DEATHS

IN THE COMMUNITY

BRITISH MEDICAL ASSOCIATION
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PREFACE

This booklet both reflects the current situation in England and Wales, and makes recommendations which the BMA believes would improve the processes of death certification and of investigation of unexplained death. The legislation which governs these procedures in Scotland and Northern Ireland is very different, and thus the text does not apply to those countries.

However the effects of those improvements in the legislation which the BMA seeks should, where appropriate, be adapted to fit the legislative processes in Scotland and Northern Ireland so that a common standard will prevail throughout the United Kingdom, even though governed by differing legislation.

INTRODUCTION

In 1964 the British Medical Association responded to increasing concern among the medical profession about the laws relating to the disposal of dead-bodies, and to the changing pattern of disposal of the dead by publishing the first edition of "Medico-legal Investigation of Deaths in the Community"[1]. The report reflected those concerns and was part of a campaign to change the laws.

Much of the concern felt by the British Medical Association at that time was highlighted by the evidence in Dr John Havard's book "The Detection of Secret Homicide"[2].

The BMA's initiative in this field was followed by the appointment of a (Home Office) Departmental Committee of enquiry under the chairmanship of Mr Norman Brodrick, QC. His committee eventually reported in 1971[3]. They largely endorsed the non-controversial recommendations in the BMA report, and many of those have subsequently been implemented.

Many of the other recommendations including those which related to the establishment and adequate funding of Forensic Medicine Departments, whether within or outside Universities, with all the implications this has for the future of the forensic medicine service, have yet to be acted on.

Because so many of these recommendations have not been introduced and because of further changes in the patterns of disposal of the dead during the past 20 years, the BMA felt that there was a need to revise the BMA report on this subject. A further reason is that there remains considerable confusion amongst the medical profession as to the exact nature of their statutory obligations arising out of the death of a patient.

This report has therefore several functions. It is intended that it shall inform the reader of the present laws surrounding the certification of death, the investigation of sudden, unexpected or unexplained deaths, and the formalities surrounding the disposal of the dead. At the same time it highlights those areas where the BMA feels reform is essential in the public interest.

This report was produced as part of the work of the Forensic Medicine Subcommittee of the BMA. The Subcommittee members are:-

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The Subcommittee is grateful to BMA News Review for the cover illustration.

The report is arranged to give a general overview of the development of the coroners inquest, and of death certification first, before detailing some of the specific legislation in each area.

The final part of the report is a summary of those recommendations, mentioned in the text, which the Association feels would improve the opportunity of death certification procedures detecting the concealed homicide.

ONE

HISTORY - GENERAL

The system of reporting sudden and unexpected deaths to a special court has a long history in England, although both the relevance of the reporting and the efficiency of the subsequent enquiry have only relatively recently been the subject of legislation.

Until legislation in the 19th century empowered the coroner to request an examination of the body by a medical practitioner there was little impetus for the development of a forensic medicine service in the UK.

Until the middle of the last century the only information on the cause of death, or indeed record of the number of deaths, relied on the Bills of Mortality[4]. By these, two old women "searchers" were appointed in each parish. They viewed the dead bodies and recorded the numbers of deaths. The returns they submitted were often grossly inflated, especially at the times of epidemics of infectious diseases such as cholera, and the reports led to states of panic in the local population. The system was also open to bribery as the women were often paid by the families not to inspect the bodies. It was not, however, this abuse which led to a reform but panic-mongering during epidemics led to the introduction of the registration of deaths in 1836.[5]

Prior to this the registration of burials had left almost one-third of all deaths in England and Wales unaccounted for[6]. At the same time the coroner had no provision for payment for the performance of a necropsy, so that investigation of suspicious death was very limited.

At that time it is worth remembering that of the 15,000 people practising medicine in the UK only 10,000 had any kind of recognisable qualification. The then newly-formed British Medical Association was already campaigning for the abolition of "quackery", but that was not to be accomplished until the Medical Act of 1858[7] laid down the qualifications necessary to practise medicine as a registered medical practitioner. Meanwhile the Registrar General had sent out books of death certificates in 1842 to the 10,000 doctors who were licensed to practise by the Royal Colleges, or by the Society of Apothecaries, and invited those practitioners to certify the cause of death of those patients they had attended before death.[8]

It was expected that this certification would give some ideas of the numbers of deaths from the epidemic diseases. What happened, unexpectedly, was that the number of deaths reported to the coroners rose substantially.[2]

However any expenditure by the coroners, who were paid on the

basis of the numbers of inquests they held, had to be authorised by the Justices in Quarter Sessions. The justices were unwilling to agree to payment either to the coroners themselves, or to the recovery of fees and expenses incurred in the holding of an inquest[9]. They maintained that no inquest should be held unless there were manifest evidence of felonious violence[2]. This attitude meant that the 1836 legislation had little effect on the detection of homicide until the coroners were freed from the control of the justices. In 1860 the County Coroners Act placed the remuneration of the coroners on a salaried basis[10], thus removing one bar to the holding of an inquest. At the same time a public scandal had arisen because of the failure of the courts to stem a widespread outbreak of poisonings - in particular infanticide committed for insurance monies ("burial clubs"). The coroners finally became administratively independent of the justices when the administration of the Quarter Sessions was transferred in 1888 to the newly constituted local authorities[11].

