The Worshipful Company of Arbitrators
The Master's lecture – March 24th 2011

Dealing with Death - Coroners' Work and Proposed Reforms

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 On the whole we have been astonished at the good work done by coroners with out-of-date and imperfect machinery.....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

No, not a recent quotation, but one from a century ago – and as relevant today as it was then. It is taken from the report of a Committee chaired by Sir Mackenzie Chalmers that reported in 1910[1], and which was the first public examination of coroner issues since the passing of the Coroners Act 1887. I will return to it and other proposals for reform later, but first I must say something of the origins of the coroner system and how it operates today.

Origins:
"No-one is quite sure of the origins of the ancient office of coroner" – so it is stated in the opening words of ***Jervis on Coroners***, the standard textbook about the law and practice of coroners currently edited by Professor Paul Matthews, HM Coroner to the City of London[2]. The 1st edition, published in 1829 and written by Sir John Jervis, Lord Chief Justice of the Court of Common Pleas[3], stated "*the office is of such great antiquity that its commencement is not known*". Coroners probably existed before 1194 but it was in Article 20 of the Articles of Eyre of that year that coroners have their first recorded mention. This provided that in every county 3 knights and clerks were to be elected as "keepers of the pleas of the Crown" (***custos placitorum coronae)*** to look after the records of cases in which the Crown was interested and to have regard to the financial interests of the king.

The Crown was interested not only in the administration of criminal justice but also in revenue derived from that administration. Revenues then included the forfeiture of sureties and the seizure of the possessions of felons (only abolished in 1870). Crown revenues also included the confiscation of deodands (any instrument used to kill a person, found by the coroner's jury to have been so used – and hence a source of armaments for the king). If someone's horse and cart killed you for example, they were forfeit to the Crown. (In passing one is rather inclined to wonder if coroners might do some good today if they could seize the cars that caused the deaths on our roads!) [***? mention GWR locomotive***]. Wrecks and treasure trove also formed part of the revenues. Originally coroners had to be from the landed gentry, presumably so that if they failed in their duties, any failure could be made good from their personal possessions!

Suicide

One difference between then and now is worthy of mention. Suicide was once regarded as "*a most heinous description of felonious homicide*". No person was entitled to take his or her own life because that gave rise to two offences. First, a spiritual offence "*invading the prerogative of the Almighty and rushing into His presence uncalled for*" and secondly, a temporal offence against the King, depriving him of his right to call upon you to bear arms and fight his wars. Suicide, Sir John Jervis told his readers in 1829, "*ranked as amongst the highest of crimes*" and thus the consequences of a coroner's finding of death by killing oneself were profound. The deceased person forfeited all personal chattels, real and personal, and, if married, any possessions, including land, did not go to the surviving wife but to the King. There were originally also some ecclesiastical forfeitures, with no right to a burial service and no right to burial in consecrated ground in a churchyard. *[**BCP rubric:** The burial service "is not to be used for any that ... have laid violent hands upon themselves"]* The *residuum* of this is that, today a coroner must be satisfied beyond reasonable doubt, not just on the balance of probability, about the deceased's intention before recording a conclusion that an individual did kill himself or herself. There must be no other possible explanation.

In the 13th and 14th centuries coroners were the principal agents of the crown in bringing criminals to justice – long before the commercial policing arrangements on the Thames River, or the formation of 'Peelers', the origins of the modern police service. Indeed, coroners were

leading figures in the county until the 15th or 16th centuries – and, according to some sources, even now rank immediately after sheriffs in order of precedence on civic occasions. However, with the development of the police services, the justices of the peace and the extension of the role of the county courts, the role of the coroner became more circumscribed and their main duty became the holding of inquests into violent or unnatural deaths.

Coroners never held office directly under a royal warrant, as did the sheriffs. From 1194 until 1888, the freeholders of the county elected county coroners. The Local Government Act of 1888 made coroners' appointments the responsibility of the local authority. Coroners still hold office under the Crown – it is a freehold office, so local authorities may appoint us but they cannot get rid of us! The office of coroner today continues to reflect executive powers as well as judicial functions – and of course the procedures in coroners' courts are inquisitorial, not adversarial.

Death Certification

You may or may not be able to live in peace but assuredly you cannot die entirely in peace! Once dead, there are in England and Wales some statutory procedures to be followed.

In many countries of the world, no-one is too troubled about causes of death; if you die, especially in a hot country, the likelihood is that you will be buried the same day. There will probably be no autopsy and precious little forensic investigation. Many countries are perfectly content with causes of death certified as "cardiac arrest" or "natural causes".

