carefully resolved.

16. We note the Government’s intention to “capture” all existing resources for redirection towards the new system. In part, these resources are currently provided by the bereaved in terms of fees for medical certification. This creates an imbalance between the overall costs of burial and cremation. We hope that the new arrangements will ensure that the medical certification expenses are recovered equitably, regardless of the choice of disposal.

17. We are disappointed that the Briefing Note on Coroner Service Reform, published on 6 February 2006 to coincide with a Parliamentary Statement by Harriet Harman MP, Minister of State for Constitutional Affairs, indicates that the Government will not be introducing a requirement to report every death to the coroner for a second scrutiny. This effectively means that the critical defects in the current death certification and investigation process are to continue. Whilst the Briefing Paper confirms that government will be considering “affordable and proportionate further reforms in these areas”, there is no indication of a timetable. We consider that this work should be completed as soon as possible, preferably within a year.

THE ALTERNATIVES TO THE CURRENT SYSTEM AS PRACTICED IN OTHER JURISDICTIONS

18. We have no particular view as to alternatives to the current system as practiced in other jurisdictions other than to urge compatibility with current proposals to amend the relevant legislation in Scotland where the Scottish Executive are considering implementing a two tier system of death certification for both burial and cremation.

19. It is the intention that death certification in Scotland will be more robust than at present, with the training of doctors in the completion of statutory forms being identified as an area requiring attention and for doctors in training grades allowed to sign the certificates under supervision.

20. The General Register Office for Scotland will hold information to allow an audit of information held, to identify any trends, thus providing some reassurance to the public.

Federation of British Cremation Authorities

February 2006

Evidence submitted by the Health and Safety Executive (HSE)

INTRODUCTION AND EXECUTIVE SUMMARY

1. The Health and Safety Executive (HSE) welcomes the opportunity to present evidence to the Committee. HSE is a regulatory authority with statutory responsibility for the investigation of breaches of duties under the Health and Safety at Work etc Act 1974 (HSWA). This includes investigating work-related deaths to determine if they were the result of a breach. The HSE works closely with Coroners to help meet the expectations of society and the bereaved following work-related fatalities. HSE previously contributed to the Fundamental Review of Death Certification and Coroner Services and commented on various of the Think Papers produced by the Home Office prior to the publication of the position paper (Cm 6159) Reforming the Coroner and Death Certification Service. The HSE agreed with many of the conclusions reached by the previous reviews concerning the current state of death investigation. The HSE’s comments are restricted to the proposals for England and Wales as a separate body has responsibility for health and safety issues in Northern Ireland.

2. The HSE supported the broad objectives set out in the foreword from the then Home Secretary to the above paper, namely that, as with properly managed health and safety, an effective system for the investigation of deaths is a vital component of a civilised society. The HSE believes that fundamental change is necessary for the coronial system to continue to meet the wishes of society and to function in a changing legal landscape. The HSE therefore noted the broad commitments made in the Minister of State’s statement of 6 February 2006. The HSE is committed to fairness during inquests. In light of the critical defects in the current death certification procedures and the coronial service identified by the Fundamental Review, HSE
believes that the key to addressing those defects and to an effective coronial service lies in the adequate resourcing of any future arrangements. As such the HSE has concerns that the recent proposals from the Department for Constitutional Affairs (DCA) may not go far enough.

3. The HSE supports the proposal to rely on specialist, legally qualified, Coroners to provide an accountable, death investigation system. The HSE recognises that there will be pressures on the resources available but does not wish to see the obvious societal advantages of an improved coronial system lost. The recent ministerial statement suggests that the DCA accepts that reform will require additional funding. As with any changes it may be easier to gain agreement to the broad principles but it is the details which will determine the effectiveness of the new system and whether it provides a system fit for the twenty-first century and afterwards.

4. The HSE supports the move for reform and wishes to see the following as components in any new system:

   — Judicial Coroners responsible for both the investigation of deaths, including work-related deaths, and the holding of an inquest;
   — Improved support for the bereaved;
   — A system that applies Article 2 of the European Convention on Human Rights (ECHR) appropriately and differentiates other cases;
   — A system that adequately marks societal concern through the holding of an inquest, particularly in cases involving work-related fatalities;
   — A centralised and funded structure supporting Coroners that is able to make economies of scale and provide Coroners with adequate accommodation, administration and investigation services;
   — Consistency of approach in applying the law and meeting the expectations of everyone involved in the inquest process.

5. The HSE fully supports the view that the needs of the bereaved should be one of the key factors at the centre of the new system. We anticipate that groups, which speak on behalf of the bereaved in work-related deaths, will wish to address the Committee on proposals for representation at inquests. The anecdotal evidence of Inspectors of Health and Safety suggests that the bereaved require improved personal support during the inquest process. Whilst HSE supports the concept of a Charter, HSE’s Inspectors are aware that written advice is not always the most effective way of communicating with the bereaved during the grieving process. Any system should recognise the pressures on those who support the bereaved and the special skills required to adequately counsel them. That work should be supported by managing the expectations of all those involved, through the setting of boundaries for what an inquest can achieve.

6. Any reforms must recognise the changing nature of society. The HSE is pleased to note that there will be improved training for Coroners and hopes that this will ensure an improved sensitivity and awareness of diversity issues. Any reforms and particularly any Charter will need to consider which categories of the bereaved will have access to the rights outlined by the DCA, for example the interests of some members of a bereaved family might be at odds with others within the wider family group. Coroners will need to be equipped to exercise discretion so as to avoid unnecessary distress including from any challenges that might prevent or delay “closure” on the grieving process.

CORONERS’ INVESTIGATIONS INTO WORK-RELATED DEATHS

7. The HSE believes that it is also vitally important to recognise that the bereaved may also have expectations of subsequent legal proceedings and that this should be recognised not only in the arrangements put in place for inquests but also in their application by Coroners.

8. However the HSE stresses again, as it has throughout previous consultation exercises, the importance of inquests to the proper investigation of work-related deaths. The HSE’s believes that the conclusions reached by the Fundamental Review in relation to the projected increase in incidents of industrial disease further supports the view that work related deaths are and will be of sufficient public importance to require an independent inquiry by a Coroner. The HSE is concerned by the DCA proposal that Coroners should have a wide discretion not to proceed to an inquest where there are criminal or other investigations or other proceedings in connection with the death that appear likely to resolve the issues that an inquest would have determined. In light of the judgment in R (Hurst) v Coroner for North London [2003] EWHC 1721 Admin it is difficult to conceive of any criminal proceedings, other than those set down in section 16(1)(a) of the Coroners Act 1988, that would properly meet this criterion, but we are aware of incidents where Coroners, on the grounds of cost have sought, despite the current case law, to force a HSE prosecution to precede an inquest.

9. Whilst the Health and Safety Commission Enforcement Policy Statement refers to death or serious injury as an aggravating feature to any breaches of health and safety requirements, the Commission expects health and safety enforcing authorities to prosecute where death has occurred and there is sufficient
evidence. However HSE is not required to prove death or the cause of death in order to secure a conviction. HSE investigations cannot be seen as an alternative to an investigation. Any such suggestion would have serious resource implications for HSE and would impact on its ability to carry out its wider regulatory responsibilities.

10. HSE strongly opposes any suggestion of reducing the categories of work-related death, including occupational disease and incidents at work, that currently require an inquest to be held. We believe that if there were to be a statutory change in this way this would risk sending a message to society that work-related deaths are not to be given the fullest consideration. This would inevitably jeopardise the Government’s strategy for reducing fatal accidents and those that result in serious injury and cases of work-related ill health.

POWERS AND RESOURCES

11. The DCA proposals and the Home Office position paper accept that Coroners should retain responsibility for the investigation of deaths. Coroners currently have no statutory powers to enter premises or to seize documents. It is suggested that new legislation will be required to give the Coroner or his/her agents increased powers. The HSE supports these proposals. At present there is confusion as to who carries out these functions on behalf of the Coroner. Whilst other bodies might carry out enquiries that touch on circumstances surrounding the death the HSE believes that it should continue to be the responsibility of the coroner to set the ambit of his/her investigation. Bodies carrying out other functions might be able to assist the Coroner but in many cases the statutory functions of those bodies, including HSE, differ from those of the Coroner and do not provide the bodies with the vires to act on the Coroner’s behalf. The HSE believes that it is important for the Coroner’s investigation to be seen to be independent and therefore other bodies should not be asked to carry out the Coroner’s functions.

12. Any powers provided to the Coroner or his/her agents will need to be compatible with the ECHR. Careful consideration should be given to precisely what powers are required in order for the Coroner to fulfil his/her statutory responsibilities. There should be a specific requirement on the Coroner to consider the rights of persons who might be the subject of subsequent proceedings, including criminal prosecutions.

13. HSE believes that this demonstrates a further need for a statutory definition of the purpose of the coronal process and in particular the inquest hearing. The limitations and guidance are currently contained in a confusing mixture of the Coroners Act 1988, the 1984 Rules (in particular Rules 36 and 42) and case law, such as R v HM Coroner for North Humberside & Scunthorpe (ex parte Jamieson) [1994] 3 All ER 972.

14. At present the shortage of resources to investigate on behalf of the Coroner can lead to excessive delays before an inquest can be held. This in turn impacts on those legal proceedings, which, for legitimate legal reasons, must await the outcome of the inquest. HSE policies place a heavy responsibility on its inspectors to keep the bereaved informed of developments. These efforts are often undermined by delays that are beyond their control. This also impacts on the possibility for the bereaved to have proper “closure”. Delays can also arise from a lack of administrative support (see below).

CHRONOLOGY OF PROCEEDINGS

15. At present Section 8(1) of the Coroners Act 1988 requires a Coroner to hold an inquest as soon as practicable following a death, and s/he is not permitted by the Rules to adjourn an inquest for the sole reason that criminal proceedings arising from the death have commenced. However, the Coroner must adjourn where proceedings for murder, manslaughter, infanticide, causing death by dangerous driving, causing or allowing the death of a child or vulnerable adult, or aiding, abetting, counselling or procuring suicide are ongoing. Unlike the police and DPP, HSE has no statutory locus to request that a Coroner to adjourn the inquest pending the conclusion of criminal proceedings.

16. However in line with the current case law HSE prosecutions will generally take place after the conclusion of the inquest. Whilst HSE does not seek to use the inquest as an opportunity to test the available evidence in advance of enforcement proceedings it is mindful of the fact that a jury could still return a verdict of unlawful killing, in which case the CPS may reconsider the evidence with a view to prosecuting for gross negligence manslaughter. As a result it is HSE policy that a final decision on enforcement action will not normally be made until after the inquest.

17. This approach also underpins the workings of the Work-Related Death Protocol. The Protocol provides guidance on the arrangements between the major investigative and prosecuting authorities with interests in work-related deaths to ensure the most effective methods for investigating and possible prosecuting offences arising from the circumstances surrounding this type of fatality. The Protocol has been developed over a number of years and is designed to assist in ensuring that all proceedings connected with the fatality can be effectively managed and thereby meet the possible expectations of the bereaved. HSE investigations and subsequent proceedings are generally directed towards the issue of risk and may therefore not explore all the issues that are relevant to the inquest or which the bereaved wish to know about. Whilst it might initially appear attractive to seek a course that might reduce both the length and the cost of an inquest, a departure from these arrangements attracts the type of legal risk touched on at paragraph 16 above, potentially impacting on all signatories to the Protocol.
JURIES

18. The DCA envisages removing the mandatory requirement for juries in work-related deaths. The presence of juries in the most sensitive cases represents the fact that the type of case identified in section 8 of the Coroners Act 1988 are of particular concern to society. There appears to be no strong argument for the removal of, or reduction in the use of juries in work-related death cases, and jurors in the Coroners’ courts face no real additional difficulties to those who sit elsewhere. (It has been argued that inquest juries might be confused by the different standards of proof required for different verdicts. However juries in criminal courts are asked to deal with different burdens of proof, such as in cases under the HSWA where there is a reverse legal onus, and this has not given rise to problems in practice.)

19. If it is accepted that juries are required where Article 2 of the ECHR is an issue, and we can foresee arguments before Coroners for the summoning of juries in other work-related cases. The health and safety duties are the same regardless of whether the undertaking involves the State. On the other hand, the calling of juries and the management arrangements required to organise jury-inquests, may take some time, and may involve some difficulty. This has, on occasions in the past, given rise to some delay in arranging inquests into work-related deaths. Undue delay is something that must be avoided, in the interests of justice and in the interests of the bereaved. There may therefore be good reason to remove the mandatory requirement for work-related deaths to be before a jury. The Coroner could be given the discretion to decide whether or not a jury should be called.

THE AMBIT OF THE CORONER’S INQUIRY

20. The HSE notes the DCA’s intention to remove doubt as to the compatibility of inquest arrangements with Article 2 of the ECHR. The HSE believes that this has already been achieved in part through the decisions of the House of Lords in Regina (Middleton) v West Somerset Coroner and Another [2004] 2 AC 182 and subsequent case law, although the question of clinical decisions remains Regina (Takoushis) v North London Coroner and Others [2005] EWCA Civ 1440. The HSE wishes to see greater clarity in the ambit of inquests that are not required to consider issues involving the State.