Although the Births and Deaths Registration Act of 1874 had made it obligatory for a doctor, who had attended a deceased person during the last illness, to issue a certificate stating - to the best of his knowledge and belief - the cause of death[12], this legislation was relatively ineffectual until amended by the Births and Deaths Registration Act 1926[13] which stopped the registration of a death, without a doctors certificate of death from natural causes, unless such a death were reported to the Coroner.

The Coroners Act of 1887[14] had given the coroner the authority to investigate not only violent or unnatural deaths, but also all sudden deaths of unexplained cause. The Coroners Amendment Act of 1926[15] allowed the coroner to dispense in certain cases with an inquest when the necropsy showed that the death had been neither violent nor unnatural.

When the administration of the coroners system was transferred to the local authorities in 1888 the appointment of coroners by local popular vote was abolished, and coroners instead became local authority appointees[11]. There were, however, no qualifications for holding the office of coroner apart from a remaining, mediaeval, requirement to have an unspecified holding of freehold land - which historically had, on occasion, been satisfied by the purchase of a grave plot in the local cemetery[16]. The Coroners Amendment Act of 1926 abolished this freehold condition, and introduced the requirement that the coroner be duly qualified medical practitioner, solicitor, or barrister of at least five years standing[15]. These requirements have not been altered since that time.

The 1926 Act [15] also laid down fees for necropsies and for attendance at inquest by medical practitioners, these previously having depended on local scales laid down by the local authorities. In 1954[17] the Home Secretary was empowered to lay down these fees by regulation, and in 1977[18] by administrative action.

In 1935 concern was engendered following a number of controversial inquests. A Departmental Committee was set up under the chairmanship of Lord Wright[19]. This reported in 1936 and made a number of recommendations on the power and appointment of the coroner, but these were largely unimplemented until the Coroners Rules of 1953[20]. These rules and subsequent amendments were consolidated by the Coroners Rules 1984[21].

The coroner lost the right to receive statutory notification within 24 hours of death of all foster children when the Children's Act of 1958 was passed[22]. The statutory duty, introduced in the nineteenth century to combat uncontrolled baby farming was felt necessary because of the ease with which a child can be killed without leaving external signs of violence, and because of the possibility of a certificate of death from natural causes being issued by a doctor who has not seen the child for several days before death. However it was the Lord Chancellor himself who amended the Bill, withdrawing the statutory duty and relying instead both on an obsolete common law requirement that persons about the deceased will notify the coroner of deaths coming within his jurisdiction, and on the requirement of the Bill for parents to notify the local authorities within 48 hours of death. Since 1958 child abuse and homicide have increasingly been in the news, but this simple measure aimed at detecting these crimes and ultimately at deterring the potential criminal has not been reintroduced. In the debate on the Bill in 1958 the Lord Chancellor said "I can think of few subjects of legislation where we need to be sure that our proposals are the wisest, safest and the most humane that we can devise ....."[23]. The Act which emerged failed to satisfy these criteria.

TWO

THE BRODRICK REPORT

In 1960 Dr John Havard published as part of the Cambridge studies in Criminology, a book on the medico-legal investigation of sudden and unexplained deaths entitled "The Detection of Secret Homicide"[2]. Four years later the British Medical Association published the first edition of this report[1]. The two together stimulated public debate on the efficiency of the English system for detection of secret homicide. In 1965 an Inter-Departmental committee on death certification and coroners was set up under the chairmanship of Mr Norman Brodrick QC. The Committee's report was published in 1971[3].

The general conclusion drawn by the Brodrick committee was that the warnings contained in both the BMA report and in Dr Havard's book were unfounded; that is the existing system of certification, and of investigation of death, did not allow deaths which required investigation to remain undetected.

Many previous investigations had questioned the accuracy of death certification. Despite this the Brodrick report was placatory, and the evidence from which the committee drew its conclusions has never been published.

In 1950 a Departmental committee of inquiry into cremation[24] had found that increased safeguards were necessary to prevent the abuse of cremation as a means of destroying evidence of unnatural death. The findings of Brodrick ran directly contrary to this committee's report. But again its evidence was not published.

Shortly after the publication of the Brodrick report there was extensive publicity of a case of multiple murders by thallium poisoning[25]. This showed conclusively that it was possible to conceal homicide as natural death. As a result of this the government showed little inclination to act on many of the recommendations of the Brodrick report.

It is a matter of great regret to the BMA that following the Brodrick report no action was taken to improve the forensic medicine service; undergraduate and postgraduate education in the legal aspects of medicine, education on certain aspects of the coroners work, and the organisation of training programmes in forensic medicine. At the same time a complete review of the system of death certification has largely been bypassed in favour of piecemeal amendments aimed at facilitating the cremation procedure.