However, things are different in England and Wales. For decades if not for centuries, England has wanted a say in the means by which you come by your death. "They" (*i.e.* officialdom) want to know what pathological disease process you died of and to list and categorise it, for a variety of purposes.

So, if a death occurs in England, the death has to be registered. It does not matter whether or not you are a British citizen; the same rules apply to all, including visitors to the country who die here; and information about the death has to be passed to the Registrar of Births and Deaths by "the informant" within 5 days.

[Parliament has set out the rules in the Births and Deaths Registration Act, 1953 and in rules made thereunder. Section 15 provides

"... the death of every person dying in England or Wales and the cause thereof shall be registered by the registrar of births and deaths for the sub–district in which the death occurred by entering in a register kept for that sub–district such particulars concerning the death as may be prescribed:

Provided that where a dead body is found and no information as to the place of death is available, the death shall be registered by the registrar of births and deaths for the sub–district in which the body is found."]

If you were undergoing medical treatment when you died, your attending doctor must (it is mandatory) issue a medical certificate of the cause of death (MCCD).

Section 22 of the Act provides:

"... (1)In the case of the death of any person who has been attended during his last illness by a registered medical practitioner, that practitioner shall sign a certificate in the prescribed form ***stating to the best of his knowledge and belief the cause of death*** *and shall forthwith deliver that certificate to the registrar."]*

Various complications come into play if the doctor in attendance cannot or will not issue the MCCD. I need not trouble you with all the details, but they usually involve informing the Coroner. *[Incidentally, for clarity, it is the Registrar of Deaths who issues the "Death Certificate" once the death has been registered. Doctors may believe that they issue the death certificate but they do not. What they issue is the MCCD.]*

The point is that, for a death to be registered, there must be a known, natural medical cause of death and that cause must be made known to the Registrar, however much the individual shunned medical care during life or wished to keep personal and confidential his or her medical information. Without an MCCD there is scant prospect of avoiding some form of examination of the body after death to ascertain the cause of death. This may in part explain why England and Wales has one of the highest rates of autopsy in the world – some 22% of all deaths and two or three times as many as most other western countries.

If there is no doctor in attendance during the final illness, or the doctor cannot certify a medical cause to the best of his knowledge and belief, the likelihood is that the case will be referred to the relevant coroner, responsible for the area or district in which the body was found.

Functions today

Coroners hold office England and Wales but not in Scotland. The Scots have a different system of procurators fiscal, sheriffs and fatal accident inquiries. The system in Northern Ireland is different in detail but broadly in line with that in England and Wales.

Coroners are appointed by the local authority, which has to pay all their properly incurred fees and expenses, but they are not answerable to anyone but the Lord Chief Justice, Lord Chancellor and the Office for Judicial Complaints.

To give you some idea of the caseload, in 2009 500,100 deaths were registered in England and Wales of which 229,600 (c.46%) were referred to coroners[4]. (The remaining 54% are 'signed up' by the attending doctor on a Medical Certificate of Cause of Death, of course.) Of the deaths referred, 108,360 underwent autopsies - some 22% of all deaths. That, as I said earlier, is a considerably higher proportion of autopsies than in any other westernised country.

This figure of 46% has risen sharply in the last decade. Before that, about one third of deaths were referred to coroners but, the referral rate has risen for several reasons – the Shipman effect, the alteration to general practitioners' contracts so that they no longer have to provide personal out of hours cover and changes to working hours to name but three. Another reason is the increasing use of multi-disciplinary teams and care in the community by nurses, so that patients die without having seen a doctor for some weeks.

So, following a death there may be no-one available to issue the Medical Certificate of Cause of Death and the case has to be referred to the coroner – who, EU working hours directive notwithstanding – has to be available at all times, personally or by his deputy, to deal with any duties in connection with post-mortem examinations and inquests.

Where a coroner is informed that there is a dead body lying in his or her jurisdiction, he or she must inquire into the death if there is **reasonable cause to suspect** that the death was **violent or unnatural**, or that it was **sudden but the cause is unknown**, or occurred in **prison**, etc. Coroners also have jurisdiction over **treasure**, but I do not intend to talk about that tonight.

In brief, there are broadly **three ways** in which a death reported to a coroner will be treated. **First**, the coroner or his officer may make inquiries of the doctor who was in attendance during the final illness, and with relatives or others who have a claim to be regarded as "properly interested persons". If satisfied that all is explicable and satisfactory, and there is nothing 'unnatural' that appears to require further inquiry, the coroner may issue '**Pink Form A'** – this allows the death to be registered with no need for either post-mortem examination or inquest. Most of the discussion takes place with coroners' officers rather than the coroner him or herself. This procedure is used where the person who died has been under treatment and his or her doctor can be confident about the medical cause of death, but there is some technical problem such as not having seen the patient within the last 14 days or having died within 24 hours of admission to hospital or of an operation, etc.

