A review of the coroner system in England and Wales: a commentary

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ABSTRACT – The certification of deaths and their investigation is flawed and has not been subject to comprehensive revision for many decades; the current system is fragmented. Despite its historical 'stability', it is poorly understood by many who have to use it and the lack of supervisory structures within the system means that there is no leadership, accountability or quality assurance. No formal linkage to or communication with other public health services and systems exists, minimising its epidemiological value. There is a lack of clear participation rights in these processes for bereaved families. The standards for the treatment and support of the bereaved are woefully inadequate and have contributed in a major way to certain *causes celebres*. A report in 2003 suggested that death investigation should be a service that is consistent and professional, able to deal effectively with legal and health issues, work across the full range of concerns about public health and public safety and support, and audit the death certification process. The role of those supporting the current system must be properly established in a framework of accountability.

KEY WORDS: bereavement, coroner system, death certification, inquests

The systems for the certification of deaths by doctors and for their investigation by coroners in England, Wales and Northern Ireland have been seriously neglected over many decades. Both systems have come under increased public scrutiny because of important failings, clearly identified by recent events, including Harold Shipman's murders of his patients and the findings of the Allitt Inquiry. The *Bowbelle/ Marchioness* disaster and the revelations of the Bristol and Alder Hey inquiries are further events that have made it clear that current systems do not provide adequate protection against malpractice or proper support for the bereaved. It is clearly necessary to restore public confidence in the protection afforded by the death-certification process and to improve the response of the coroner service to families.

The certification and coroner systems are both of considerable age. The certification process had its origins in the first half of the nineteenth century and was last changed significantly in the 1920s. There were reviews of the coroner system in 1910 and 1936, and of death-certification and coroner services between 1965 and 1971, but no significant action followed either of the two most recent reviews. The most recent review, *Death certification and investigation in England, Wales and Northern Ireland. The report of a fundamental review, 2003*,[1] under the chairmanship of Mr Tom Luce, is the basis of this commentary.

Current position

We make no apology for explaining the current position. Our enquiries during the recent review of the process of death certification and investigation revealed widespread ignorance and disregard of current regulations in the medical profession.

Registration of a death by a registrar of births, deaths and marriages provides a permanent record of the death and its cause. Such registration is legally required before the body can be buried or cremated and before the personal representative and family can settle the affairs of the person who has died. Before a death can be registered, the registrar must be provided with notification of the death and a certificate of the cause of death from a doctor or coroner. These registrations provide the main input to the national mortality statistics used for monitoring national and local health trends.

For most deaths, the doctor who provided care during the last illness completes the certificate of the medical cause of death. This is delivered to the local registrar, who issues an authority for the disposal of the body. If the body is to be buried, then there are no more formalities. If there is to be a cremation, then a personal representative or family member completes a cremation application, the doctor who has provided the medical certificate of the cause of death (MCCD) completes a further certificate, and a second doctor completes another certificate after seeing the body and talking to the first doctor. These certificates then go to the medical referee at the crematorium, who checks them and gives or withholds the final approval necessary for the cremation to proceed.

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Deaths that may require further investigation are reported to the coroner, who decides whether to carry out further enquiries. Violent or unnatural deaths, deaths in police custody and certain other deaths (deaths due to suspected industrial disease, deaths of those detained under the provisions of the Mental Health Acts) must be reported to the coroner by the registrar if no-one else has done so; so too must sudden or unexpected deaths. When a death is reported to a coroner, s/he decides whether s/he is satisfied as to the nature of the death on the basis of the facts already available, whether to arrange an autopsy and/or whether to hold an inquest. If the coroner chooses not to continue the investigation to autopsy or inquest, s/he informs the registrar and doctor of this and certification takes place with the coroner's concurrence.