THREE

MEDICAL CERTIFICATION OF THE CAUSE OF DEATH

I. Obligation on the doctor to provide a medical certificate of the cause of death

Since the Births and Deaths Registration Act of 1874[12], [and under all the subsequent amending legislation], a registered medical practitioner *who was in attendance upon the deceased during his last illness* has been obliged to provide a "Medical Certificate of the Cause of Death".

The problem which most often arises is the result of the failure to define in legislation "attendance during the last illness". The doctor has to decide whether he was in attendance, and has little or no help in this. The lack of undergraduate teaching in the legal aspects of medical practice merely compound the problem.

If the doctor decides that he was not in attendance during the last illness, the death will have to be reported to the coroner. Because of this the Registrar General has suggested that doctors, who are unsure about the definition of attendance in a particular case, should discuss that case with the coroner. If the doctor does not feel that he was in attendance the coroner is still free to dispose of the death on pink form "A", indicating that he does not wish to accept jurisdiction over the body.

The only guidance is that which is contained in the statutory instruments issued under the Births and Deaths Registration Acts[26]. Under these the registrar is required to refer to the coroner any death where the certificate indicates that there was more than 14 days between the last visit of the doctor and the death.

It has also been accepted practice for a doctor to issue a certificate having viewed the body after death , as an alternative to having had clinical contact with the patient before death.

Both the lack of guidance on what constitutes attendance, and the suggestion that viewing the body after death is an acceptable alternative to clinical knowledge of the patient, must be regarded as very serious defects in the existing system of death certification.

II. Viewing the body after death

The United Kingdom and the Republic of Ireland are the only European countries where the law does not require the doctor to view the body before issuing a death certificate.

In practice, the proportion of deaths which are certified without

the body having been seen has dropped substantially over the last 50 years[27]. This is largely due to the rapid increase in the proportion of cremations. [The doctor issuing the cremation certificate is required to inspect the body.]

Table 1: Decline in cases of not viewing the body after death

YEAR	BODY NOT SEEN AFTER DEATH (%)
1928	48.5
1947	38.8
1959	25.2
1980	1.8

The Brodrick report[3] recommended that inspection of the body by the certifying doctor become mandatory, but no government has sought to enforce this legislation despite repeated representations by the British Medical Association.

III. Problems related to current trends in practice organisation

With the increase in the number of general medical practitioners practising as members of a group it becomes increasingly common for a patient to be seen on different occasions by different doctors, all of whom are conversant with his medical history. And indeed, although more than one doctor may have seen the patient during the last fortnight of his life, the doctor called at the time of death may well be another partner or a locum tenens.

Present legislation means that if the doctor who ascertains the fact of the patient's death is not the doctor who has attended the patient during the last 14 days of his life, during the last illness, he may not issue a death certificate. Assuming therefore that it is unlawful to issue a certificate on the basis of an inspection of the body after death, the death must be reported to the coroner. The reasons for this reporting to the coroner are thus purely organisational, and do not contribute to the efficiency of the system.

Similarly, in the summer holiday period many more deaths are reported to the coroner than at other times of the year. This is because the general practitioner may be away and their colleagues, although often fully conversant with the patient's history, are unable to issue a certificate without referral to the coroner because of the fourteen day rule.

The increasing use of deputising services also leads to more cases being reported to the coroner. In these cases the deputy will be less well informed of the patients background medical history.

In many of the former cases the coroner will either decline to accept the case, or will issue a form "A", and both of these allow the doctor to issue a certificate of death which is acceptable to the regis-

trar. But numbers of cases are needlessly referred to necropsy.

This complex procedure is cumbersome, costly to the community, and not infrequently causes delay to the bereaved relatives' funeral arrangements.

Set against this is the fact that necropsy significantly improves the information available on cause of death[28,29], and that the system is designed to ensure that deaths requiring investigation are not disposed of.

The Association recommends that examination of the body should be mandatory in all cases before the issuing of a death certificate. If a doctor has been in attendance on the deceased in the 7 days prior to death it should be permissible for the certificate to be issued by the partner of the attending doctor or a member of the same group practice. Similarly, if the person dies at home after being seen by a hospital doctor (eg as an out-patient), the GP should be able to complete a death certificate after telephone contact with the doctor who attended the patient at the hospital, and after he has viewed the body.

IV. Cause of Death vs. Fact of Death

Since 1874 it has been a legal obligation of a doctor in attendance during the last illness to provide a Medical Certificate of the Cause of Death (a "death certificate")[30].

In many countries doctors certify the *fact* of death. In the UK doctors certify the *cause* of death, the fact of death being self-evident from the provision of the cause of death. In those cases where a doctor is unable to verify the cause of death it would seem sensible that the doctor should instead certify the fact of death. Brodrick recommended that this be the case, and that the certificate of the fact of death should be sent, in cases where the cause cannot be certified, to the coroner. This recommendation has not been acted upon.

After issuing a death certificate the doctor issues a 'Notice to Informant' to the person [30], usually a close relative, to whom he has given the death certificate. The "Informant" then has 5 days to register the death. The doctor has an obligation to cause the delivery of the certificate to the registrar. Although this may be done by post[30], the doctor normally hands the certificate to the Informant, who will then convey the certificate personally to the registrar.