Secondly, if a coroner is informed of a death and has reasonable cause to suspect it was sudden and of unknown cause and believes that a post-mortem examination may prove an inquest to be unnecessary, he may direct a post-mortem examination to be performed by a 'legally qualified medical practitioner'. If on learning the result of the post-mortem examination the coroner considers an inquest to be unnecessary because there is nothing 'unnatural' about the death, he or she may issue '**Pink Form B**' to enable the death to be registered. This is helpful where people die not having seen a doctor for months or years and no-one knows what they have died of.

Please note that the fact that someone has died from a natural cause does not necessarily make the death not unnatural. (later - *ex parte Thomas* and *Touche* cases)

The **third** course is where the circumstances of a death are violent or unnatural, or the medical cause of death is not clear after post-mortem

examination. There is no statutory definition of 'unnatural', so considerable discretion rests with coroners as to how it is interpreted. In such a case, neither of the Pink Form procedures A or B is appropriate and so an **inquest** will be opened. This is usually done within a few days of the death. The inquest is then adjourned and the body is released for burial or cremation. Further inquiries will then be put in hand and, in due course, the inquest will be resumed and concluded. About 12% of deaths reported to coroners result in an inquest.

At an inquest a coroner must only deal with the 4 statutory questions – who, when, where and how[5]. Coroners must not express ***any*** opinion on ***any*** other matter[6] and may not determine, or appear to determine, criminal liability on the part of a named individual or civil liability[7]. However, a coroner may make may use of the **Rule 43** procedure to alert authorities to the desirability of taking action to prevent the recurrence of further similar deaths.

The current law

Coroners are currently governed by the **Coroners and Justice Act 1988** (as amended), by the Treasure Act 1996 and by **The Coroners Rules 1984** (as amended). They also must pay heed to a large body of case law made as a result of judicial reviews in the Administrative Court of decisions of coroners to which objection is taken.

A **Coroners and Justice Act 2009** has been enacted and received royal assent but the part concerning coroners has not yet been implemented. More of that later!

Coroners conduct **fact-finding inquiries**, not trials, to establish answers to four questions – **who** died, **when** did they die, **where** did they die and **how** did they die. It is ***how***, not ***why***, an individual died – an attempt to answer "by what means" and, in some cases to which the Human Rights Act applies, "in what circumstances" the death arose. The inquiry is inquisitorial. There are – or should be – no litigants (a point that appears to have escaped the notice of many who appear before the coroner).

Everyone should see it as their duty to assist the coroner with the facts, not to obfuscate or to hide relevant evidence. Of course, human beings, and especially lawyers used to an adversarial system, don't always quite

see it that way, and not everyone quite understands their obligations to assist with all the relevant facts.

> *"All those who have information which could help coroners' inquiries should disclose it voluntarily and not only when requested"***.**

Violent deaths include things like homicides, road accidents, hospital misadventure, factory accidents and deaths at work. *(e.g. Fall down lift shaft; electrocution; dumper truck; unloading lorry.)* **Unnatural** deaths are much harder to define – and we have no help from the Courts! The word carries its ordinary meaning, so there is great scope for discussion about what amounts to a death that is unnatural. The fact that a death arises from natural cause does not mean that the death is not unnatural – it all depends on the surrounding circumstances. *(ex p Thomas & Touche)*

Problems and the need for reform:

Although the statute governing our function today is the Coroners Act 1988, do not, please, think that it is a modern statute. The 1988 Act is a consolidating Act, with amendments to give effect to recommendations of the Law Commission. It did not change the meaning of the Acts that it consolidated.

The main Act was that of 1887, and that, too, was itself a consolidation of a number of exceedingly ancient acts mainly passed in the reigns of Edward I, Edward III and Henry VIII. The 1887 Act put into one statute the main legislation affecting coroners and implemented some of the recommendations of parliamentary Select Committees of 1860 and 1879. Thus do the essential ingredients of the modern coroner service date back centuries, to a time well before the reign of Queen Victoria and the statute of 1877.