Many reports to the coroner are made by doctors, usually because they cannot fulfil the requirements of attendance for certifying the death. The doctor may certify the death if s/he has seen the patient during the 14 days (28 days in Northern Ireland) before death or if s/he has seen the body after death. Presently, around 62% of deaths are certified by the doctor providing care in the last illness, 15% by the doctor after consultation with the coroner and 23% by the coroner. Doctors certifying deaths do so as a statutory duty under the Births and Deaths Registration Act (1953) and not as a condition of their employment in the National Health Service (NHS), since certification of death is not an NHS responsibility. The completion of death certificates is treated as an independent activity for which there is no answerability to the NHS or other employer. However, in these as in other matters, doctors are subject to regulation of their conduct by the General Medical Council.

Major faults of the current system

Any examination of the systems dealing with both conventional and coronial deaths makes it clear that both are internally fragmented. Both deal with individual deaths and do not concern themselves with patterns or trends. The failures relating to this depend to a large extent on the fact that the certification and coronial processes are distinct. The coroner has no information on or responsibility for deaths not reported to her/him. No public authority has to see that the certification process is being carried out properly and that deaths that ought to be investigated by the coroner are reported for investigation. There is, thus, little to stop an unscrupulous doctor from certifying her/his way out of trouble. These failures are magnified by the fact that there is a lack of supervisory structures within the coronial service and, therefore, no leadership, accountability or quality assurance.

There is no formal linkage to or communication with other public health services and systems, either locally or nationally (eg those concerned with looking at drug abuse, public health trends, safety and effectiveness of medical practice, or adverse reactions to medicines). There is persuasive evidence (detailed in our report) suggesting that the coroner service is not identifying some suicides, drug-related deaths and deaths to which adverse reactions to prescribed drugs may have contributed.

Essentially, the death-certification process and the process leading to a completed coronial investigation are carried out in isolation from the mainstreams of medicine and justice administration. This isolation minimises the likelihood of modernisation of knowledge and skills. This has, perhaps, contributed to the differences in activity levels and priorities in England and Wales compared with other nations and jurisdictions. Broadly, in England and Wales, deaths are reported to coroners on a scale varying between 50% higher and double those of other jurisdictions; the autopsy rate is between double and triple the autopsy rate elsewhere, and the rates for public inquests are much higher than in most of the other jurisdictions.

Position of the bereaved

There is a lack of clear participation rights in these processes for bereaved families. They are largely excluded from the death-certification process – they do not have a right, for example, to see the MCCD. They are not systematically or reliably given information and help concerning autopsy-based decisions or involved properly in other processes and inquests. The evidence-disclosure arrangements at inquests fall below modern judicial standards of openness, fairness and predictability. We believe that standards for the treatment and support of the bereaved are woefully inadequate and have contributed in a major way to certain *causes célèbres*. There is a common failure to give bereaved families adequate support and to recognise that many will suddenly and unexpectedly experience these systems while being ill-informed; they are sometimes treated insensitively in their distress. This failure is related to the lack of a reliable or systematic response to minority community wishes, traditions and religious beliefs.

Failings in the process

There is a lack of professionals with appropriate medical skills to supervise, support and audit the death-certification process and to work within the investigation process. This is despite the fact that a large number of deaths reported to the coroner, or referred to the coroner's office for advice, are the result of natural disease and, thus, affect all sections of the community. The results of this failing are amplified by a general lack of sustained and consistent training of coroners, coroners' officers and other contributing professionals in the requirements of these systems and in the skills required to work with bereaved families.

Most coroners are part-time and many work as lawyers in private practice. Compared with other areas of justice and public administration, there is no effective national dedicated service leadership. There is a lack of resources to deal effectively with the most complex or contentious cases at inquest and of any clear and reliable process for clarifying the relationship between the inquest and other formal processes for investigating deaths (eg by public inquiry or criminal proceedings).

Importantly, it appears that there is no clear modern legal base for the conduct of most death investigations, no agreed objectives or priorities for them, no mechanisms encouraging

the systems to adapt and to develop in accordance with the changing needs of society, and a general lack of resources and support. Some coroners have difficulty finding premises for inquests and lack even a minimal amount of secretarial and administrative support.