V. Where deaths have been notified to the Coroner

According to normal custom and practice, doctors who have informed the coroner of a death which they feel lies within the coroner's jurisdiction, do not issue a death certificate, even when they

have been in attendance on the deceased during his last illness; that is even when they have a statutory duty so to do.

This has always been considered the sensible course because the certificate issued in these circumstances had the doctors initials in box "A" on the back, and the registrar was unable to register the death from that certificate until instructed to do so by the coroner.

Following the coroner's enquiry, and either as a result of an inquest or of a necropsy, the coroner notifies the registrar of the actual cause of death.

In the circumstances, the completion of a death certificate by the attending doctor with a speculative, or occasionally knowingly-false, cause of death is superfluous. Indeed when the case had been reported, because the doctor either had no knowledge of the cause of death, or where the doctor feared the death might be unnatural, the issuing of such a speculative certificate could serve no useful purpose.

It was with considerable surprise, therefore, that the profession noted the alteration of the text of the instructions in each death certificate book in 1978. The Registrar General was now requiring that attending doctors issue a certificate in every case - regardless of whether the case had been reported to the coroner. In clarification the Registrar General explained that in many cases of unnatural death there would be no doctor in attendance, and no last illness, so no problems would arise.

Despite this argument the fact remains that the majority of cases referred to the coroner, are referred because the doctor does not know the cause of death. The production of a vague, non-specific, or even partially blank, certificate fulfils no useful purpose.

The Registrar General's instruction has made it more difficult to give clear, concise instructions to medical students and young doctors about their legal obligations. Meanwhile, the Brodrick report had recommended that a doctor should either issue a death certificate, or report the case to the coroner.

VI. The Duties of the Registrar

When the death certificate has been lodged with the registrar, usually by the Informant, the death is then registered on the basis both of that certificate, and of an interview with that Informant. The registrar has the duty to notify the coroner of the death[26] in certain circumstances. These are:-

(a) the deceased was not attended during his last illness by a medical practitioner;

(b) he is unable to obtain delivery of a duly completed medical certificate;
(c) it appears from the death certificate (or otherwise) that the deceased was not seen by the certifying registered medical practitioner after death, nor in the 14 days prior the death;
(d) the cause of death is unknown, or is expressed in terms which imply some doubt on the part of the certifier;
(e) he has reason to believe the death to have been unnatural, or directly or indirectly caused by any sort of accident, violence or neglect, or to have resulted from abortion, or any form of poisoning, or to have been attended by suspicious circumstances;
(f) death occurred during an operation, or before recovery from the effects of the anaesthetic;
(g) according to the certificate death was due to industrial disease or industrial poisoning.

Similarly the registrar must refer to the coroner any alleged stillbirth[26] which he has reason to believe was in fact a live-birth.

VII. Duties of others to notify the coroner

The registrar is the only person who has a statutory obligation to notify the coroner of any death. Although it remains an offence deliberately to obstruct the coroner in the performance of his duties, the old common law requirement that citizens must notify the coroner of any deaths coming within his jurisdiction is no longer enforced[2].

A doctor does not have to notify the coroner of any death. It is legally acceptable for the doctor merely to issue a certificate which he knows will lead to the registrar notifying the coroner, but it is very bad practice so to do without also informing the coroner.

The certificate carries box "A" on the back. Initialling of this by the certifying doctor indicates to the registrar that the doctor has informed the coroner about the case, and reduces the delay to the family, and indeed the delay before the investigation of the death is begun.

The majority of certificates which the registrar will have to notify to the coroner are issued by doctors - usually very junior hospital staff - who are either unaware that certain phraseology on a death certificate will cause the registrar to inform the coroner, or who are unaware of the proper procedures to be carried out when notifying the coroner of a death which, for whatever reason, the doctor is unable to certify. Many unnecessary referrals to the coroner, and

unacceptable delays for the family, could be avoided if undergraduate tuition in the legal aspects of medical practice were improved.

Brodrick suggested that instead of the initialling of Box "A" the certificate should be of both the *fact* and of the *cause* of death. Thus when the doctor is unable to certify the cause of death the certificate given to the Informant for delivery to the Registrar would only be a certificate of the fact of death.

VIII. Accuracy of Certified Cause of Death

In the first edition of this book we suggested that there was considerable disquiet over the accuracy of the information contained on death certificates. The BMA had used a paper published in 1962 by Dr M A Heasman[31], a medical statistician in the General Record Office, and the same paper was considered by the Brodrick committee. The two groups came to very different conclusions using this source document.

The British Medical Association believes that the paper shows that there is substantial evidence to show that death certificates issued without benefit of necropsy, reveal considerable discrepancies from those issued after necropsy.

The Brodrick report took the view that there was no serious deficiency in the accuracy of hospital certificates. Subsequently there have been a number of further studies which all confirm the BMA's view.