21. The HSE believes that there are clear advantages to having defined boundaries to an inquiry. A failure to differentiate between the requirements of an inquest required for the purposes of Articles 2 of the ECHR would not allow resources to be targeted at those cases of greatest public concern and result in unnecessary delay to all cases. The use of an extended Coroners’ inquiry in every case would have implications for disclosure and increase the risk to future legal proceedings. Extended inquiries require significant expenditure that would have to be diverted from other functions. In HSE’s case this would be from its core role of reducing risks and protecting people.

INQUEST OUTCOMES

22. HSE notes that many Coroners have already adopted the use of more narrative verdicts and are not limited only to Article 2 of the ECHR inquests. The HSE believes that more of what were termed “considered outcomes” by the Fundamental Review may, in some cases, better serve the needs of the bereaved. The HSE believes that this development needs to be defined within any reforms. The boundary between implied incrimination and non-incriminating public comment can be hard for Coroners to define and the public to understand. HSE is concerned that the expectations of the bereaved for subsequent legal proceedings are not placed in jeopardy because of the nature of an analytical and narrative inquest outcome.

23. HSE sees strength in the suggestion that verdicts might be a hybrid of the existing system, which would still allow the Coroner the ability to refer matters such as an unlawful killing to the Crown Prosecution Service. This is particularly important if the state is to avoid situations where new evidence might come to light in the course of the inquest that might support a murder, manslaughter or corporate manslaughter charge that should be referred to the Director of Public Prosecutions as other enforcing authorities need to know when they might proceed safely with their own charges without risk of prejudice to those more serious charges (R – v – Beedie [1997] 2 Cr App R 167 CA).

DISCLOSURE

24. HSE anticipates that any reforms will favour clear, consistent and predictable rules of procedure, including those on disclosure, with a presumption in favour of disclosure of all relevant witness material. HSE is in favour of a system that supports greater consistency. What is relevant will depend upon the matters being considered by the particular inquest and, as a simple matter of administration of resources, any rules of procedure will need to clearly differentiate between what is required to meet the requirements of Article 2 of the ECHR and what is needed for those inquests where those requirements are not engaged.

25. HSE continues to have significant concerns as to how a change in procedures may impact upon matters of disclosure. There are restrictions on the way in which information obtained using Inspector’s powers may be used and disclosed, some of which flow from the HSWA. There are broader concerns about the need to avoid potential prejudice to possible criminal proceedings. HSE has worked closely with the
Coroners’ Society in an effort to develop a system of disclosure that avoids these difficulties. These arrangements are not well understood outside HSE and the Society. The current position has the potential to reflect negatively on HSE, and the justice system generally, and can cause frustration on the part of all those involved.

26. In light of HSE’s statutory obligations to enforce we welcome the announcement that it is the DCA’s intention that it should be the Coroner who is responsible for investigating the circumstances surrounding a death. We believe that this will prevent inquests being used as an opportunity for pre-action discovery or advance disclosure of a criminal case. A properly defined legal definition of the purpose of an inquest will also assist in minimising the risk of prejudice to future proceedings and will help to protect the Article 6 of the ECHR rights of a suspect and any subsequent criminal trial.

27. HSE would not support any proposals with regard to disclosure that may, in any way, put future criminal proceedings brought by HSE, or other regulators, in jeopardy. Coroners must be properly resourced to undertake their own enquiries. Coroners will then be able to direct their Officers to gather evidence sufficient for the inquest, which the Coroner will then be free to disclose as appropriate, within any proposed Rules of Procedure.

STRUCTURE AND INDEPENDENCE

28. The structure, independence and resourcing of Coroners are organisational matters that are not specifically for HSE. However, there are some aspects that would have an effect on how HSE can properly carry out its functions and how work-related deaths are investigated. We would therefore make the following observations:

— Judicial post holders under the guidance and instruction of a Chief Coroner would, we believe, be central to a successful coronial system that meets expectations—particularly those of bereaved families, and on the State in terms of the ECHR. One of the most important purposes of the coronial system is the protection and promotion of Article 2 of the ECHR rights. The independence of the coronial system should be reflected in its main purposes, and the service should be seen to be as objective as possible. This should allow the Coroner to comment on flaws in State services, if that is appropriate.

— Insofar as investigations by the Coroner’s staff are concerned, the current system involves some decision-making and executive work. We suggest that staff undertaking such activities report to the Coroner. This is fundamental to enabling an independent and sufficient inquiry.

— The current system of local authority funding has led to marked inequalities in the level of resource (including investigative resource) that is available to Coroners, and therefore inequalities also in the service that Coroners are able to provide to their communities—both in terms of their investigations and the extent of the inquiry hearing itself.

— We would welcome explicit provision for any Chief Coroner to issue binding Practice Directions. At present, despite the laudable efforts of the Honorary Secretary of the Coroner’s Society there is nothing to require a Coroner to adopt the sensible practices advocated at a national level by the Society.

— HSE is of the view that the cost of any proposals needs to be evaluated against the service that it will provide to society. It is disappointing to note that the proposals indicate that the investigation of deaths will continue to be funded at a local level. The Fundamental Review referred to the need to rationalise the current arrangements. We believe that there is the potential to make savings through economies of scale that are not available at local authority level, thereby ensuring that all possible resources are made available for the performance of the Coroner’s statutory duties. In the absence of consistent funding within Central Government control we cannot see how the public can expect a consistent level of service.

— In terms of accommodation HSE believes that delays in the inquest process could be prevented if coroners had easy access to courtrooms (possibly managed by HM Courts Service). Whilst it is not essential for Coroner’s offices and courtrooms to be co-located, this might be preferable in eliminating unnecessary travel and administrative costs.

— As the interests of the bereaved must be at the centre of any new service careful consideration must be given as to the location of inquest centres so that inquests are accessible to all both in terms of public transport, and in terms of facilities. The current ad hoc arrangements often do not meet the needs of the bereaved. Accommodation is often uncomfortable lacking basic services such as refreshments and quiet rooms. This adds to the distress of grieving relatives.
Evidence submitted by the City of London Corporation, City Remembrancer’s Office

INTRODUCTION

1. The City Coroner is appointed by the Common Council of the City of London to inquire into deaths reported to him and into cases of treasure that is found. The City Coroner’s district is coterminous with the City’s boundaries notwithstanding the City’s responsibility for the whole of the tidal Thames from Teddington to the Kent and Essex coasts as Port Health Authority. The City Coroner has consequently only a very small number of deaths to deal with (between 125 and 150 per annum), compared to the other London coroners, and his is the only part-time coronership in London. The present holder, appointed in 2002, is a practising City solicitor and a part-time law professor at King’s College London.

APPOINTMENT, SUPERVISION, PERSONNEL

2. Every coroner must be either a lawyer or a medical practitioner of at least five years’ standing. While coroners are appointed and financed by local authorities, they are judicial officers holding an independent office under The Crown, rather than employees. Although local authorities have some control in financial matters, they have none over coroners’ actual decisions. In practice, coroners are responsible to the High Court in respect of their decisions, and to the Lord Chancellor in respect of their behaviour. The local authority is obliged to indemnify the coroner in respect of his legal costs (and any costs he might be ordered to pay to another party) in any legal proceedings brought arising out of his acts or omissions as coroner. The last judicial review of a decision of the City Coroner dates back to the 1980s. There is no known instance of the Lord Chancellor disciplining the City Coroner.

3. Every coroner must appoint a Deputy, and may appoint an Assistant Deputy. Like the coroner, each of them must also be either a lawyer or a medical practitioner of at least five years’ standing, and each has the same powers to hold inquests. The present Deputy is the (full-time) coroner from another London district. His is principally a medical qualification. The present Assistant Deputy is another practising City solicitor, although from a different firm than the Coroner. As the law requires, at least one of them is available at all times, day or night, 365 days a year.

4. Every coroner is aided by one or more “coroner’s officers” who are, in effect, caseworkers. Until well after the Second World War, the City of London Mortuary Superintendent acted as coroner’s officer. Nowadays, the City Coroner has one full time officer, and two part-time officers. They are all serving members of the City of London Police, but attached to the Court, and under the direction of the Coroner in relation to their duties as his officers. The coroner’s office is staffed and open to the public every weekday other than bank holidays. There is a rota providing a 24-hour, seven days a week, out of office service for urgent matters, accessible through the City of London Police.

5. The caseload of the City Coroner is small, but extremely varied. There are deaths from road accidents, industrial accidents, domestic accidents, drug overdoses, hospital deaths after surgical operations and other treatment, river drownings, suicides, prison deaths, deaths in police custody, terrorist action, “ordinary” homicides, and so on.

TREASURE INQUESTS

6. In addition to holding inquests into certain kinds of deaths, a coroner holds inquests into treasure that is found in his or her district. Medieval law held treasure trove to be gold or silver that had been hidden with a view to retrieval later. The Treasure Act 1996 widened this to include other categories such as coins and other objects. All treasure found in the City, including the Thames foreshore, or in (the historic borough of) Southwark belongs by law to the City of London as a franchise of the Crown (Charter of Edward IV, dated 9 November 1462), rather than to the Crown itself. Compared to other coronial jurisdictions, the City has more treasure inquests than its size would indicate (there were three in 2005). This fact is due to the rich history of the City, the thriving archaeological services here, and above all the constant need to redevelop the existing buildings once they become uneconomic.

HISTORY

7. Originally coroners were elected in each county to look after local matters in which the King has a financial interest. They also had certain ministerial functions, such as to act for the sheriffs, where the latter were disqualified through interest for acting. In cities like London, which were outside the control of the counties, special arrangements prevailed. Because the City of London was especially important to the King, the office of Coroner in the City of London was until the late 15th century held by a royal officer called the King’s Butler or the King’s Chamberlain (not to be confused with the City Chamberlain, or Chamberlain of the Guildhall). Sometimes, particularly in periods when the City was weak in power, this person was also appointed the City’s Mayor as well.
8. However, by charter dated 20 June 1478, King Edward IV granted to the Mayor and Commonalty of the City (in consideration of £7,000, a large sum of money for those days) the right to appoint the City Coroner. By charter dated 23 April 1550, King Edward VI granted them a similar right to appoint two Coroners for (the historic borough of) Southwark, whose administration was also granted to the City, even though it was physically on the other side of the river. Being appointed by an independent corporation rather than being elected by the county, these coroners were known as “franchise” coroners.

9. For many years it was usual to appoint the same person to be both Coroner of the City and Coroner for Southwark. The last person to hold both offices ceased to do so in 1932, after the right to appoint the Southwark Coroner was transferred by an Act of 1926 to the London County Council. The Inner South London Coroner, whose district includes what is now the London Borough of Southwark, is now appointed by the council of that borough, in succession to the Greater London Council.

10. The City Coroner is still appointed by the City of London, although now under the general law (the Coroners Act 1988) rather than by Royal Charter. Now no longer a “franchise” coroner, he has the same duties and powers as any other coroner. From 1888 to 1977, though, he had jurisdiction, under a special Act of Parliament, to hold inquests into non-fatal fires in the City.

11. Because of the way prison legislation was drafted, he also had jurisdiction over deaths in Holloway Prison from when it was built in 1852 to 1965. Even today the coroner for Inner North London (in whose district Holloway Prison lies) invariably offers to transfer jurisdiction in relation to Holloway deaths to the City Coroner, and the offer is always accepted. There are however only one or two such deaths a year.

12. The City of London Mortuary and Coroner’s Court was formerly on the eastern side of Golden Lane, dating from the late nineteenth century. The buildings were damaged in the Second World War, and the court was for some years held in the Cripplegate Institute, on the western side of Golden Lane.

13. The current purpose built mortuary, offices and court date from the late 1960s, and form a part of the oldest part of the modern Barbican complex, in the public services building known as Milton Court (where the City Fire Station was also housed). The City mortuary ceased to be used as such in 2002, when the City contracted with the London Borough of Camden to use its public mortuary instead of maintaining its own. The old mortuary is now used as a storeroom for the Guildhall School of Music and Drama. The City Coroner’s Court and offices are expected to move to new accommodation provided by the City at Walbrook Wharf in 2006 or early 2007, after which the Milton Court site will be redeveloped.

City of London Corporation
City Remembrancer’s Office

March 2006

Evidence submitted by the Brethren Christian Fellowship (The Brethren)

1. WHO ARE THE BRETHREN?

For the purpose of this submission, we will not go into detail about the history of the Brethren (sometimes referred to as the Plymouth Brethren but are now more commonly referred to as the Exclusive Brethren). It is perhaps sufficient to say that the movement commenced in Dublin in about 1828 and now comprises around 45,000 worldwide who are found in 19 countries including 9 Member States of the European Union. Further information can be found at the only website endorsed by the Brethren: www.theexclusivebrethren.com.