How to change things

We made a large number (122) of recommendations, of which the main points are these:

- The death-investigation service (coroner service) should be a consistent and professional service based on full-time leadership throughout England, Wales and Northern Ireland.
- The service should deal effectively with legal and health issues, work across the full range of concerns about public heath and public safety, and support and audit the death-certification process. This will require a new appointment – a statutory medical assessor.
- A common process of two-tier certification for all methods of disposal of the body should replace the present three-tier system for cremation.
- Consistency of service to the bereaved should be ensured by a family charter of rights and responsibilities and be part of a change that anticipates a more informative involvement for this group in coroners' investigations and greater accessibility to outcomes.
- The role of those supporting the current system (coroners' officers, pathologists, court staff, etc) must be properly recognised and established in a proper framework of accountability.

More detailed considerations for the future

Reporting

All deaths should be subject to professional verification that life has ended. This verification should be made after the body has been viewed. Verifying that a death has occurred should be defined statutorily as a step distinct from certifying the cause of death. It may be performed by a doctor (who may or may not be the doctor who also certifies the cause of death) or by other suitably qualified personnel and there should be, in England/Wales and Northern Ireland, respectively, national protocols agreed with representatives of the police force, the medical and other healthcare professions, and the funeral services industry. These would govern the circumstances in which verification should occur, the information that should be recorded (this should include who was present at the death), the groups of personnel able to perform the function, and the training they should have.

To make it clear what responsibilities doctors have in reporting deaths, there should be an organisation that issues statutory guidance on the types of death that should be reported to coroners, and by whom. That guidance should be kept under review.

Normally, the doctor providing care during the final illness, or the police officers who attend the scene of a traumatic or sudden death, should, where appropriate, report deaths to the coroner, but the range of people with the power to do so should include other professional healthcare personnel and members of the care inspectorates, fire service personnel and funeral staffs. As a matter of course, a doctor or police officer reporting a death to the coroner should be obliged to take all reasonable steps promptly to inform the family that the death has been reported. In order to provide support for doctors in death certification, to audit the death-certification process and to create links between death certification and the death investigations performed through the coroner service, a new post of statutory medical assessor should be created in each coroner area, to be filled by doctors working alongside the coroner.

Families with anxieties about a death should be encouraged to pursue matters with the second certifying doctor. If the family is left with significant unresolved anxieties, the second certifier should report the death to the coroner. Families and others who have continuing concerns should be able to report a death directly to the coroner's office.

It will be necessary for the legislation governing death certification in England and Wales to be amended to allow for adaptation of the certification system. Piloting of change is necessary, and there is a need for differences of approach in different settings where this would be desirable. There is the same need for legislative change in Northern Ireland.

The existing cremation-certification process should not be continued. There should be a common certification process for all deaths not reported to the coroner, whether the body is to be buried or cremated, and that process should in each case bring two professional opinions to bear before disposal of the body is authorised. For the second certification of deaths in the community, the statutory medical assessor in each coroner area should appoint a panel of doctors to provide all second certifications. They should be experienced clinical doctors, chosen for their skills and professional independence. They should concern themselves both with the safety of the certification process – ie the safeguarding against certifying deaths, which should be investigated by the coroner or police force – and with the accuracy and suitability of the disease-related data given in the certificate. They should invariably speak to the first certifier and be able to see the clinical case notes, including the note of the last occasion the first certifier treated the patient, any recent hospital discharge note or other note authenticating the diagnosis relevant to the death, and the list of medicines prescribed for the patient in the period preceding death.

They should be available to talk to or see members of the immediate family if that is requested.

The problem of the inquest

- We recommended that the short-form 'verdicts' used in England and Wales as inquest outcomes should be given up in favour of narrative and analytical outcomes. This would allow, where necessary, the traditionally narrow scope of inquiry at inquests to be extended sufficiently in order to enjoy public and family confidence in complex or

contentious cases, including those that at present often lead to calls for ad hoc judicial inquiries.