A number of prospective studies have been published where the cause of death, based on clinical information alone, was compared with the cause of death after necropsy; discrepancies occurred in approximately half the cases. In about a quarter of the cases there were serious divergencies, necropsy showing that the fatal lesion was often in a completely different anatomical system to that suggested by the clinical certificate. Still other studies have suggested even worse correlations, with anything up to 30% total disagreement.

Cameron and McGoogan[28], who performed one of the prospective studies, went so far as to suggest that, as the diagnosis at death was so often inaccurate, the diagnosis in life might also frequently be incorrect and that this might account for as much as £10 million mis-spent in each NHS region in erroneous therapeutic measures.

There has been a great deal of criticism of these studies. But it is worth remembering that the studies were all prospective, that is that the doctors filling in the clinical certificates knew that a necropsy would be performed and were motivated to take more than the

usual amount of care in certifying the cause of death. The deaths all occurred in hospitals where the clinicians had the benefit of a variety of investigations, and the post-necropsy cause was arrived at by the clinician and pathologist in co-operation. It is likely, therefore, that the surveys show certification at its most accurate.

In general practice it is probable that the accuracy will be even lower[32]. Many causes will be arrived at using, in part, clinical information gathered by hospital clinicians and drawing the same conclusions as the hospital doctors from that information.

IX. Joint Working Party on the Medical Aspects of Death Certification

The concern felt by the profession on the inaccuracies in death certification shown by the various surveys, led to symposia by the Royal Colleges of Physicians and of Pathologists and the formation of the above working party[33] which produced a report on the subject.

The main recommendations of the Joint Report included:-

(a) For hospital deaths the certificates should be completed by senior doctors, not provisionally-registered house-officers.

(b) The necropsy rate on hospital deaths not reported to the coroner should be increased.

(c) Death certificates should indicate the name of the consultant to give more continuity when further information is requested by the Registrar General [implemented 1985][34]

(d) Hospital doctors should be encouraged to make more use of necropsy findings as a means of medical audit.

(e) The standard of medico-legal necropsy should be improved to give more epidemiological information, in addition to the nature of the primary cause of death.

(f) More details of occupational status should be recorded at death. [In the revised form of certificate, introduced in 1985[34], any known or suspected occupational hazards contributing to death must be recorded on the certificate. This seems somewhat unnecessary, as such factors have always been grounds for referral to the coroner.]

(g) Tuition on the proper completion of death certificates should be included in both under- and post-graduate education.

NOTIFICATION TO THE CORONER

I. Doctors

As stated earlier there is no statutory requirement for a doctor to notify the coroner of any death. The system which has evolved in this country - whereby the doctor informs the coroner of all deaths which he feels may lie within the coroner's jurisdiction - is entirely voluntary.

In most cases the doctor who notifies the coroner does so about the death of his own patient. More rarely, the doctor has been called to see a dead, or moribund, person, but in such cases it is usually the police who notify the coroner.

The Working Party on Coroners Rules[35,36] drew up a list of deaths which must be notified to the coroner. These are, broadly, similar to the registrar's list[26].

(1) When no doctor has treated the deceased during his last illness.

(2) When the registrar has been unable to obtain a duly completed death certificate.

(3) When it appears to the registrar that the deceased was seen by the certifying medical practitioner neither within 14 days before, nor after death.

(4) When the cause of death appears to be unknown.

(5) When the registrar has reason to believe that death might have been caused by violence, neglect or abortion, or to have been attended by suspicious circumstances.

(6) When the death apparently occurred during an operation, or before recovery from an anaesthetic.

(7) When it appears from the medical certificate that death may have been due to industrial desease or industrial poisoning.

Other causes of death which should always be reported to the coroner include deaths in police or prison custody.

Confusion has also arisen because of the "classical" definition of deaths which should be reported to the coroner as "sudden, unexpected" deaths. Many deaths which are "sudden" could be said to be "expected" -eg cases of severe coronary insufficiency. A better definition of cases to be referred is "sudden *and* unexplained".

Although the Working Party on Coroners Rules produced a list which is meant to cover all eventualities, in practice, like so many things in this difficult area, it is interpreted in many ways. Confusion may therefore arise in areas such as deaths associated with medical and surgical procedures, deaths after emergency admission to hospital etc.

At the same time although deaths occurring in prison or police custody are reported to the coroner they should be included in the list so that doctors serving these establishments may be in a position to notify these deaths. Similarly, where there has been any allegation of defects in medical diagnosis or treatment, or in medical care, it is often advisable to notify the coroner.

The first edition of this book deplored the abolition by the Children's Act, 1958[22] of the requirement that all deaths of foster children had to be reported to the coroner within 24 hours of death. Noting a number of tragic cases since then the Association recommends that this duty to notify be restored and extended to all deaths of children who have been the subject of care orders, or who are on the at risk register.

Deaths of children due to injuries will normally be reported to the coroner under the Coroners Rules Working Party List items 4 or 5. The reporting of such cases is essential because of the necessity to produce accurate statistics on Non-Accidental Injury.