2. BRETHREN’S INTEREST IN GOVERNMENT

It is true to say that widespread interest among the Brethren in government and international affairs has intensified in recent years. Nevertheless, over the last four decades in particular, many Brethren members have become known personally to MPs, Government Ministers, Peers etc. The Brethren are not an extreme fundamentalist minority group as might be suggested by some. They are a group of sincere Christians who pray for and support what is right in Government according to Holy Scripture. Government is ordained of God, as set out in the following quotations from the Bible:

“For there is no authority except from God; and those that exist are set up by God,”—see Romans chapter 13 v 1

“that supplications, prayers, intercessions, thanksgivings be made for all men; for kings and all that are in dignity”—see 1 Timothy chapter 2 v 1

The Brethren believe there is abundant testimony both from the Bible and history itself that the Western World, namely Europe and its outgoings (essentially the Americas and Australasia) has prospered as a direct result of embracing Christianity. This came to pass through entry into Europe by the Apostle Paul, his port of entry being Philippi where amongst other things he gave the exhortation to “Believe on the Lord Jesus and thou shalt be saved, thou and thy house”—see Acts chapter 16 v 31.
3. PURPOSE OF SUBMISSION

The principle that is controlling our request for the Government to take action is that, as believers on our Lord Jesus Christ, our bodies are not our own but belong to Him—"and ye are not your own for ye have been bought with a price",—1 Corinthians 6 v 19 & 20. We are seeking a way in which the lawful requirements can be met—that is, a natural, terminal cause of death is found, acceptable to the Coroner; at the same time, the least possible interference is made to the body, especially that no organs are retained without permission when the death is natural, so that the body is held respectfully and complete for burial. The need is for the Human Race—every man, woman and child — to be protected. God’s rights as Creator and Christ’s rights as Redeemer must be recognised.

4. EXPERIENCE AND THE CURRENT SITUATION

We are making this submission as having had experience in the past of the failure of the current situation prevailing in the Coroners system. In the case of Mr and Mrs Taylor the Coroner was not prepared to instruct the pathologist. Since this time, in circumstances requiring a Coroners post mortem, it has meant a personal approach to each Coroner, which has usually been met with sympathy resulting in a control. In the case of Mr and Mrs Thewlis, slipshod practice by the Coroner including the acceptance without question of an incomplete post mortem report resulted in a child’s heart being retained for research purposes.

At present: when a sudden and unexplained death occurs, the Coroner automatically orders a post mortem. No parental or next of kin consent is required. The legal term is that “The body belongs to the Crown”.

At present: when a post mortem has to take place, we cannot deny the right of the Crown to possession of the body to establish the cause of death. We do deny the right of anyone for extending the examination and retaining parts beyond this point without permission.

5. ACTION POINTS

Coroners need:
— a framework, someone that they are answerable to—at present it is a “post-code lottery” varying from area to area.
— power to exercise discretion, waive a post mortem under prescribed criteria.
— power to authorize a limited post mortem.

Question 1: Could there be a provision for exemption from a post mortem when circumstances allow?

We ask that in instances where:
(a) A sincere conscientious objection to a post mortem is voiced.
(b) No suspicious circumstances are present.
(c) There is no mark or blemish on the body.
(d) There is a full acquaintance of the family doctor with the home background and the patient’s terminal illness.

The Coroner should have the ability to waive the post mortem if so requested.

Question 2: Could there be a provision for a limited post mortem where the above is not possible?

We ask that: when a conscientious objection and a request for the body to be complete for burial is voiced by the parents or next of kin, the Coroner may see fit to instruct that he does not want the post mortem to extend beyond what is necessary to establish the immediate cause of death. The enclosed letter from Prof. James Underwood of the Royal College of Pathologists would indicate their support for this proposal.

In view of the body being interfered with as little as possible could consideration be given to the use of MRI scanning equipment to ascertain the cause of death? We have first hand knowledge of this method being used in a very recent case in Australia. We are also aware of a trial of this procedure by the Jewish community in Manchester. We realise this equipment is expensive and existing facilities are over-subscribed but would submit that this could be organised on a regional basis as we envisage that only a relatively small number of post mortems would require the use of this equipment.
6. CONCLUSION

We had a personal interview with Mr Tom Luce and Mr Michael Galagher at the beginning of the Review, which was followed up with a detailed Submission and a response to the Consultation Document, both of which are indexed under Christian Conscience in the Report of the Fundamental Review 2003 CM5831. We have had a meeting in Whitehall with Rosie Winterton, the Minister responsible for the Human Tissue Bill. We attended virtually all the Retained Organs Commission meetings. We followed the passage of the Human Tissue Bill through Parliament at every stage; we are thankful for the provision enshrined in the Act, based on the principle of Consent. We are also well acquainted with Hugh Whittal, civil servant at the Dept. of Health.

— The Recommendations for Coroners included in the Royal Liverpool Childrens Enquiry by Redfern at Section 56 pages 354 and 355 are valuable and we feel they should be adopted.

— We wish to be constructively supporting the government in this Review in order to offer protection to all mankind.

Stuart Taylor and David J Thewlis
The Brethren Christian Fellowship (The Brethren)
March 2006

Evidence submitted by The Committee on the Administration of Justice (CAJ)

The Committee on the Administration of Justice (CAJ) is an independent non-governmental human rights organisation that monitors the human rights situation in Northern Ireland and works to ensure the highest standards in the administration of justice. The organisation was awarded the Council of Europe Human Rights Prize in recognition of its work to place human rights and equality provisions at the heart of the peace agreement secured in 1998.

CAJ has been active on the issue of inquests for many years. Our focus has predominantly related to deaths caused by the security forces or where there have been allegations of collusion, but we have also provided advice and assistance to others.

We have long been of the view that the inquest system in Northern Ireland is in need of serious and far-reaching change in respect of almost all its powers and functions. From the perspective of those families we have worked with over the course of the last twenty years in Northern Ireland, the inquest system has not only failed to address the concerns they may have about their loved one’s death, but has in fact compounded the sense of injustice and loss which they already feel.

We have only recently become aware of the work of the Committee on this issue, and were unable to prepare in the timeframe a full response. However, we enclose for information previous work by CAJ on this issue (namely, “Response to consultation document issued by the Coroners Review Team”, December 2002 and “Response to the Report of a Fundamental Review of the Inquest System (Luce Review)”, October 2003), much of which we believe is still relevant. It is worth highlighting, in particular, a number of issues in relation to Northern Ireland which the Committee may want to consider.

As a result of a number of cases in Northern Ireland, there is ongoing legal uncertainty on the scope of inquests into deaths that occurred before the introduction of the Human Rights Act in 2000. In the case of In re McKerr [2004] UKHL 2, it was held that investigation of deaths occurring before 2000 were not required to be compliant with Article 2 of the European Convention on Human Rights. Appeals on this point are awaiting hearing in the House of Lords in a number of other cases (Re Jordan’s application and Re McCaughey and Grew’s application). However, we have recently become aware that these appeals are not expected to be heard until 2007. This raises a number of points of concern.

— The delay in dealing with these cases is unacceptable, and has a knock-on effect on a large number of outstanding inquests into pre-Human Rights Act deaths that have been held in abeyance pending the House of Lords judgment.

— In addition, if the position in McKerr is maintained, this will potentially lead to differential treatment or a two-tier inquest system, with deaths occurring post-2000 requiring an Article 2 compliant investigation, and those occurring pre-2000 not doing so. The arbitrariness of a cut-off date in the terms of the protection of such fundamental human rights is deplorable.

— If the position in McKerr is maintained in the House of Lords, this effectively provides an escape route to the various agencies of the state involved in outstanding cases in Northern Ireland. CAJ believes that these agencies need to be presssed to agree to run the remaining cases in an Article 2 compliant manner regardless of, and indeed given the delay, prior to the outcome of the pending House of Lords cases.

— It is worth noting that in the ongoing inquest into the death of Dermot McShane, the Police Service of Northern Ireland and Ministry of Defence have agreed the scope of the inquest to allow it to proceed without awaiting the House of Lords cases. The proposed scope goes beyond the narrow pre-2000 formulation of “by what means and in what circumstances” to include orders and control
of the operation etc. While welcome, it is still not clear whether this is sufficient to withstand challenge under Article 2. It is also worth noting that this case involves a relatively uncontroversial death that was caused by an army vehicle in the course of a riot, which may explain the relatively benign approach being adopted in this case.

— One relatively simple way of dealing with this issue, and allowing outstanding cases to be dealt with in an effective, prompt and Article 2 compliant manner, would be to pass a short piece of legislation which would direct coroners to treat cases currently open as post-2000 deaths regardless of when the deaths occurred.

We hope the Committee finds these points of assistance in its inquiry. We look forward to reading the outcome of the Committee’s inquiry in due course, and are happy to offer any further input that may be required.

The Committee on the Administration of Justice (CAJ)

February 2006

Evidence submitted by Mrs Bev Hurst, Secretary, MRSA Action UK

Please forgive my intrusion, we have recently attended a meeting with the BMA and it was suggested following a discussion we had on Death Certification that we contact yourself with regard to the reform of the Coroners System and Death Certification. We thought it might be productive to try and set up a meeting with yourself and a delegation from MRSA Action UK, a voluntary organisation representing people who have suffered as a result of Hospital/Healthcare Acquired Infections.

We would like to know if the committee is taking public comments on this subject. We firmly believe that the incorrect completion of Death Certificates has a vast impact on the relatives who have just suffered a great loss, although we do believe that the review of the complaints system might go a little way to help this situation. We also believe that the incorrect completion of a Death Certificate distorts the analysis of causes of death, could have a detrimental impact on research relating to deaths and have a knock on effect on the impact of the development of drugs etc.

I have spoken at length with Dr Richard Taylor on the Health Select Committee and presented him with anecdotal evidence of incorrect completion of a Death Certificate and he agreed, as did a panel of senior doctors, that it was not acceptable for Death Certificates not to have full and complete details on them. Dr Richard Taylor further looking into this matter as he is not aware of any changes in policy that might indicate why infections are being omitted from Death Certificates today. I also wrote to Sir Liam Donaldson the Chief Medical Officer because I have a copy of the directives given to doctors regarding Death Certification and it is obvious that these directives are not being followed. We are to meet with Professor Brian Duerden in June on this matter and other subjects.

MRSA Action UK was founded by a group of people who wanted to campaign the government for change and actively support the growing numbers of people coming to the MRSA Discussion forum for advice.

Whilst working with each other the group pulled together the response to the Government Consultation Action against Healthcare Associated Infection in England. We also responded to the code of Practice and indeed Baroness Barker recently took forward our amendments to the Code of Practice in the House of Lords. We are also in the middle of putting our response together on the Annual Health check consultation 2006.

We have met with the Healthcare Commission and offered our help with the National report they are compiling on the scale of the problem. This will involve evidencing the scale of the problem and helping identify good practice.

In November of last year we presented a petition to Downing St, organised a Wreath Laying Ceremony at Westminster Abbey and also the same day met with the Health Select committee. The next day the 2nd reading of the Health Bill took place and some of the comments made by us in the meeting were voiced on the floor by Dr Richard Taylor notably the way Death Certificates are now written omitting the mention of MRSA and other HAIs as a cause of death.

We have had meetings with the Department of Health and are working closely alongside them to raise public awareness and to give more transparency of information to patients and their families.

We have also met with numerous professional bodies and have further meetings lined up, the general consensus coming out of each of these meetings are we are all singing from the same hymn sheet with regards to safer standards being needed within our Health Service and that the standard of patient care cannot possibly be upheld with the amount of cuts taking place at the minute.

I realise you are an extremely busy but this is a very important Health issue and I think it would be a very good productive meeting on both sides.
We generally welcome the introduction and provisions of the Health Bill and its attendant Code of Practice. Dependant on the commitment of individual NHS Trusts to embrace its provisions and arrangements employed to monitor its application we believe genuine improvements in healthcare are achievable. It is apparent that a lack of continuity and commitment displayed by individual NHS Trusts has been a major contributory fact in the rapid increase in Hospital Acquired Infections.

As a group of people representing people who have suffered HCAI's we can resonate with the opening remarks of the Secretary of State for Health when opening the debate on the NHS Redress Bill on 5 June.

“People want to know why the treatment went wrong, they want an apology from the hospital or doctor concerned and they want to be reassured that lessons have been learnt so that others will not suffer in the future”.

In accordance with this statement we would bring to your attention an issue which causes many people to voice complaint and/or pursue litigation. Unfortunately many people, particularly the elderly, enter hospital with serious illness and subsequently contract infections which contribute to their death. The Medical Certificate of Cause of Death completed by the attending doctor, however, in the majority of cases fails to acknowledge that the infection may have been a contributory factor and relatives become very agitated in these circumstances. We frilly appreciate that the Draft Coroner’s Bill recently introduced to parliament is the province of the Dept for Constitutional Aairs; encourages litigation the cost of which fall upon the NHS. Furthermore lack of complete information prevents adequate research being undertaken and is perhaps causing unnecessary deaths. It also leads to a misinterpretation of current trends and statistics.

The former Health Minister Jane Kennedy commented on this in a letter to Dr Richard Taylor (Wyre Forrest—Health Select Committee).

“MCCD directives are clear that when a Healthcare Associated Infection is part of the sequence which leads to death it should be written in pat It of the MCCD”.