Just about everyone agreed that the system was much in need of reform, especially those who work within the system. There is much that requires improvements, albeit that most of the time it creaks along thanks to the ingenuity and good will of those working within it, determined for the sake of the bereaved to make the system work despite its many imperfections. I will just list a few of the problems

5 departments of state –

1. MoJ oversees coroners – but does not fund them

2. Home Office oversees police (police supply coroners officers and regulate forensic pathology)
3. HM Treasury oversees registrars of deaths (to whom coroners reports after inquest are sent) and receives the data of the Office of National Statistics
4. Dept for National Heritage oversees Treasure Function
5. DoH has an interest in death certification statistics (but no powers)

Local Authorities have a role as well as government departments – they provide the funds and therefore have great influence over local levels and quality of service - but do not audit the service or indeed have the skills to do so. But they are under severe financial pressures.

All deaths or just some deaths? Luce v Shipman/Smith
Fragmented – no-one is interested if it will cost money! (MoJ/LA/Police)
Under-funded and under-resourced
Part time in the majority of jurisdictions
Lack of formal medical input
Use of inquest as a substitute for a public inquiry – Rail crashes; PoW; Feltham YOI;
Overlapping investigations – HSE, PPO, IPCC, LCSBs, etc.
Mass fatalities – Marchioness; 7/7; rail crashes;
Deaths abroad – obligation to inquire into them but poor resources and powers
Inquests held in public – suicides – family concerns re press & media reports
Paediatric cases – paediatric pathology – moving bodies more than one area for PM
Lack of a set of rules (compare other courts – white book, green book, etc.)
Lack of consistency – but should it be local or national? Historically it has been local.
No formal status for coroners' officers – and no formal training
Poor training for coroners – voluntary, not mandatory
Need for juries – summoning thereof
Unsympathetic handling of bereaved
Post-mortem examinations – too many?
Post-mortem examinations – how well done? (NCEPOD)
Research and the coroner's post-mortem examination – histology; HTA limitations

Coroners wanted reform as much as – or perhaps more than –anyone else!

Reform process:
From time to time since the 1887 Act there has been recognition of the need to reform the death certification and coroner system. Over the **20th Century** there were three attempts a reform. I mentioned at the start the Committee chaired by **Sir Mackenzie Chalmers** that reported in 1910[8], and which was the first public examination of coroner issues since the passing of the Coroners Act 1887.

Another Report, chaired by **Lord Justice Wright**, followed in 1936[9] and another, chaired by **Judge Norman Brodrick**, in 1971[10] known colloquially as The Brodrick Report. It was painstaking and comprehensive. It made many recommendations for reform – most of which have been ignored by successive governments.

Yes, there have been minor tinkerings, such as to remove the requirement for coroners or their juries to view bodies and, in 1977, the removal of the ability of coroners or their juries to indict for murder or manslaughter at an inquest, following the inquest in the Lord Lucan nanny case. However, none of the three major 20th century Reports were acted upon in an effective way.

What then of the **21st Century**? Many factors drove the renewed desire for change, but two things perhaps above all others renewed interest in reform: the retained organs issues of **Alder Hey, Bristol, etc.** and the concerns raised in the wake of the case of **Dr Harold Shipman**. In January 2001 **Dame Janet Smith** was appointed by the Secretary of State for Health to conduct an inquiry into the issues arising from the conviction of Dr Harold Shipman for the murder of 15 of his patients. In July 2001 the Home Office Minister (then Beverley Hughes MP) appointed a committee to review and report upon death certification and the coroner service. One of Dame Janet's inquiries ran in parallel with the other (**Luce**) inquiry (but seemingly in separate tunnels with little or no cross-fertilisation of ideas or proposals and different terms of reference).

2 reports were published in 2003 with different conclusions and recommendations. Government consulted and finally published a reform Bill that was regarded by many as inadequate. The problems were largely over cost – to have implemented the full reform packages recommended in the 2 reports would have been costly.

Eventually, the Coroners and Justice Act 2009 completed its passage through Parliament in November 2009 and received Royal Assent. The Act dealt with much besides coroner reform and some parts of the act that have nothing to do with coroners have been brought into operation. At present, none of the provisions about coroners are in force. Why?

One of the main planks of the 2009 Act was the introduction of the office of a **Chief Coroner** and a Medical Adviser to the Chief Coroner – both national rather than local roles. At the moment there is no central direction and no appeal system – only judicial review is available for coroners' decisions that are thought to be wrong. The Chief Coroner was to provide central direction and to deal with appeals. He was also to produce guidance, taking advice as necessary from the Medical Adviser.

Another key feature of the 2009 Act was the idea of the introduction of local Medical Examiners, who would scrutinise all deaths, whether for burial or cremation. However, the oversight of the Medical Examiner system is under the care of the Department of Health, whereas the main coroner reforms are under the care of the Ministry of Justice – something of a challenge for joined-up government.