II. The Fourteen Day Rule

In 1893 the Select Committee on Death Certification[37] recommended that this requirement be altered so that a doctor must have made at least two attendances upon the deceased, one of which should have been in the eight days prior to death. Brodrick[3] had suggested that the present 14-day period be reduced to 7.

Ideally the deceased should have been seen within a shorter period before death, but for practical reasons the statutory limit will have to remain 14 days. However the certifying doctor should always be required to view the body after death.

III. Duties of others to notify the Coroner

(1) "Qualified Informant"

When the doctor issues a death certificate he has a statutory duty to hand to the "qualified informant" a notice that the certificate has been issued.

Under present law[30] the informant has 5 days to register the death. In Scotland the opportunity for delay is even greater with the Informant having 12 days to register the death.

To avoid the loss of evidence which may arise out of unnecessary delays the BMA recommends that the Informant should obtain a death certificate within two days of the death (excluding public holidays) and, if he has been unable to obtain the certificate, to notify either the coroner's officer or a police officer of the death within that same period.

(2) Nurse

Occasionally the professional nurse who has attended the deceased during his final illness may be in a better position than the medical practitioner to suspect the presence of suspicious factors in the death. This may also occur when the nurse or other attendant is "laying out" the body.

(3) Funeral Directors

It is often difficult for the doctor to examine the whole body surface in domestic surroundings, but in the course of their duties the funeral director may notice some abnormality which suggests the presence of a suspicious factor in the death.

We recommend that the above groups of people should have statutory obligation to notify the coroner of any circumstances which may warrant the coroners investigation of a death.

The coroners society have suggested that all deaths of British subjects occuring overseas should be the subject of an investigation by the relevant consular department on begalf of the Foreign and Commonwealth office. We support this view.

Any person who has a professional involvement with the disposal of the dead, such as nurses, embalmers, and funeral directors, should have a statutory obligation to inform both the coroner and the medical attendant if they notice anything suspicious about the body.

FIVE

INTERFERENCE WITH THE BODY

When a suspicious, or unexplained, death is reported to the coroner the expectation is that evidence on the nature of that death will be obtained by forensic examination of the remains. Interference with the body may remove evidence, or seriously compromise the accuracy of the subsequent forensic investigation. It is essential, therefore, that such interference be kept to the absolute minimum necessary; that is the removal of the body from the place of death and the removal of parts of the body under the provisions of the Human Tissue Act, 1961[38].

Currently the majority of deaths result in some degree of interference with the body before the certificate of disposal is issued. Even the normal procedures of "laying out", performed routinely in most hospital deaths, may interfere seriously with forensic evidence. However more drastic interference with the body should not be permitted before the certificate of disposal is issued.

Embalming is not the extremely rare procedure that many people suppose. In practice there are two types of embalming procedure, and the first of these is performed in the vast majority of deaths.

1. Temporary: This involves one injection site only and is aimed merely at delaying the putrefactive changes until after the funeral service.
2. Full embalming: This involves about 6 injection sites, with about 3 to 4 gallons of a 1% solution of preserving fluid being used.

Embalming is important because even the temporary, limited, procedure renders ineffectual the majority of tests for poisons. It will nullify the tests for volatile poisons, and interfere with the isolation processes for the non-volatile organic compounds. In particular formaldehyde, an almost invariable constituent of embalming fluid, condenses with cyanide and many other compounds altering their identifying reactions.

Currently the Informant has 5 days to register the death. Provided registration offices are open for far longer hours than many currently are, there is no reason why this period should not be substantialy reduced.

SIX

STILLBIRTHS

According to both the substantive criminal law, and indeed the laws related to the inheritance of property, a child that is stillborn cannot be regarded as a child that has died, but instead as one that has never had independent life.

A newborn child must have been completely extruded from its mother, regardless of whether the umbilical cord is still attached, and also to have shown signs of life, or to have breathed, before it can be considered to have been "born alive"[30].

This complex definition matters, not only because of the laws of succession and property inheritance, but because a child that has never been "alive" in this definition cannot "die". The killing or destruction of that child, while any part of it remains in the maternal passages, cannot therefore be homicide, even if the child has shown signs of life.

It is very easy to kill a newborn child with minimal signs of violence, and to pretend that the child was in fact stillborn. Because of this and because of the absence of a charge of homicide in cases where the child has been destroyed before "being born alive", a series of Acts were necessary to protect the unborn child.

The crime of child destruction[39] was introduced as a statutory offence in 1929 under the Infant Life Preservation Act. Despite this, stillbirths are treated very differently to neonatal deaths, and until that anomaly is removed the temptation to disguise neonatal homicide as a stillbirth will remain.

Since 1926 all stillbirths in the UK[15] have had to be registered. The law defines a stillbirth as "a child which has issued forth from its mother after the twenty-eighth week of pregnancy and which did not at any time after being completely expelled from its mother breathe or show any other signs of life"[30]. Such a child must be registered in much the same way as a live birth. But the "Qualified Informant" has six weeks to register the stillbirth[30] and, in practice, no certificate from a professional witness is required.