It is clear when speaking with the many people who have been affected by losing a loved one that this is simply not happening. Upon questioning the doctors concerned they are under the impression that because Hospital/Healthcare Acquired Infections are not classed as notifiable diseases then there is no requirement to mention them. We believe this failure to follow the Office of National Statistics guidelines is symptomatic of the blame culture and secretiveness that pervades the NHS. We again note the Government’s intention to reverse this culture and provide openness for patients and their relatives/carers.

Mrs Bev Hurst
Secretary/Northwest Regional Rep
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April and May 2006

Evidence submitted by Hon Mr Justice Sullivan, Chairman Tribunals Committee,
Judicial Studies Board (JSB)

TRAINING FOR CORONERS AND THE JUDICIAL STUDIES BOARD

I am writing in my capacity as the Chairman of the Tribunals Committee at the Judicial Studies Board in response to your invitation for the JSB’s views on judicial training for coroners in order to inform your Inquiry into Coroners reform.

ABOUT THE JSB

The Judicial Studies Board is an independent judicial body. Since April 2006 overall responsibility for judicial training rests with the Lord Chief Justice. For administrative purposes the JSB is part of the Directorate of Judicial Offices for England and Wales. The Judicial Office and JSB are sponsored, funded and staffed by the DCA.

The JSB has the responsibility for organising and delivering training for full and part-time judges exercising Criminal, Civil and Family jurisdiction in the county courts and in the Supreme Court. It also has a responsibility for setting and monitoring standards of training for lay magistrates and has an advisory role in respect of training for chairmen and members in tribunals. I should add that at present, the JSB has no formal responsibility for coroner training nor is it funded to support their training.
THE JSB AND CORONIAL TRAINING

In March 2001 the Board agreed to explore the possibility of taking on a responsibility for providing coroners with training to support their judicial function once the outcomes of the Luce Review and the Shipman Inquiry were known. It also agreed, in the interim, that the JSB should become involved in the training of coroners by offering advice, guidance and support to the Home Office (now DCA) Coroners’ Study Committee (CSC) on the development and provision of training for coroners. For governance purposes the responsibility for liaising with the CSC fell to the Tribunals’ Committee of the JSB which I chair. In effect, the JSB agreed to extend to coroners the same degree of support that it provides to judicial officers sitting in administrative tribunals. To that end, coroners were invited to attend training events organised by the Tribunals Committee of the JSB, including its range of judicial skills courses and training skills courses for the tribunals’ judiciary. The JSB is represented by a member of the JSB Secretariat at meetings of the Coroners’ Study Committee. This provides the link between the Tribunals’ Committee and coroner training.

Most Coroner’s Study Committee members have now attended most of the Tribunals Committee’s range of courses and the JSB has provided some speakers and contributors for coroner courses. The JSB can also provide advice and guidance on training but it has no budget for coroner training and can only assist where and when resources allow.

RECENT DEVELOPMENTS IN CORONER TRAINING

In recent times cross-fertilisation between the CSC and the JSB has increased. One CSC member has attended the JSB Recorder (criminal law) induction course. The JSB’s full-time Director of Studies and the Tribunals’ Committee’s Training Director have contributed to a programme of successful summing-up courses for coroners and the Tribunals Training Director has contributed to planning and delivery of new style induction training for coroners.

Partly as a consequence of this closer working relationship, the Director of Studies felt able to invite two of the most experienced members of the CSC to the JSB Course Directors’ Conference in September 2005. This was the first time that judicial officers from outside the JSB’s constituent groups had attended. The CSC has been keen to use JSB practices and models where appropriate. The appointment of an experienced judicial figure to act as course director for an individual course or programme of courses is a JSB practice which the CSC has adopted to good effect. Two CSC members have been acting as directors for the continuation and induction training programmes for some years and two other members recently took the lead on the summing-up and state deaths course programmes. Having a CSC member who is responsible (to the CSC) for the planning, organisation and delivery of a particular course, as well as acting as course chairman, tutor team leader and the focus for participant’s questions, has worked well in JSB training and is now proving a success in coroner training.

The CSC is also looking at a range of other JSB practices and guidance including competence framework development, appraisal schemes and mentoring. However it is recognised that coroners are unique and that JSB practice cannot always be applied to the coroner jurisdiction without alteration. Until there is reform of the coroner service, it is doubtful that any of these initiatives could yet have national acceptance.

It is safe to say that coroner training has improved considerably since the JSB first became involved in 2001. Courses are now much more participative with more focus on judicial skills (rather than law and practice). There is now a small group of experienced and very capable coroners who have undertaken JSB training skills training and who organise and deliver training. They rely for support on one Executive Officer within the DCA Coroners Division.

One of the CSC’s members, Chris Dorries, is I understand advising the Select Committee during the Inquiry. He has been very closely involved in the work that CSC is doing with the JSB and would I am sure he would be willing to expand on the details of our collaboration.

BARRIERS TO EFFECTIVE TRAINING

Improvements in training content and delivery and an increase in the range of training provided by the CSC has resulted in greater acceptance by coroners generally but there are a number of barriers.

I am told there are still a number of Coroners who do not attend training regularly (or at all) or indeed encourage their Deputies and Assistants to do so. Although they are now very few and far between the CSC has been unable to persuade a small hard core to attend.

DCA funding for training is (or has been) sufficient to provide an adequate range of training courses in any given year for coroners (nothing is provided for coroner’s officers or until very recently for their administrative staff). However, it is not sufficient to meet the fees and expenses of those attending. Local authorities can usually be persuaded to meet travel expenses but unlike part-time members of the judiciary (who can claim half the daily sitting rate for each day of training they attend), deputy and assistant coroners are not usually offered a fee to attend training and this may explain, in part, a reluctance to attend. There are also difficulties in coroners arranging cover whilst they are on courses, since they have to arrange for and pay for deputy cover themselves.
The CSC has no formal locus. Its work is getting better known and the sense is that it is increasingly seen as being coroner led rather than departmentally led, but unlike the JSB it doesn’t have a formal place in a “judicial” hierarchy (as there is currently no hierarchy with coroners).

The CSC has been tackling these issues as best it can, but they are, in the main, issues which the CSC can do little of significance about pending reform of the system. Given this context, what has been achieved in the last five or so years by a handful of dedicated coroners with the minimum of resources and support is perhaps all the more remarkable.

The future

On the question of Coroner training and JSB links in the long term, much will of course depend to a large extent on the role of coroners under the reforms. The JSB will welcome the opportunity to comment on the plans but I would not want to prejudge anything before the government’s intentions emerge formally (or indeed before the Board has had a chance to consider its response).

Suffice to say that that at this stage the JSB has not ruled out taking on a more direct responsibility for coroner training (as it does for the district and circuit benches), nor the possibility of acting in an advisory capacity, perhaps supplying some generic training and monitoring and evaluating training provision, (the approach which the JSB adopts for the Magistracy and Tribunals).

One final observation. All of the JSB’s existing customers (and the JSB itself) now come under the overall leadership of the Lord Chief Justice (to a greater or lesser extent). If the new coronial system is to fall outside that structure (and I should stress that the future structure of the Coronial system is in no way a matter on which the JSB could or should comment) then that may ultimately have an impact on the Board’s view in relation to the JSB’s future role.

Once the Government’s intentions for reform of the Coroner Service are published I will be in a position to ask the Board to consider the extent of its remit for Coroners. Of course, any role that the Board decides that it should undertake for a newly reorganised coronial system will need to be fully resourced.

The Honourable Mr Justice Sullivan
Chairman Tribunals Committee
Judicial Studies Board
June 2006

Evidence submitted by the Royal College of Pathologists

The Royal College of Pathologists agrees that reform of the coroner system is needed and strongly supports most aspects of the draft Bill. However, we are particularly concerned by the many important issues which are omitted from the draft Bill. We note with regret that even the Summary to the draft bill acknowledges that it addresses only “some of” the weaknesses in the present coroner system.

We believe it to be self-evident that a successful coronial system is entirely dependent on collaboration between legally qualified personnel, principally coroners, and medically qualified personnel, principally pathologists.

1. Death Certification

We remain of the opinion that the failure to reform the death certification process is a mistake. Reform has been recommended by a succession of reports, including the Brodrick Report (1971), the Luce Report (2003), and most recently by Dame Janet Smith’s report on the Harold Shipman affair. We believe that a reformed death certification system, coupled with appropriate statistical analysis of patterns of death, would be a considerably more effective tool to detect and prevent similar crimes in the future than is this Bill. We believe that a reformed death certification system would be a reassurance to the bereaved. Rather than increase bureaucracy, it could replace or even reduce the existing bureaucracy of the cremation form system, and by eliminating the obsolete aspects of that system it need not significantly increase overall cost. The decision not to abandon cremation forms (an expensive-to-families and demonstrably unjustified and ineffective procedure—see the Shipman reports) is highly regrettable.

We have been informed that a decision not to address these issues has been taken at a high level and is unlikely to be reversed. We regard this position as mistaken, but as a result we have therefore sketched out our proposals only briefly in Appendix A below. We would be delighted to discuss this in more detail if there is any possibility that this decision might be reversed.
2. THE PROVISION OF MEDICAL ADVICE

The draft Bill emphasises the legal aspects and barely mentions the medical aspects of ascertaining a cause of death. We were seriously concerned by this. We have respectfully suggested to the Department of Constitutional Affairs that a meeting with the Royal College of Pathologists, as the body charged by its Royal Charter with upholding the standards of practice in pathology in the UK, would have been appropriate before, rather than after, the draft Bill was published. Ascertaining the cause of death is almost invariably dependent on medical expertise, and the draft Bill does not acknowledge this. The Department for Constitutional Affairs has said that legal advice indicated that medical input need not be mentioned on the face of the legislation; with respect, our medical advice accords rather greater importance to the medical aspects of the process.

3. We have received a verbal explanation of the intentions regarding improved medical input to the process. We were assured that it remains the intention to appoint a chief medical examiner to advise and assist the chief coroner, and that guidance will be produced on how to obtain appropriate medical advice at a local level.

We remain very disappointed that there is no intention to appoint medical advisors at a local level, because correctly investigating and identifying the cause of death is in most cases primarily a medical process. We suggest that concerns about the potential cost and bureaucracy are dependent on the mechanism employed and on the role and duties of the local medical examiners. Our suggestions are in Appendix A.

4. THE CONDUCT OF A POST-MORTEM EXAMINATION

We are concerned that under Clause 26, it appears to be the coroner who tells the pathologist how to examine the body—eg MRI scan only, gross examination only, which organs may or may not be sampled for further analysis, whether or not toxicology studies might be done etc. This is not appropriate. A legally qualified coroner cannot sensibly make these decisions without medical advice. This reflects the lack of medical input into the legislative process so far. Whatever may be apparent at the time of reporting the death, the actual autopsy process usually reveals other and additional aspects. It should be up to the professional judgement of the pathologist to determine what is done—as is the case at present under Coroners Rule 9 re taking samples—not just that of the coroner or his officers. See also Appendix A.

5. INVESTIGATION OF SUDDEN UNEXPECTED DEATHS IN INFANCY—(a)

Baroness Kennedy’s report into Sudden Unexpected Death in Infancy (SUDI) had recommended that tissue blocks and slides should be retained “in perpetuity” after a post mortem examination in a case of sudden infant death syndrome (SIDS), in case future developments justified re-examination of those samples. We explained that the Human Tissue Act 2004, far from implementing this recommendation, had made such retention illegal in England, Wales and Northern Ireland, because such retention would be illegal without “appropriate consent” once the work of the Coroner had been completed. The situation in Scotland is exactly the opposite, because under the Human Tissue (Scotland) Act the blocks and slides become part of the deceased’s medical record and the pathologist is specifically prohibited from disposing them or returning them to the parents.

This polar difference between Scottish and English law is contrary to the stated intention of Ministers that the tissue legislation in the two jurisdictions should have broadly the same effect.

6. We suggested that the Coroner should retain a formal interest in cases where a cause of death has not been ascertained, until such time as a definite cause of death is ascertained, or for a suitably prolonged period (such as 100 years).

We regard this suggestion as self-evidently reasonable. It would have the benefit under the Human Tissue Act 2004 of giving the Coroner the power to decide whether or not small tissue samples should be kept “in perpetuity” in cases of SIDS, as Baroness Kennedy recommended, because SIDS is recognised to be an acknowledgement that a specific cause of death could not be identified. Similar concerns apply to the much smaller number of adult deaths where a cause of death cannot be ascertained.

7. INVESTIGATION OF SUDDEN UNEXPECTED DEATHS IN INFANCY—(b)

Baroness Kennedy’s report into Sudden Unexpected Death in Infancy (SUDI) had recommended that certain time-sensitive samples (such as blood, cerebrospinal fluid and nasal swabs for microbiological investigation) should be taken as soon as possible after the death of a child had been confirmed, to maximise the chances of ascertaining the cause of death. Baroness Kennedy clearly anticipated that this sampling would usually occur in an accident and emergency departments, before transfer of the body to a mortuary.
We explained that the Human Tissue Act 2004 has made this sampling illegal, even if authorised by a Coroner, unless the accident and emergency department is covered by a Human Tissue Authority licence to undertake such sampling. The cost and complexity of obtaining such licences is disproportionate to this sampling. We believe that many A&E departments will not be covered by the licence obtained for an on-site mortuary.