- We recommend that each of the new coroner jurisdictions we envisage – one for England and Wales and one for Northern Ireland – should have a rules committee and that there should also be a statutory coronial council, or possibly two if Northern Ireland prefers to have its own. Our objectives here were to provide new mechanisms to achieve consistency and suitability of process, especially for the handling of inquests, and to build into the coronial system a capacity for systematic and consistent development, which at present it lacks.
- As things stand, the main drivers for change are the individual case decisions of the higher courts, in recent years often concerned with the application of the European Human Rights Convention to death investigations. These case decisions will continue to be important, but in the nature of things they are delivered in response to the cases that happen to reach the higher courts. There is at present no mechanism for settling proactively such essential matters as disclosure practice and policy. We consider that the effectiveness and predictability of the coroner system would be enhanced greatly by the creation of these rules committees. If, as is likely, they serve to reduce somewhat the number of cases reaching the higher courts, they would be instruments of economy as well as of benefit to inquest participants.
- A recommendation for a coronial council is worth some comment. One of the most striking aspects of the coroner function is the closeness of the interaction it has, or should have, with other essential functions in modern public administration. In particular, it works alongside, and its outcomes contribute to, death-registration and public health services. At present, however, there are no mechanisms to ensure that these relationships work well and that there is a well understood and consistently observed division of functions between the various services.

Is a public inquest necessary?

Those deaths that require further examination by a lawyer and the coroner with assistance from those who are medically qualified are examined in order to satisfy three principal aims:

(i) to allay public concern where suspicion as to the cause of death may arise or has arisen

(ii) to discover, as far as possible, the circumstances and cause of death where these merit investigation beyond the abilities of a doctor

(iii) to identify strategies that will, when put into effect, make it less likely that deaths in similar situations will occur in future. The purpose of public forensic inquests should not be to act as a dry run for investigations that should more suitably be conducted by the police force or prosecution authorities or through criminal or civil court proceedings.

Only a very small proportion of deaths reported to the coroner lead to a court hearing, the inquest. We found that a disturbingly large proportion of these achieved little useful result beyond that which would have been attained without a court hearing and that they might have been better dealt with through a suitably searching, although less public, investigation. There is a clear difficulty: it is easy to criticise, as some have done, our suggestion that there are too many unhelpful 'public' inquests on the grounds that if conducted 'privately' there is too much of a risk of a cover-up. Although we acknowledge this concern, we found that the easy solution was not to continue to hold so many inquests unnecessarily and wastefully in public. Rather, the conduct and outcomes of investigations into deaths that do not, on any view, need to be the subject of examination in court should be more informative and both more publicly and more easily accessible by those (including relatives) who do not want to be shut out from a process that might concern them. In most Australian states and Canadian provinces, public inquests are a comparative rarity and ordered only where it is considered on tightly defined criteria that, thereby, some sensible purpose may be achieved through holding them. Our inquiry did not advocate so drastic a curtailment of the scale of public inquests, since it considered that the needs of families and the local and national communities should be accommodated flexibly. Rather than perpetuating a crude distinction between 'public' inquests on the one hand and 'private' investigations on the other, the aim should be to investigate most deaths as a posthumous service to the deceased and to her/his family and friends, without necessarily infringing the privacy of either, and to investigate through public inquests those deaths that may give rise to significant issues of public concern or need the full forensic process that a public court hearing can provide.