The informant is required to produce a certificate signed either by the attending doctor or the attending midwife, who are expected to have examined the body of the child and stated not only that it was not born alive but also the estimated duration of the pregnancy, and, to the best of their knowledge and belief, the cause of "death"[40].

If, however, the birth were attended by neither a doctor nor a midwife the informant may make a statutory declaration that no doctor or midwife attended and that therefore no certificate has

been obtained.

If the birth were not attended, but subsequently a doctor or midwife is called, they may examine the body of the child and similarly issue a certificate of stillbirth.

The registrar is required to notify the coroner if he has any suspicion that the child was, in fact, born alive[26]. Because of the six week period allowed for the registration of the stillbirth, and the fact that the registrar will probably not be aware of the stillbirth until the informant attends to register it, the delays in starting the investigation of suspicious cases are often considerable.

It is therefore disturbingly easy under the current legislation for a newborn child to be destroyed, and the homicide to be concealed as a stillbirth. Only when all stillbirths are handled by the registrar in the same way as deaths will this anomaly be resolved.

External examination of the body of a newborn infant gives no clue as to whether the child was stillborn or born alive. The first "definite"sign is that of healing of the umbilical stump, and as this takes some days to occur it is of no particular use in determining whether a child was stillborn.

It is therefore self-evident that stillbirths should not be registered without the attending doctor or midwife's certificate. should the attending doctor or midwife be unable to certify the death as a stillbirth they should have a statutory duty to notify the coroner, or the coroner's officer. Similarly the "Qualified Informant" should have a statuory duty to inform the coroner within twenty-four hours of the birth is he/she has been unable to obtain a certificate of stillbirth.

Currently the stillborn infant can be disposed of with few restrictions other than those in the Public Health Acts[41], and the law relating to public nuisance. There is no record of where the disposal has occurred because the person who receives the certificate of disposal does not have to notify the registrar where disposal has been effected, unlike other deaths. This situation is unsatisfactory, and as well as the amendments to registration of stillbirths mentioned above, we recommend that this be brought in line with the procedures for other deaths.

In 1986 a modified certificate for stillbirths is being introduced[42]. This has been the subject of detailed discussion between the BMA, the Home Office and the Registrar General. Perinatal mortality studies have increased the proportion of stillbirths and perinatal deaths which have been the subject of necropsies. The new certificate allows the certifier to indicate that he has either taken account of information obtained from a necropsy or that such information will be available later.

The new certificate will have five separate areas in which the certifying doctor or midwife can enter unrelated conditions which may have contributed to the stillbirth. They are entered under the headings "main condition of the foetus", "other conditions in the foetus", two similar spaces for conditions in the mother and a final section for "other relevant causes".

Because the child was never alive there is no box "A" on the reverse to indicate that the doctor or midwife has informed the coroner. The intention is that, if the practitioner is unable or unwilling to certify the stillbirth, he should notify the coroner and issue no certificate.

At the same time a new certificate for perinatal deaths, which will more realistically define the perinatal period as 28 days rather than the current 14 days, will be issued. The certificate is very similar to the stillbirth certificate but does have Box "A" and "B" on the reverse to indicate notification of the coroner, and the possibility of additional information being available later.

In keeping with the new adult death certificate both forms have the name of the hospital consultant where the death occurred in hospital.

SEVEN

THE CORONER

In the fourteen years since the Brodrick report was published many of the recommendations which referred to procedural matters in relation to the coroner's duties have been implemented. However the majority of the recommendations regarding the provision of a necropsy service and the support services for forensic pathology remain "under discussion".

When the first edition of this book was written it was already obvious to the Association that a reorganisation of coroners districts was necessary. There was some reduction in the numbers of coroners under the Local Authority reorganisation of 1974[13]. The new legislation[14] to fragment the large Metropolitan Counties will mean the division, again, of large coroners districts. This fragmentation will worsen the present problems where many coroners have too little work to maintain their own experience at a high level, and there is little or no opportunity for the local appointments committees to gain experience in appointing suitable people to the post of coroner.

At the same time the terms of service for the coroners are in need of reform. The service is not centralised, and coroners are currently employed on parity with the chief officers of the local authority. The coroners themselves feel that an analogy with the county court registrars would be more appropriate as their work - part administrative and part judicial enquiry - is very similar. As local authority employees the coroners suffer from a number of disadvantages - not least being that the pension arrangements expect the employee to work for the local authority for forty years; coroners are employed at age 40 on average, and so only have the opportunity to build up half the maximum pension entitlement. These "domestic" matters are important to the population as a whole. Until the situation is improved we cannot ensure that the most able people will seek to become coroners.

I. Pattern of work

The majority of coroners occupy the office on a part-time basis. They are, in the main, solicitors who perform their duties as coroner in time spared from the performance of their other professional duties. Because the post must be continuously manned there is an army of assistant and deputy coroners[15], who cover for the coroner during absences, eg on leave, and also when the part-time coroner's other professional responsibilities interfere with his duties as coroner.