It is our understanding that this consequence of the Human Tissue Act 2004 was not recognised before that Act obtained Royal Assent. It is our hope that the present Coroners Bill could be an opportunity to amend the legislation, to give Coroners the power to authorise such limited and urgent sampling even if the body is not in an appropriately licensed location.

8. INTERFACE WITH THE HUMAN RIGHT ACT 1998

One interpretation of the HRA is that all deaths following medical intervention in health centres and hospitals, ie where agents of the State may be involved, should be meticulously investigated. Is it the intention to reinforce the investigation by Coroners of such deaths? Will the desired standard of the autopsy examination be defined? See also the next point.

9. Consistency of procedures and standards of investigation. We are very concerned that under the present system there is considerable and unjustifiable variation in many aspects of the Coroners work. In addition to legal concerns about whether and how to conduct an inquest, which deaths require investigation, the nature of written reports etc. these issues include medical matters such as whether to conduct a limited post mortem examinations rather than a full post mortem examination, the standards to which the autopsy is performed (including the level of justification for post-mortem tissue sampling and toxicology investigation) and the standard of reporting of the post mortem examination.

10. APPEALS AGAINST A CORONER’S DECISION TO UNDERTAKE A POST-MORTEM EXAMINATION (DRAFT CHARTER FOR BEREAVED PEOPLE, SECTION 15)

We believe that the stated 24 hours in which to make such an appeal is too rigid, because it could preclude some investigations which must be undertaken rapidly in order to ascertain the cause of death (such as microbiological sampling) and could have the effect of unnecessarily delaying the examination in cases where religious beliefs demand rapid burial. We understand that the Department of Constitutional Affairs has acknowledged that flexibility will need to be available on this point. We suggest that the mechanism by which such appeals may be lodged and assessed needs to be clarified.

11. WHO SHOULD UNDERTAKE A POST-MORTEM?

The draft Bill (clause 26(1)) uses the term “medical practitioner”. But it is a regrettable fact that the majority of newly qualified UK medical graduates have never seen a post mortem examination, much less been trained in how to conduct one. It would be more appropriate to use the term “qualified pathologist”. If a precise definition of this term is required we would be happy to assist. The amended Coroners Rules 9 and 121 use the term “pathologist”—following discussion with the Home Office and RCPath—so this Bill should do the same. The restriction in clause 26(2–3) still pertains, in the (unlikely but not impossible) event that the prospective autopsy pathologist did somehow possibly contribute to the patient’s demise.

12. WHERE SHOULD POST-MORTEMS BE PERFORMED?

The Bill should refer to mortuaries licensed under the Human Tissue Authority, with appropriate standards etc.

13. RETENTION OF HUMAN REMAINS

In Clause 53, does the term “the body” include parts thereof? If so, down to what size—bearing in mind that the Human Tissue Act’s definition of “human tissue” can be satisfied by a single human cell?

Appendix A

A SUGGESTED APPROACH TO THE MEDICAL SCRUTINY OF CAUSES OF DEATH

1. The Death Certificate should be completed by a medical practitioner responsible for the deceased person’s medical care, as now, but with reconsideration of the current restriction that the doctor must have seen the deceased within 14 days before death (28 days in Northern Ireland). This certificate should be completed even if the responsible medical practitioner believes that the death would have been referred to the Coroner under present arrangements.

2. The information required for such certification should be extended to include the location of death and the names of the medical practitioner(s) and others primarily responsible for the care of the deceased immediately prior to death. This information should be used routinely to scrutinise patterns of deaths, with
investigation by the Coroner of any unusual patterns to detect any preventable causes of death (such as another Harold Shipman, but also including healthcare which has fallen below expected standards for non-malicious reasons).

3. A number of approved Medical Examiners should be appointed by each Coroner, to provide appropriate cover for the main hospitals and centres of population in the area. These would probably be provided by part-time secondment of existing hospital consultants (including pathologists) and GPs rather than full-time posts.

4. Training for these Medical Examiners should be made available to ensure consistency of approach.

5. The death certificate and the medical casenotes should be delivered to a local Medical Examiner for scrutiny. If an appropriate medical practitioner cannot suggest a cause of death the medical notes should be referred to the Medical Examiner without a death certificate.

6. The Medical Examiner would be expected to scrutinise the casenotes pertaining to the recent history of the patient, to an appropriate level to confirm that the stated cause of death seems reasonable. Guidance and training on the appropriate level of detail of this scrutiny would be provided nationally. In most cases it should only be necessary to examine the notes pertaining to the terminal illness. The Medical Examiner would have the authority to question any other person about the death. Notably, if the stated cause of death does not seem reasonable, the Medical Examiner would contact the doctor certifying death to make enquiries.

7. If the Medical Examiner considered that referral to the Coroner is justified, this would be the next step, along with a recommendation on whether or not a post-mortem examination is likely to provide relevant information beyond that available from other sources. We believe that many unnecessary post-mortem examinations could be avoided in this way. Other sources of information (e.g. key healthcare workers involved in the deceased’s care) might also be identified for the coroner’s benefit. If an autopsy is the outcome, the Medical Examiner can also assist the coroner in advising what clinical questions are to be addressed by the procedure, and therefore what needs to be focussed on by the pathologist.

8. If referral to the Coroner is not indicated, registration of the death would proceed as at present, followed by authorisation of burial. This process could be simplified.

9. The present Cremation Form system should be abolished.

10. The current requirements for completing the second part of the cremation forms should also be abolished:

   (a) The requirement to speak to the doctor who completed the first part is rarely of value, as it is in effect to ask whether he/she has lied in completing the first part; the answer to that question is invariably negative. Modern patterns of working also mean that it often introduces an unnecessary delay, as the doctor in question may cease to be readily available.

   (b) Examination of the external surface of the body is most unlikely to identify any suspicious features which are not already obvious to carers, undertakers, mortuary staff etc. In practice this examination is often extremely cursory.

11. Examination of the available medical casenotes is currently good practice in relation to cremation forms, but it is not a legal requirement. We believe that it should be.

12. We acknowledge that a requirement to examine medical casenotes will necessitate establishing systems of secure transport of casenotes to an appropriate Medical Examiner. In some cases this may also introduce a delay; the system should be engineered to take account of the concerns of those with religious beliefs which require rapid disposal of the body. But at most, any delay should be no more than the delay introduced by the current cremation form system. We suggest that these problems of transport and timeliness would be minimised if Medical Examiners are part-time, sufficiently numerous, and geographically distributed.

   The examination of casenotes will be greatly facilitated when current plans to make casenotes available electronically are implemented.

13. Remuneration for Medical Examiners, in straightforward deaths due to natural causes, should be proportionate to the current fees for completing cremation forms. We have not undertaken a formal financial assessment, and to do this accurately would require a pilot study. However, as the majority of deaths in the UK result in cremation, we believe that this proposal is unlikely to be any more bureaucratic, onerous, time-consuming or expensive than the current arrangements for disposal by cremation. If (as we recommend) this approach was to be applied to all deaths then it might be regarded as inappropriate to charge the bereaved relatives for the process, as currently happens with cremation forms. This would then result in an increased cost to the public purse, even though the overall expense does not increase. We would welcome this; we have long believed that the current system of charging relatives for cremation forms is an inappropriate “death tax” which should be abolished.

14. Savings are likely to result from more efficient identification and investigation of Coronial cases, with fewer post-mortem examinations.
15. Any stigma which might be associated with referral of a death to the Coroner would be reduced overall, because the number of deaths formally referred to the Coroner should be reduced.

16. The public would be reassured that the cause of every death undergoes independent medical scrutiny, and may be surprised to know that, despite the crimes of Harold Shipman, this is not the case at present.

Professor P Furness, Vice-President
Professor J Crane
Professor S Lucas
Dr C Wright
On behalf of the Royal College of Pathologists

July 2006

Evidence submitted by Epilepsy Bereaved

1. INTRODUCTION

1.1 Epilepsy Bereaved aims to prevent seizure-related deaths and to provide specialised support for the bereaved. There are about 3 seizure-related deaths in the UK every day. Approximately 600 of these deaths are sudden and unexpected deaths (SUDEP). These deaths usually are in the young (20–40 years) and occur at night during sleep (they are likened to an adult cot death) and usually occur in the community at home. SUDEP accounts for about 600 sudden unexpected deaths per annum and is part of a larger issue of sudden unexpected/unexplained death in the young (given that in addition there are on a conservative estimate 300 cot deaths per annum and 400 cardiac-related deaths in the young).

1.2 Epilepsy Bereaved has a Scientific Advisory Committee including 14 experts in epilepsy and sudden death. In 2002 we led a NICE National Sentinel Clinical Audit into Epilepsy-Related Deaths working in partnership with 5 medical Royal Colleges. We have also published independent research into the experience of the bereaved with experience of sudden unexpected death in epilepsy. In 2006 we worked as a partner with the Royal College of Pathologists to bring leading experts and organisations concerned with sudden explained death in the young (Epilepsy Bereaved; Foundation for the Study of Infant Deaths (FSID) and Cardiac Risk in the Young (CRY)) together to discuss the system for investigation of death and the support needs of the bereaved.

1.3 Epilepsy Bereaved welcomes this opportunity to submit evidence to the Constitutional Affairs Select Committee. We have had insufficient time to properly review the draft bill, but are submitting a short statement of our general views at this time.

2. WHAT PROBLEMS ARE THERE WITH THE CURRENT SYSTEM

2.1 Sudden and unexpected (SUDEP) deaths in young people with epilepsy require full and appropriate investigation. Research evidence firmly indicates the importance of post-mortem in determining the number of epilepsy deaths and the preventative measures that need to be adopted. Without post-mortem it would not be possible to identify deaths due to other causes including suicide; toxic poisoning or alternative mechanisms for sudden death. It would also not be possible to determine from a public health perspective to what extent epilepsy deaths could be avoided by improved services eg counselling on taking of medications and in some families genetic counselling. The quality of national statistics on certified causes of death is vital for monitoring of public health, setting targets for health care policies addressing a problem and research aimed at reducing sudden unexpected deaths in the young.

2.2 The National Sentinel Audit 2002 investigated 2,412 post-mortems with epilepsy on the death certificate. The Coroner investigated 45% of these deaths in England and Wales; 3% in Northern Ireland and the Procurator Fiscal investigated 30%. The deaths were otherwise certified by a doctor.

2.3 The National Audit found, consistent with previous research, that there were serious disparities in the level of investigation and certification of epilepsy-related deaths. The National Audit identified serious quality assurance issues in relation to post-mortems of epilepsy-related deaths. The National Audit revealed that investigation and recording of these deaths was inadequate in 87% of post-mortems and that doctor certification of epilepsy-related deaths was only inappropriate in two-thirds.

2.4 We would like to emphasise the importance of preventative lessons from premature deaths in the young. The National Clinical Audit of Epilepsy-Related Deaths found that 42% of epilepsy deaths were potentially avoidable. The Government produced an Action Plan on Epilepsy in 2003 in response to the National Audit, but no action plan to reduce deaths will be effective unless there is quality assurance in the accurate investigation and recording of epilepsy-related deaths.

2.5 Epilepsy Bereaved commissioned an independent report from the College of Health Report in 2002 to investigate the experience of the bereaved through sudden death in epilepsy. This research mirrored the findings of the National Audit finding that families experienced a lottery of service provision both before
and after an epilepsy-related death leaving bereaved relatives feeling excluded from information, support and services. One third of all relatives interviewed were concerned about the investigation of death and half of all families had difficulties getting relevant and appropriate information after a death. The College of Health Research 2002 clearly identified the needs for relatives to have information about epilepsy-related deaths and how these deaths should be investigated as well as general information about the system and sources of support.

2.6 In May 2006 Epilepsy Bereaved worked with the Royal of College of Pathologists to bring together leading experts and organisations concerned with sudden unexpected deaths in the young. This included organisations concerned with a conservative estimate of some 300 cot deaths per annum; 400 cardiac-related deaths in the young per annum and some 600 sudden unexpected deaths in epilepsy per annum. The meeting looked at systems for investigation of sudden unexpected deaths in both Scotland and England and Wales. Concern was expressed about the lack of standardisation including pathologists not being authorised/resourced by Coroners to undertake necessary investigations into the cause of death. It concluded with a general consensus that there was an urgent need for standardisation and quality assurance in the investigation and certification of all sudden unexpected/unexplained deaths in order to implement prevention strategies. The meeting also concluded with a recognition of the vital role of the voluntary sector in working to prevent deaths and in supporting the bereaved. This is an area of significant public interest which needs to be addressed.

3. EXISTING PROPOSALS FOR REFORM

3.1 We support the proposals for a chief coroner, full-time coroners, fewer districts and medical support (although we would like to see a strengthening of the independence of the system with for example recruitment through the Judicial Appointments Commission). We also support the general provision within the draft Bill of increased formation to the bereaved and welcome the appeal rights for the bereaved.