Following the general election of May 2010 the new coalition government discovered that the purse was empty and the cupboard bare. After some reflection the Secretary of State for Justice and Lord Chancellor, Kenneth Clarke, and the relevant Minister, Jonathan Djanogly, announced that the Office of Chief Coroner was unaffordable and the government would not be proceeding with that part of the 2009 Act.

This produced a major problem for government because so much of the practical implementation of the 2009 Act relied on there being a Chief Coroner. The office of Chief Coroner could not be abolished without a further piece of primary legislation. So it was that the Office of Chief Coroner joined a variety of other public bodies in what was colloquially

known as the "bonfire of the quangos". The Public Bodies Bill currently before Parliament contains a clause to abolish the role of Chief Coroner.

However, there has been a little problem for HMG! Not everyone was content about the proposal to abolish the Chief Coroner. So, when the clause in the Public Bodies Bill came up for debate in the House of Lords, their Lordships revolted! By a very substantial majority they rejected the clause in the Bill that would have abolished the Chief Coroner. That has the effect, for the moment, of restoring the office of Chief Coroner. I say for the moment because the matter will of course come back to the House of Commons – later this year, possibly in April.

It remains to be seen whether or not HMG will stick to its determination to abolish the Office of Chief Coroner (and if so whether or not there will be the customary game of ping-pong between the Commons and the Lords) or whether, like the sale of the nation's forests, HMG will back away and effect a smart U-turn!

The practical difficulty for Ministers, civil servants and others is that until the issue is decided by Parliament one way or the other, no implementation of the 2009 Act can take place. With a Chief Coroner the reforms would be rather different than if the Office is to be abolished. So we all continue to wait to see what will happen.

A less important problem also arises from the Public Bodies Bill. Among the bodies to be abolished are the Primary care Trusts. Now, it was the PCTs that were supposed to appoint and manage the Medical Examiners, the new posts that will scrutinise all deaths. Without PCTs it remains to be seen who, instead, will appoint and monitor the Medical Examiner service. What does appear to be clear is that the government is committed to the introduction of a Medical Examiner service, which will scrutinise all deaths. It is to be organised through the Department of Health and the scheme will apply to all deaths irrespective of the means of disposal.

At present there are different rules depending on whether one is to be buried or cremated. However, the Medical Examiner system is supposedly to be funded by a fee payable by all who die – in effect a tax on death! Hitherto there was no fee payable for a death certificate – only for applications for cremation. I wonder how great a furore will arise

once the public and the media appreciate that there will be a fee payable (thought to be around £100) for the Medical Examiner's scrutiny!

There is a well-known Chinese curse – "*may you live in interesting times"* – and we do indeed (coronially-speaking) live in interesting times.

Will there ever be reform and if so how radical will it be? In view of the fate of the three twentieth century reports of Mackenzie Chalmers, Wright and Brodrick, and the bowdlerisation of the 21st century Reports of Tom Luce and Dame Janet Smith, I do not propose to engage in breath-holding! The disappointment is that the 2009 reform Act is a severely diluted version of the reform proposals – with probably no opportunity for further reform for at least another century.

There are not many votes in death and the dying. Our current system for dealing with death certification, registration and disposal is much in need of reform. Just when a reform Act was passed at last after so much debate and consultation (the first substantive reform since 1887, remember), a central plank of the reforms is under threat on what are stated to be purely financial grounds and there must at least be a risk that the reforms will either not be implemented at all, or will be implemented in a form that is weak and less than satisfactorily effectual.

Thank you. I will be pleased to try to answer any questions that you might have.

<u>References & citations:</u>

[1] Coroners' Committee: Second Report of the Departmental Committee appointed to inquire into the Law Relating to Coroners and Coroners' Inquests, and into the Practice in Coroners' Courts. Cd 5004 [1910]

[2] *Jervis on Coroners;* 12th edition with 3rd Cumulative supplement; Ed. Paul Matthews; Sweet & Maxwell*, 2006*

[3] A Practical Treatise on the Office and Duties of Coroners; John Jervis [1829]; London, S Sweet, Chancery lane

[4] Department of Constitutional Affairs; Coroners: Annual Statistical Returns 2005

[5] The Coroners Rules 1984 (as amended); rule 36(1)

[6] Ibid, rule 36(2)

[7] Ibid, rule 42

[8] Coroners' Committee: Second Report of the Departmental Committee appointed to inquire into the Law Relating to Coroners and Coroners' Inquests, and into the Practice in Coroners' Courts. Cd 5004 [1910]

[9] Report of the Departmental Committee on Coroners, Cmd 5070 [1936]

[10] Report of the Committee on Death Certification and Coroners, Cmnd 4810 [1971]