Inquest outcomes and 'short-form verdicts'

Inquest outcomes, known as 'inquisitions' and, commonly, 'verdicts', are frequently misunderstood with regard to their legal value. They have no status in criminal or civil legal proceedings. Although necessary in Article 2 of the European Convention on Human Rights cases – typically where death might have occurred at the hands of an agent of the state, such as a police or prison officer – in order to satisfy the requirement that an inquiry must, in such cases, reveal the circumstances in which the death occurred and lead to the identification of any criminally liable perpetrator, inquest outcomes cannot legally be cited in support of a claim for civil or criminal liability. For this reason, we concluded that those 'short-form verdicts', or the concluded outcome specified in the inquisition, that give the appearance of attributing liability to an individual or institution, eg 'unlawful killing' or 'accident contributed to by negligence', should be dispensed with in favour of more neutral labels that would be focused on the factual circumstances of death. These would be useful for research and statistical purposes, rather than being a token for something that families might see as compensation for the fact that the person who they perceive as civilly or criminally responsible for the deceased's death has 'got away with it' as a result of not being prosecuted.

We also concluded that the information included in inquisitions is often insufficiently informative about the circumstances of death to satisfy the purpose of an inquest. We therefore recommended that inquest outcomes, as with those of non-inquest investigations, should be much more of a narrative than at present and provide a coherent, concise and properly informative account of what led to death. They would also, in suitable cases, identify the failings of systems or individuals that were contributory to death and, if apt, include the coroner's recommendations for future action that would be likely to render similar deaths less likely to occur in future.

Inquest juries

If our recommendations relating to inquest outcomes were to be adopted, there would be difficulty in resolving the issue of how juries could be used to participate in a way that created outcomes more useful than those currently produced. Juries cannot be used to create essays. Acknowledging the strong views of some – that juries, certainly in Article 2 cases, are here to stay – the best we could do was to suggest that juries could be used only for the resolution of the issues relating to disputed facts (where these could be identified with precision). As a personal view of the authors, it might be said that this is not a satisfactory compromise; perhaps the best way forward is for juries to be phased out as public confidence in the independence of the new system increases.

Legal representation at inquests and public funding for the family of the deceased

There is no doubt that the spectacle of the family of the deceased, seen in lonely un-legally represented isolation in a court and surrounded by the heavy guns of lawyers representing other 'interested persons', makes a sad sight. Opinions vary as to whether the solution to this is either to make legal representation for the deceased's family more readily available from the public purse or to reduce the role of lawyers at inquests in a way that makes them less of a gladiatorial combat. Whilst 'combat' is an appropriate term in so many criminal trials, what we are considering is not a venture to discover who was, legally, to blame for the death but rather what circumstances caused it. It may be that if our recommendations are implemented, then the useful contribution that lawyers will be able to make will be reduced to such an extent that families will feel less intimidated and cowed by the tactics of those who they perceive as being 'against' them.

We are strongly of the view that the coroner's jurisdiction should remain inquisitorial and that the coroner's findings should not determine matters of liability that lie more properly with the criminal and civil courts. However, we thought it sensible to make a number of recommendations that would, to some degree, lessen the severity of the traditional doctrines that have grown up around the inquisitorial approach, eg that there are no parties to an inquest, that families have no right to prior disclosure of material, or preclude for the inquest court's consideration any overall interpretation of the evidence that it has heard.

Worse problems elsewhere

Our problems are not unique. In the modern world, aspects of birth and death certification are assuming a greater significance. In January 2004, all Buenos Aires doctors had to re-register and provide new examples of their signatures following a bizarre murder case in which a woman with five gunshot wounds to the head was certified as having died of heart failure. This case exposed a racket where doctors had supplied pre-signed death certificates to undertakers in return for money; these had also been used to record a preferred cause of death for insurance fraud. In Argentina, non-existent children have been registered to establish the rights of residence of the parents of an 'Argentinian' child. We escape these failings in England, Wales and Northern Ireland. In the view of one of us (CLB), a major disgrace is that the medical profession has not sought linkage between birth and death records and has made so little use of the autopsy/non-autopsy certification comparisons in epidemiology. Proper investigation of death is a service to the living, the meaningful mantra of the coronial service in Toronto.

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Reference

1 Home Department. *Death certification and investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review 2003,* CM 5831. London: HMSO, 2003.