3.2 Our main concern is the omissions in the draft bill. First, the omission of certification will mean that many of the bereaved experiencing sudden unexpected/unexplained deaths in the young will not be given the level and quality of service in the investigation of death that is necessary. We are also concerned that the draft bill has removed the requirement for investigation where a death is “sudden and cause unknown” and that under the new bill, there continues to be a serious risk that sudden unexpected/unexplained deaths in the young will lack standardisation in the level and quality of investigation needed to begin to use public health strategies to reduce the number of these deaths. We consider that sudden unexpected deaths where the cause of death requires ascertainment through specialist investigation should be identified as a dedicated area on the grounds that there is a high public interest in reducing unexpected/unexplained deaths in the young. This is an area that requires particular attention from a matter of quality assurance and public interest. This public interest has been recognised by the Chief Medical Officer for England (Chief Medical Officer’s Annual Report 2001) and in a European White Paper (EUCARE, 2001). The College of Health report involving 127 relatives in focus group meetings and 78 in depth interviews found that relatives recommended a dedicated resource in each local area supported by national guidance on the investigation and reporting of sudden deaths in the young. Good practice in the investigation of these deaths should be subject to nationally recognised guidelines that standardise investigation and ensure that specialist investigations by pathologists are undertaken where this is important to ascertain the cause of death. There needs to be a dedicated resource aimed at a standardised training for all those involved in the investigation of sudden unexpected/unexplained deaths. The role of the voluntary sector in supporting relatives and educating professionals should also be recognised and supported.

3.3 We would like to see a strengthening of the proposal for a charter for the bereaved through the provision of some method for enforcement by the bereaved. The voluntary sector has an important role to play with expertise in the development of literature and specialised sources of support. Sudden Unexpected/Unexplained Deaths should be one of the categories identified as a particular form of loss with information provision about specialist support services available.

3.4 Regarding process, our experience is the bereaved are at a disadvantage in the current adversarial system in the absence of resourced representation. We consider that an inquisitorial system is preferable to an adversarial system and that there is a need for advocacy for the bereaved. Specialist advocates trained in sudden unexpected death; bereavement awareness and the procedures of the inquest would be a substantial improvement on the existing system where nearly all the bereaved we are in contact with have no support at Inquests. A trained lay advocate system would be a step forward in the absence of legal aid for Inquests.

3.5 We consider it unfortunate that the proposed reforms will miss a key opportunity for creation of a national Coroner Service, with all personnel working within it responsible to the Chief Coroner. We are concerned that even with the proposed reforms the system will not adequately address key issues of fragmentation; standardisation; quality-assurance and under-resourcing.
4. ALTERNATIVES TO THE CURRENT SYSTEM AS PRACTISED IN OTHER JURISDICTIONS

4.1 We have experience in Scotland of the Fatal Accident Enquiry process. The Findlay Inquiry (October 2002) concerned a family with two sudden epilepsy-related deaths of a mother and daughter. The Inquiry into the death of the daughter some 10 years after her mother led to a determination that the death of a young woman followed a “catalogue of errors” and the judge determined that all GPs should audit their epilepsy patients, that guidelines should be implemented and that most patients should be given information about the risks of SUDEP. This was an excellent outcome for the family concerned and for development of services generally. Although it was not binding it received significant public interest and in Scotland it led to the Scottish Executive writing to all Health Boards and Trusts. It was a major catalyst in Scotland to the introduction of managed epilepsy clinical networks. This is why we would support an approach which identified sudden unexpected deaths in the young (whether potential sudep or cot deaths or cardiac-related) as an area of public interest where key lessons could be learnt to prevent deaths in the future.

4.2 In Sweden the investigation of sudden and unexpected deaths is the responsibility of the local public health official who may consult medical records and medical personnel before deciding the appropriate level of investigation.

4.3 We would like to see a system which was focused on the public interest in public health eg identification of cause of death and systems defects. Where there is a sudden unexpected/unexplained death we would like to see the early involvement of a dedicated official with training in sudden unexpected/unexplained deaths in the young and public health who would be consulted by the Coroner about the level of investigation whether by post-mortem only or by post-mortem and inquest. Where an inquest is held we are advocates of the “considered” narrative as developed by the Scottish Fatal Accident Enquiry System focusing on a factual account and recommendations to learn lessons and prevent future deaths. As a specific area of public interest, we would like to see sudden unexpected/unexplained deaths in the young subject to a national monitoring by the Chief Coroner.

Jane Hanna
Director
Epilepsy Bereaved
July 2006

Evidence submitted by Nigel Meadows, HM Coroner for Plymouth & SW Devon

INTRODUCTION

The views expressed herein are purely personal and do not represent the view of the Coroner’s Society of England and Wales or the South Western Coroner’s Society.

GENERAL POINTS

1. Shipman

The Bill does nothing to deal with the issues raised by the Murders committed by Dr Harold Shipman. Indicating that this will be dealt with by NHS Reforms could be viewed as a missed opportunity. The NHS Reforms will not prevent another Dr Shipman. Admittedly it is very difficult to prevent a determined doctor unlawfully killing their patients.

2. Hospital Mortuaries

The Bill does not address the National issues concerning the acquisition or purchasing mortuary usage and the skills and expertise of Histopathologists who do the vast bulk of Coronial post mortems. It is therefore still left to Local Authorities and their Coroners to try and negotiate the best possible deal. There are no national performance standards or pricing schedule.

3. Treasure

The retention of a Treasure Inquest System is also a missed opportunity. This is an historical anachronism which should be abolished in the 21st Century. Treasure Inquests serve no useful purpose and could easily be dealt with administratively by the British Museum with an Appeal process being available via the Civil Courts. The objections of the Departments of Media, Culture and Sport are in reality without foundation. Treasure Inquests are largely a total waste of time which really achieves nothing. The money to be utilised in the creation of a Treasure Coroner, his Deputy and supporting staff and all that goes with that could be
utilised far better to providing the real service which Coroners are meant to give. Whilst it may be academically interesting, since this is the first opportunity for major reform to be taken probably in 100 years, Treasure Inquests should come to an end.

4. Resources
   
   The view expressed at the first introductory meeting held in London that the Coroner’s Charter sets out the level of Service that the Government would expect currently to be provided for the public is totally and utterly unrealistic. The draft Coroner’s Charter plainly and without doubt will require additional staffing/resources/manpower to try and achieve that. The whole system will become far more bureaucratic.

5. Appeals
   
   Introducing an Appeals system will inevitably lead to delay in post mortem examinations, leading in turn to storage problems of bodies at mortuary’s and undertakers. It will be time consuming and expensive. It will lead to lawyers developing an area of new legal practice based upon raising objections to all manner of decisions which Coroner’s operate. Coroners and their Officers use their experience to talk to families at present to try and persuade them of the most appropriate course which then proceeds with the de facto consent (in the vast majority of cases) of the “next of Kin”—whoever they may be. It is impossible for any system to have 100% success. The ultimate sanction of simply being able to proceed and only being stopped by a High Court Judge which on the face of it seems somewhat stringent and arbitrary, in practice actually works. Quite often post mortems and various tests and analysis have to be conducted very shortly after a death (ie septic shock). Any delay in examination can only prejudice the result of those enquiries. Even in more routine post mortems delays of several days only to evidence being lost or minimised with the natural decomposition processes. I would suggest a much more limited basis for Appeal.

6. Luce
   
   The Luce Report identifies that the current system is under resourced substantially for the burdens placed upon it. The Local Authorities still would retain the obligation to fund the Service which plainly is going to be more time consuming and expensive in the future. However, no extra funds are provided by HM Government to Local Authorities for this. I have always been a believer in the proposal for a separate Death Investigation Agency separately funded by the Government should be set up. All Local Authorities are under tremendous financial pressures with competing budgetary demands. The Lord Chancellor’s was cut by 8%. Local Authorities around the Country are having to cut and trim their budgets. Where on earth in the pecking order of spending will the Coroner’s Service come?

7. Section 33
   
   Section 33 of the draft Bill indicates that the Local Authority “must” provide and maintain proper accommodation for investigations and inquests. Most Coroners around the Country have totally inadequate accommodation. How is this to be interpreted by Local Authorities? Are they to build purpose built Courts? Having access to, for example, Magistrates’ Courts in rural areas have been much diminished because of the closure programme. Getting time to sit at Crown Courts is notoriously difficult. To have the sort of facilities envisaged by the Coroner’s Charter, for example, for Jury Inquests or in fact any Inquests of length and complexity where numerous witnesses will be called, requires an appropriate Court Venue. This would inevitably entail Local Authorities in substantial capital expenditure. They should be told whether or not this is the case so that they can plan and start building now! If not, what on earth does it mean?

8. Coroners Officers
   
   The expectation expressed that the draft Bill suddenly removed the uncertainty from Local Authorities and Police Forces as to the current provision and future of Coroners Officers is total nonsense. The vast majority of Coroners have the assistance of Coroners’ Officers employed by and paid for by their Police Authorities. If Local Authorities are to take on this responsibility even on the present staffing levels, where are the funds going to come from to pay for this. The extra demands on the service will inevitably lead to extra staffing demands which will mean that the Local Authorities would actually be taking on a far bigger employment problem than currently exists.

9. Nowhere in the Draft Bill is there a formal acknowledgement of the current role and expertise of Coroners Officers. This should be addressed.

10. The general scheme to put Coroners on a much more additional judicial footing is laudable but plainly there is so much work to be done in preparing the draft rules/regulations it is surprising that they were not provided to start off with. We need to see them now.
THE DRAFT BILL

Section 1
Will the Coroners Rules define “reasonable cause to suspect” actually is or may be?
“Do persons otherwise lawfully detained in custody” include those persons detained under the Mental Health Act 1983? In many cases those persons claiming dire circumstances which warrant further investigation particularly in the light of recent publicity concerning, for example, the care of those with learning disabilities, what about those patients who are caught in what is known as the “Bournewood Gap”. In other words, where they are not formally detained but to all intents and practical purposes they are detained but not in name.

Section 2
This broadly represents the current position under Section 15 of the Coroners Act 1988 this when the Chief Coroner “may” direct a Senior Coroner to conduct an investigation. Precisely upon what basis and criteria would such a discretion be exercised.

In view of the expanded definition of a body, would this not potentially cause problems.

Section 3
Again the issue of the basis upon which the Chief Coroner would exercise the discretion and on what basis needs to be resolved.

Section 4
Personally I have conducted several Inquests into deaths which have occurred in Scotland which have actually proved very useful and informative for the relatives. Fatal Accident Enquiries are rare in Scotland. Once again a discretion is provided but without any knowledgeable basis upon which it can and would be exercised. This may be used as an attempt to minimise the number of enquiries of this nature. Is the Chief Coroner always to be pressed into granting permission for an investigation where there are family members pressing hard for one? What if there are no family members but the case does deserve some sort of investigation but it will prove expensive and time consuming.

Section 5
There are numerous queries and questions with investigation of death outside the United Kingdom under the current draft Section 5. What does “linked to the circumstances” mean? What does “the death might recently be expected to give rise to action” mean? What is the definition of “action”? Does that mean litigation, complaints, etc. What are similar circumstances?

A much clearer definition needs to be spelt out with regard to Service Personnel who died “on duty”. What does that actually mean? Does is mean a care accident whilst driving from one base to the other? Does it mean under active fire from an enemy? It has generally been accepted that in particular multiple fatalities and bodies being repatriated to this Country, the families in question benefit from a proper enquiry into the facts and circumstances so far as is humanly possible to determine how their loved ones died. It seems to me that this current section is drafted to stop the need for any such enquiries and resolve the “Smith” case issue. It seems to avoid natural disasters being enquired into, although there may well be culpability and responsibility for many involved. In a plane crash how does one know that there could be a murder or manslaughter investigation from the outset.

Section 6
Precisely on what basis does a Senior Coroner report a death to the Chief Coroner requiring investigation. What is the public interest and how is it defined. Surely that will vary with Governments of the day. Precisely on what basis would the Lord Chancellor exercise any discretion? Should it actually be the Lord Chancellor in any event. Since he is no now no longer the Head of the Judiciary, surely the common sense and logical person is the Lord Chief Justice? If not, it is plainly then subject to Political influence.

Section 7
In practice, I do not see this to be a problem and things would work largely as they do at the moment.
Section 8
No specific comment.

Section 9
This largely represents the current law. It is safe to say that clearly it involves the exercise of discretion by the use of the word “may”, but on what basis is the discretion to be exercised?

Section 10
It is a matter of common sense that the purpose of the investigation should also be to ascertain the “medical cause of the death”. In addition to by what means the death occurred. Why cannot that simply be added? Sub-section 2 essentially gives statutory enactment to the Middleton Judgment. There will still be arguments as to precisely what “the circumstances” are in any given case.

Section 11
The Inquest is now seen as part of the investigation. Who, if anyone, can see for example the documentary evidence collated and collected by the Coroner during the course of the investigation either created by himself or his Officers or through third party sources such as the Police, the Ministry of Defence, the Security Services etc?

Section 12
The current drafting is poor. It is plainly the Coroner who conducted the investigation and heard the Inquest who should initiate steps to prevent a recurrence of a similar fatality. As presently drafted it would seem that the Area Coroner would then have to ask the Senior Coroner to take steps when that individual has not heard the witnesses, considered the evidence and been intimately involved in the case. The current Section 12 provides no teeth for the prevention of further fatalities.

Section 13
What is the basis upon the exercise of discretion for the Senior Coroner to indicate that a case should be held with a Jury? There are no such appeals against the decision one way or the other.

Section 14
There seems to be no logical basis for reducing the current numbers of Jurors who can serve. One of the strengths of the English legal system has been the use of Juries over many years. Reducing the number of Jurors will reduce the competing opinions and input that Jurors can give to a case and their deliberations. There are considerable dangers when starting long or complex cases with the few Juror anticipated to be required. Inevitably illness or stress will account and will lead to cases having to be abandoned part heard. The perception, because it is an Inquisitorial task the less Jurors need to be involved is completely misplaced. In fact the Jurors at Coroner’s Inquest have a far greater task than Juries in criminal cases because they are answering simple yes and no questions. Jurors may need to complete a series of complex findings of fact. They may wish to announce their findings in answer to a series of questions ie Middleton narrative verdicts. There are considerable dangers going along this route.

Section 15
No comment.

Section 16
This minimises the number of Jurors required to agree their verdict. You could almost have a split Jury
but with simply one member more agreeing. That plainly could be prejudicial to the interests of Justice and the individual case.

Section 17
This largely represents the current position and obviously without reference to committal proceedings which no longer, in reality, exist.

Section 18
This provides a considerable weapon both tactically and practically to a prosecuting Authority to request an adjournment. What is “an exceptional reason” for not suspending an investigation.

Section 19
No comment.

Section 20
No comment.

Section 21
This largely reflects the current position.

Section 22
This largely reflects the current position.

Section 23
No comment.

Section 24
Does this mean that a Jury does not need to be called under mandatory grounds? Sub-section 3 provides a discretion. Despite their being numerous references in the draft Bill to Chief Coroners and Senior Coroners, in this instance it is the “Coroner” who is actually to make the decision. Precisely under what basis would the discretion be exercised?

Sub-section 9 is in place to preserve the existing law so that inconsistent decisions are not reached by different Tribunals. What if further evidence comes to light which could or may alter and in some cases would definitely alter the conclusion? Surely there has to be an element of discretion in the light of fresh evidence and information coming to light.

Section 25
Appropriate time limits should be put in the section so that we should be informed promptly.

Section 26
References to “Registered Medical Practitioners” are out dated. It should refer to “appropriately qualified Pathologists” or like phraseology. This needs updating because claiming to be a doctor involved in the care of the deceased would be instructed to carry out a post mortem examination.

Sub-section 4 indicates that the report should be agreed to the Senior Coroner “in such form” as the Coroner may require. What does this involve precisely?

Section 27
If it means what it is intended to mean from explanatory notes then this is welcome.
Section 28
No comment.

Section 30
Reference once again to the “Senior” Coroner is misleading. It is plainly the Coroner who is in charge of the actual case whether that be Senior, Area of Assistant Coroner is to give the direction. The real problem with this provision is precisely upon what basis could any discretion be exercised. There will be clearly public interest claims by the media. Leaving it up to draft Rules which have not yet seen the light of day is fraught with danger. It also has to be HRA compatible. I foresee numerous Appeals and cross Appeals.

Section 31
This largely represents the current law. No specific comment.

Section 32
This provision remains anachronistic. Any expenditure incurred by a Coroner in connection with investigation and Inquest should be promptly reimbursed. Reference is made to Regulations but once again no details are provided and the devil will be in the detail. Are Coroners still to be potentially personally liable if their Local Authorities do not agree with the expenditure incurred? The idea of reimbursement is totally at odds with current modern judicial practice. If taken to the letter of the law, a Coroner would have to try and arrange some sort of massive overdraft facility which is then reimbursed at the whim of the Local Authority. This provision should be replaced with a simple indemnity requiring the Local Authorities to discharge all payments. A code of Practice can be drawn up over contentious matters so that prior authority is sought. If the Local Authority fails to agree to incur the expenditure, then there has to be an Appeal process for the Coroner. I have had potential experience of potential conflicts of interest whereby a Local Authority who is the Paymaster for the Coroner is also a major interested party at an Inquest who were trying to control and govern expenditure into the contentious case in question. That plainly raises issues of independence of judicial decision making and conflict of interest.

Section 33
Reference is made at the start of this document, precisely what is meant by Local Authority providing suitable accommodation. Implications of capital expenditure and substantial premises suitable for the needs of the bereaved and for conducting hearings is significant.

Sections 34 to 40
I reiterate this is an historical anachronism which should be abolished. Coroners should be able to concentrate on proper judicial functions. The objections from the DCMS do not stand up to critical analysis. In this day and age we should not be dealing with antiquated judicial proceedings to try and determine whether something qualifies for Treasure. It has no place in a modern system and should be replaced by a procedural requirement to report matters to the British Museum with a subsequent civil Appeal process to challenge their adjudication. It creates a tier of bureaucracy which is totally unnecessary.

Section 41
No comment.

Section 42
This is an area ripe for Appeals. Again reference is made to the Senior Coroner conducting the investigation. It will plainly be the Coroner whoever that might be whether that be Senior, Area or Assistant Coroner who is actually doing the case in question which needs to give the notice. To try and go via some bureaucratic procedure up to the Senior Coroner is unnecessary.

Section 43
This is a reflection of current law.

Section 44
This is a sensible improvement in procedure.
**Section 45**

This is a sensible improvement in procedure.

**Section 46**

Once again reference is made to a Senior Coroner rather than the Coroner in question dealing with the enquiries and investigation. Once again this is an area ripe for Appeals because of the circumstances which have to be taken into account and weighed.

**Section 47**

Sub-section 2 as currently drafted is fraught with difficulty and interpretation. What is the interpretation of “as he thinks necessary”? What if there are grounds actually to give a direction to the contrary because of the circumstances and peculiarities of the evidence in question? It would be better to exclude this sub-section entirely and leave the issue silent. As a matter of normal routine, a Coroner has to give directions to a Jury upon, for example, Rule 37 evidence under the current Coroner’s Rules and the weight to be attached to various pieces of evidence in any event.

**Section 48**

This is simply a reflection of the current law.

**Section 49**

Strangely in comparison to Section 47 there is no reference to a direction as to the weight to be attached to this evidence? What is the position and why is there an anomaly between the two?

**Section 50**

In general terms, the power of search and seizure is to be welcomed and would probably be used in extreme cases. Once again reference is made to the Senior Coroner conducting the investigation and it plainly may involve an Area or Assistant Coroner.

**Section 51**

Who is actually going to conduct the searches. Are they going to be Coroners Officers. Who are they going to be employed by? Are they then liable for criminal law/civil prosecution? Can or would the Coroner in question incur personal liability and be subject to proceedings? It is obvious that where it is based upon “reasonable grounds for believing”, that is going to be subject to challenge. What is the Coroners indemnity in this position and those acting on his behalf under his authority.

**Section 52**

This largely represents the current law and no other comment necessary.

**Section 53**

The arbitrary limit of 40 days has no doubt been chosen with the best intention to prevent distress to bereaved relatives but in practice it will cause difficulties. The systems of Appeals will become bureaucratic and expensive.

**Section 54**

See previous comments.

**Section 55**

See previous comments.

**Section 56**

What qualifications and experience does a Chief Coroner have. Are they going to be an existing Coroner. Are they going to be some other judicial figure? Will they have any knowledge and experience of the Coronial system?
Section 57
This is sensible.

Section 58
Is this going to be in addition or complimentary to the existing and current complaints system operated by the Lord Chief Justice covering Coroners?

Section 59
No comment.

Section 60
See previous comments concerning the Appeals process.

Section 61
See previous comments. It will become cumbersome, time consuming and expensive. It will delay examination of bodies and have an impact on the storage. It can also prejudice results of examinations because of the delay involved.

Section 62
No comment at this stage.

Section 63
No comment.

Section 64
No comment but necessary in view of the anticipated new system.

Section 65
The current drafting is open to many interpretations. What force does any guidance have? Does it have to be taken into account? Does it have to be followed? What if the Chief Coroner and other Coroners disagree with it? There seems to be no reason why a case could not be conducted in contradiction to the expectation formulated by the Lord Chancellor’s guidance. It seems that a new independent system is created but which still remains liable to political interference from political appointee of the Government of the day who is not head of the Judiciary.

Section 66
Plainly the draft Regulations should be made public and subject to detailed scrutiny before the Act is laid before Parliament otherwise it is putting the cart before the horse.

Section 67
Ditto with regard to the Coroners Rules.

Section 68
Ditto. What is the sanction for non-compliance by Solicitors and Barristers with directions given? Could wasted costs orders be made? How are they to be enforced?

Section 69
See previous comments concerning treasure.
Section 70

This would have to be amended to include either the Area or Assistant Coroner actually dealing with the case in question and not just the Senior Coroner.

Section 71

The compensation provision only indicates the Lord Chancellor “may” provide for payment of compensation. All existing Coroners would want to know precisely what the basis of this was. Having a standard amount of compensation would clearly not be equitable in any sense. A Coroner nearing or very close to retirement would be wholly different to a much younger Coroner of many years of potential income and pension accrual anticipated. Many Coroners who are technically referred to “part time” substantially rely on this as a source of income. In some cases it is their actual potentially only income. The notion that part time Coroners are all Solicitors in private practice who can simply go back to their practice is total nonsense. Many of us have had to give up private practice to do the job. We have no Partnerships to go back into. We have been out of practice for several years. We are wholly disadvantaged and any compensation must be based on equitable principals to pay real compensation for the losses involved of a freehold office.

Section 72

This was an historical anachronism which should have been abolished long ago.

Section 73

Necessary consequential saving provisions but again one would need to see the detail to be able to comment.

Section 74

Technically necessary.

Section 75

Largely represents the current law.

Section 76

The qualification under Sub-section 2 (a) is fraught with difficulty. The other categories largely reflect the current law. As a matter of legal interpretation you could become someone’s “partner” after a few days of a relationship which only the partner in question could substantiate which may be in considerable conflict with other members of the family within the definition currently drafted. In reality there are sometimes very much competing and different interests and views amongst what has colloquially been described as “next of kin” or the “family”. In practice this is extremely difficult if not impossible to precisely define.

Section 77

It is not possible to comment further at the moment pending regulations and Coroner’s Rules being provided.

Section 78

Noted.

Section 79

Noted. But why does it not include other sections of the Act eg Sections 71 and 72?

Sections 80 and 81

Noted.
Schedule 1
This will require careful and appropriate consultation with current Coroners and Local Authorities. The other provisions relating to appointment and location of office are largely common sense.

Schedule 2
Noted although it is strongly recommended that Treasure jurisdiction of Coroners should be abolished.

Schedule 3
Ditto.

Schedule 4
Who is going to be the complainant in relation to these offences? Will it involve the Coroner having to give evidence? Surely there could be appeals against questions which a Coroner asks or does not ask which he allows or does not allow and the consequences thereof which flow from that.

Schedule 5
The fees and expenses paid to witnesses and jurors largely affect the current position.

Schedule 6
Noted. Is there going to be a regional reflection in the Deputy Chief Coroners? Are they going to be existing Coroners with considerable experience of the Coronial system?

Schedule 7
Noted.

Schedule 8
It is thought that this will work much like the Human Tissue Authority but will require a great deal of time and support. Is there not a danger that it will become over represented with particular pressure groups interest?

Schedule 9
It would appear that the Chief Coroners and the Deputy Chief Coroners would attract Judicial Pensions the same as the main Judiciary yet the Coroners actually doing the day to day work still have Local Authority Pension Schemes which are far less generous and require much longer contribution periods. This is plainly inequitable. All Coroners should be introduced to the proper Judicial Pension Scheme arrangements the same as for example District Judges both Magistrates’ Court and Civil.

Schedule 10
Appeals. Is it clear that there should be no other appeals as secondary legislation involved?

Explanatory notes and the draft charter for the bereaved
The Charter sets out some laudable and appropriate aims and objectives as well as standards of service. In briefing meetings to date the responsible Minister and Coroner’s Service Team have indicated that the Charter sets out the current expectation of a standard of Service which is meant to be provided at the moment. As previously indicated the Luce Report clearly identified that the current service was vastly under resourced and under staffed. To suggest that the new service could be brought in and not have any effect on manpower is totally irreconcilable with common sense and experience. To provide the service anticipated will be far more labour intensive. I believe every Coroner would be delighted to provide the service anticipated if they had the resources in both time, money and manpower to deliver it. If as presently anticipated the same arrangements will continue for the funding and provision of Coroners Officers, neither the Police Forces nor the Local Authorities would wish to take on the responsibility because it will clearly have to increase. Where is the funding to cover this? The Charter sets up numerous avenues of potential appeal and challenge. What is the investigation Report referred to in paragraph 8. What does it comprise?
This is to be determined from Regulations or Coroners Rules, plainly one needs to see them before being in the position to comment. What is the basis or standard of proof to be applied in such an investigation report? Can it include speculation? Should it hypothesise?

**Regulatory Impact Assessment**

I personally believe that the basic start up costs for some of the new provisions such as the Office of the Chief Coroner etc, clearly are probably within the scope or level anticipated. However, the long-term future, for example, for the provision of suitable accommodation and the provision of staff in order to service the new system is considerably underestimated. In larger Coroners Districts, the small Authorities, eg the Isles of Scilly could be bankrupted by an emergency event or incident if they are not in a position to ensure against it. What would be the level of their contribution? Why should the bigger Authorities pick up the balance of the Bill.

The Coroner Service is unique. In order to create a career structure and interest for those persons prepared to be assistant part time Coroners let alone full time Area or Senior Coroners have to be a sufficient number and turnover of the vast majority if not all the current whole time Coroner positions could and indeed should be retained and enhanced. Working on simple population figures does not reflect local needs so as the peculiarities of jurisdictions such as big Cities with several major Hospitals, Prisons etc. Areas formed should be concentrated in those areas without whole time Coroners at the present.

*Nigel Meadows*  
HM Coroner, Plymouth & SW Devon  
July 2006

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**Evidence submitted by Alan C Crickmore, HM Coroner for Gloucestershire**

These are my personal comments and thoughts on the Draft Coroners Reform Bill.

<table>
<thead>
<tr>
<th>Clause</th>
<th>Comment</th>
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<tbody>
<tr>
<td>1</td>
<td>As “body” includes cremated remains and body parts there needs to be clear regulation on the circumstances in which jurisdiction is to be assumed. There are going to be obvious difficulties in establishing the identity of the cremated remains and the cause of death—Shipman’s victims were often cremated and I doubt if a pathologist will learn much form the urn! The type of body part which will give rise to the assumption of jurisdiction will also need to be clarified. In the past we have assumed jurisdiction only when the part has been life sustaining. A foot is a body part but does not suggest death. What if there are several parts of the same body in several jurisdictions found at different times with several inquests over a lengthy period. How will the several coroners know that the others have held an inquest and how can the same verdict be assured? Will there be a central register of body part inquests with DNA matching to exclude duplication and what if there is new evidence for the second or subsequent inquest. Who will pay for the register and how much will it cost? Why is there no duty to report the fact of a death? Why 50 years? Why not fewer? How many of us (apart from David Masters) do deaths that are so old? This may be seen by some as a device to head off other government research death inquests after the Porton Down case?</td>
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<td>5</td>
<td>5(5)(b) is unsatisfactory. I have had many deaths abroad where the investigation has been undertaken to local standards which are poor and where post mortems have been carried out and the cause of death has been wrong because of incompetence or worse eg a man reported as having had a heart attack—natural death—when in fact he died of asphyxia during an unmentioned criminal assault. Or a man said to have had a heart attack who actually drowned thus (to the family’s dismay) making his life policy void. How will we discover “reasonable cause”?</td>
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<td>7</td>
<td>Why do coroners not have to make a written request to each other? Where is the paper trail? 7(5) is nonsense. What does it mean? It seems to imply that the mortuary providers must agree but surely it is the coroner’s decision not the mortuary provider’s decision.</td>
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<tr>
<td>9</td>
<td>It should be (a) and (b) and (c)</td>
</tr>
<tr>
<td>13</td>
<td>13(2)(b) why “as such” for service policeman and not for a police officer.</td>
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| 14     | Seven jurors is an insufficient number and takes no account of jurors becoming sick etc. It means that—S16 (2)—four may agree the facts upon which the verdict is founded and three may not. This means only 57% agreement is needed in what are the most sensitive types of cases. It suggests proof on a balance of probabilities will do in cases where the criminal
standard is required. Jurors are not hard to get so why reduce the number. I would never start a prison or police death with fewer than 11.

See above

Who will ensure the appointment of the designated officer?

26(1) Why not a registered medical practitioner with suitable pathology qualifications?  
26(4) Why not a national standard form and content of report and why no time limit?

What on earth does 27(2) mean? Does it mean bodies can only be taken outside the area if the second area provider agrees?

This is a real “chicken and egg” mess! It seems that there will be a cohort of 60 to 65 full time coroners made up primarily of senior coroners, with some area coroners as well as senior coroners in some areas. The mix cannot be considered until the areas have been defined which suggests that the key will be deciding on the areas. The LAs will fight against areas which require a senior coroner and an area coroner (or perhaps several area coroners) because of the infrastructure and salary costs. There is nothing to suggest a true hierarchy and presumably the relative duties of senior and area coroners will be defined by regulation or rule.

Salaries and “Terms and Conditions” are, according to Tony Woolfenden at the Birmingham road show, to be negotiated and fixed area by area and are not intended to be linked to the judicial salary scales.

There is nothing in the Draft Bill to require the coroner to be available at all times so presumably these will be 9 to 5 appointments!

At the Birmingham road show TW said it is anticipated that there is to be a closed appointment system until all the jobs are filled but how will we know which ones to apply for? Given that all jobs will have to be made known to all coroners for the closed section we will all know what each area is offering and this will lead to disgruntlement because of the varying terms and conditions. We may all want the best jobs!

Read in conjunction with Clause 76 this is a nightmare. When a direction is given every interested party will be able to seek to vary or object and no guidance is given as to the criteria to be applied before making the direction. It runs contrary to the requirement generally for a public hearing. How can the identity of the deceased be hidden when this is a specific requirement of Clause 10 (1) (a) and is required for registration particulars—Clause 10 (1)(b). Every death is a sensitive one for the bereaved and this will create discrimination.

As the cost of the service is a key issue the regulations will need to give a wide discretion to the senior coroner to spend sums which are reasonable in connection with administration (including the employment of staff), expert evidence and the thousand and one other costs of running the service (including the cost of body transportation, storage and mortuary facilities generally). The LA should be obliged to pay the bills directly to the creditors and to pay promptly. Is it not realised that many coroners presently rely on agreements between the LA and the local NHS Trust in respect of mortuary facilities?

What standard of accommodation is proposed and how quickly will it have to be provided. I have no dedicated courtroom. I will welcome a new court built to DCA standards although I will need more than one in a large area so that matters can be heard locally. I will need admin offices scattered about too—to a proper standard. Does “accommodation” include all plant and machinery? How will this massive cost be met?

PART 2 

Given that most of us rely on the expert opinion of the British Museum, Treasure should have been taken away from coroners altogether.

It is disappointing that the criteria for private inquests should be left to Rules. Generally I am against private inquests except in those cases where an inquest is necessary because a cause of death could not be ascertained at PM and an inquest is opened and adjourned to allow the release of the body promptly while awaiting specialist toxicology, histology etc. This is often the case for SIDS and for SADS. Thus where the death is clearly natural after the results are in and there is no question of neglect aggravating the cause these inquests should be concluded administratively. Otherwise public hearings should be compulsory unless National Security is compromised. Again there is a risk of discrimination.

This is good, especially for witnesses serving a sentence, but who will pay for it and how much will it cost because all courts will have to have the facility.

This is good but not thought through. Who will actually do the entry, search and seizure? Not the coroner, surely? But his officers have no statutory authority and the police will have no locus standi unless given it.

This minefield is to be left for subordinate legislation!

Is this a reference to coroners’ officers? The draft bill fails miserably to address the need to have a standardised system of coroners’ officers and whether they should be civilian (which they should be in my view) or police. Officers should all have the same terms and conditions.
and should do the same job. The bill fails them and the system by ignoring them and their worth.

60 The list of “Interested Persons” is far too wide at Clause 76(2)(a) and will make the appeal system unwieldy and burdensome. In an average family there may be a minimum of 11 such people if we take one spouse, two parents, one child, one brother, one sister, two grandparents, one grandchild, one nephew, one niece. This doesn’t take into account the expanding effect of a divorced and remarried deceased. And then there are the friends of longstanding. How do we ascertain the other interested persons eg insurance companies or culpable individuals, speedily when some of them only become interested persons as the investigation proceeds? Has anyone actually considered the cost of appeals—which may happen one at a time—the delays resulting, and the pressure on coroners and officers because of this multiplication? The appeal process will start with the decision to hold a PM and take in virtually every decision up to and including the verdict- even mid inquest challenges as to which witnesses to call. Some cases may never finish. The attempt to oust JRIs will fail. There are HRA issues. The Deputy Chief Coroner will spend his life dealing with appeals and there will be a need for permanent extras. How long will the appeal process take? In the case of a PM appeal how many Interested Persons will need to be traced and informed of the decision before the PM is done? If more than one how will the officers cope? Where will the bodies be stored? What if some wish to overturn the coroner’s decision and others support it. Will they all be parties to the appeal and if not what of the HRA issues? How does this tie in with the present practice of doing all we can to meet the needs of certain religious faiths for prompt funerals? Do hearings stop while intra hearing appeal issues are resolved? Will appeals all be on paper (HRA?) or will there be a hearing? What will the representation position be? Legal Aid? Will there be costs orders? Will the LAs have to pay the coroner’s costs? Has anyone taken an inquest into a custody death or a hospital death and worked it through as an example? It is obvious that they have not. This clause alone will create such a massive cost implication that it is hard to believe any of the costs figures suggested by the government let alone the appeal cost estimate.

63 The make up of the Council is crucial to its success.

65 The Lord Chancellor’s expectations are hardly a good basis for a legal system.

66 and 67 The regulations and rules are likely to be long and complex and a Rules Committee should be provided for.

76 See comments on clause 60 above.

SCHEDULE 1

The critical issue here is the coroners’ areas. How will they be determined and what criteria will be used. How will LAs be persuaded to cooperate? How will it work when existing areas are merged and the provision of coroners’ officers is different (police/civilian) and their terms and conditions are different? Will the Lord Chancellor actually dictate the coroner’s salary and terms and conditions or will it be a free for all and if so how can this be justified? How will the public manage if their journey times to hearings and meetings are extended? What if the transport infrastructure is not in place—they don’t all have a car. In Gloucestershire there are already travelling times of an hour from the extremities of the jurisdiction to the nearest hearing venue.

DRAFT CHARTER

Whilst this is welcomed and to a large extent reflects common current practice the implications for manpower (officers and clerical staff), accommodation, delay and massive costs seem not thought through.

CORONERS OFFICERS

These people make the system work and are to all intents and purposes ignored. This is little short of disgraceful when one considers the stresses and strains of their role.

TIMING

The reforms, like the curate’s egg, are good in parts but need a lot more work based on practical experience. Perhaps the DCA should spend three months full time in sample coroners’ offices and courts? The end product will take time to introduce if the system is not going to collapse during transition. A good starting point would be to introduce the Chief Coroner and Coronial Council who could then take a measured view on the practicality of the reforms before introducing them a bit at a time.
MEDICAL ADVICE

The sums mentioned are very small. Presumably this provision is for assistance in deciding if a PM is necessary to establish the cause of death. Who will we ask? I presently ask my pathologists but if the suggestion is that I should ask someone else, where will I find them and what qualifications should they have?

FINALLY

Why is there no duty to report death? The main failings of the system thrown up by Shipman were to do with doctors’ MCCD practices and nothing is to be done about this.

A WAY FORWARD

I am desperately concerned that if the Draft Bill proceeds to a proper Bill and an Act along the lines contained in the Draft Bill the system will collapse and this will be to the obvious detriment of death investigation and the persons interested in individual deaths. What are we trying to achieve here? I would suggest that we are trying to achieve the following:

— A unified system of death investigation. The draft bill will not achieve this because it leaves most of the important practical issues to local areas—including funding generally. A step forward would be to make education and training for coroners compulsory. For part time coroners this might mean a compensatory payment for time away, and for all coroners provision for the cost of deputies during absence. In this way the scope on investigation could be unified, the practice of disclosure could be unified and courtroom practice could be unified. Without changing the existing boundaries artificially with no proper plan, natural wastage could be used to form appropriate larger areas just as mine has been formed. Future retirements could lead to rationalisation and LAs could be required to appoint whole time coroners as the opportunity arises.

— Appropriate involvement of the bereaved. The Draft Bill will work against this by its scattergun approach to inclusion and challenge. Most coroners should be dealing with cases using most of the Charter as a practical guide. If they are not they should be weeded out and replaced. I perceive that much of the alleged discontent arises because of the attitude and ability of individual coroners rather than the system being fundamentally flawed. The Draft Bill seems to have lost sight of the fact that the coroner is not there to preside over a committee but is there to investigate death. This should be done so that interested persons are kept fully appraised of the coroner’s plans and (if appropriate to the investigation) findings. It should not be done on the basis that every decision of the coroner can be challenged. Someone has to be in charge and the unnecessary expansion of the main group of “interested person” takes no account of the expanding effect on the workload nor the present practice of coroners to admit “any other person” who in the coroner’s opinion is properly interested.

Underpinning the failings of the Draft Bill is the lack of finance available. A full finance package would see a complete new system which was centrally funded with all employees being employed by the DCS (this would include coroners’ officers who would have statutory recognition). This will not happen but the Draft Bill will create a system which is unworkable (expansion of interested persons) and fragmented (local funding and difference of technique). This will not help the bereaved or (as importantly) the dead, who it sometimes appears are forgotten.

One final point. As the law stands many deaths, which appear to the public as suicide, are recorded as open verdicts. There should be a change which allows “took his/her own life” where it is clear that there is no third party involvement and that the deceased actually killed themselves. At present unless all other possible explanations are rules out there cannot be a suicide verdict. Common sense should be allowed to prevail. I think this could be done by Rule rather than statute.

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