II. Coroners Districts

In 1952 a Home Office circular[15] pointed out that more than half of the then coroners where holding fewer than 50 inquests a year. It went on to remind the local authorities that they held statutory powers to merge several existing districts[15] on the death or retirement of the coroner. The Local Government Act of 1972[13] replaced a number of the small coroners jurisdictions with large, county-based, jurisdictions.

It is important to note that certain geographical considerations, especially the population density, will be reflected in the number of cases reported to each coroner, and as far as possible this should be considered when the boundary is set for each post.

Currently coroners in England and Wales are appointed by local authorities. Very little merging of districts has occurred. A third of the coroners in England and Wales receive fewer than 500 cases a year, whereas 5% of coroners receive more than a third of the total number of cases in the country each year. Not surprisingly, the majority of these busy coroners are employed on a full-time basis.

Because of these anomalies we recommend that the number of existing coroners districts should be reduced, and that regional coroners offices should replace them. These should be planned geographically so that they can expect to deal with approximately 3,000 cases annually.

These large "districts" should be granted both the use of sufficient mortuary accommodation, and all the necessary scientific aids to investigation. This means that, ideally, the coroners office should be located near to a forensic science laboratory or research unit. This will also allow the coroner to utilise fully the teaching, research and statistical material which results from the coroners cases.

III. Training of Coroners

Each of the large regionally-based offices would be under the overall control of a single coroner, who would be both trained and experienced in law and medicine. The coroner would be supported by a number of assistant coroners who would act under his supervision. This organisation would allow a formal training process for coroners, and eventually obviate the necessity of appointing to the post of coroner those with no experience whatsoever in this field.

IV. Qualification for the post of Coroner

Until 1926 the only qualification needed for the post of coroner was the holding of a freeholding of land. Since 1926, however, it has been necessary for a coroner to be a duly qualified medical practitioner, solicitor or barrister of at least five years standing[15] before appointment.

The majority of coroners, currently, are solicitors who practise part-time. There are also a small number of full-time coroners, most of whom are qualified both in medicine and law.

The need for coroners to be medically qualified was first recognised by the Registrar-General in 1857[46], and a year later he added that coroners should also have taken a course in medical jurisprudence[47].

The requirement of a medical qualification is well recognised in other common law countries. In those parts of the United States where coroners have been replaced by medical examiners the medical qualification is a requirement of office, and a similar situation applies in many other countries.

The coroner must control the investigation of the death. He will have to discuss the medical aspects of the case with doctors who have been in attendance upon the deceased, and critically to examine the results of necropsy findings with pathologists and other clinicians, as well as deciding which further investigations to order.

These discussions, and these decisions, constitute much of the work of the coroner.

Because of the nature of the information with which he is presented the coroner has a unique role in epidemiology and preventative medicine. For example, in the field of therapeutics it may will be the coroner who is the first to recognise an association between the use of certain drugs and the death of patients. Unless the coroner's approach to each case is disciplined by a sound knowledge of medicine, and by clinical exerience, such opportunities will be lost.

Coroners should be encouraged both to keep abreast of the developments in medicine and law, and to maintain contact with the active practice of their professions. They should also be encouraged to participate in the teaching of medical and law students on the coroners system.

V. The Coroner's Duties

When the coroner is informed that there is a body lying within his district, which the notifier feels is within his jurisdiction, the coroner first decides whether the circumstances surrounding the death are such that he feels an investigation is warranted. That is, whether the case is, in fact, within his jurisdiction. If he decides that it is, then the next step is to institute a preliminary investigation into the case. This investigation is usually performed by the coroner's officer.

VI. The Coroner's Officer

The coroner's officer commonly is a police officer who has been

seconded to carry out certain preliminary investigations on behalf of the coroner. He will need to assess the evidence at the scene of death, preserve all necessary specimens, and also to exercise considerable tact in dealing with the bereaved.

Small coroner's districts, with limited case-loads, make it impracticable to appoint a full-time coroner's officer. Instead the work is undertaken by any officer who can, at the time the death is reported, be spared from what the police regard as more important, routine, police work. Occasionally the first officer to be called to the scene of the death will be appointed coroner's officer for that death.

The earlier recommendation of enlarging the coroners districts until they are likely to receive a considerable case load each year would also mean, if implemented, that a full-time coroner's officer would work to each office. They would be officers who had received training in police methods, but were seen to be both apolitical, and possibly outside the police system. Our recommendation is that the nature of their duties is such that they should be graded on the same level as an officer of the criminal investigation department.

VII. Brodrick

Brodrick[3] proposed that all part-time coroners should be given short-term contracts. We oppose this. We recommend that all coroners should be appointed, nominally by the Lord Chancellor's Office, or by the Secretary of State, upon such conditions as the Minister shall determine. The criterion for removing a coroner from office should be for misbehaviour or for incompetence.

EIGHT

THE CORONERS JURY

The Criminal Justice Act 1972[48], and later the Juries Act 1974[49], altered the laws concerning jurors in general. At the same time as this legislation was being drafted the Coroners Society tried to get the position of the coroners jury rationalised, but in fact confusion has worsened over the last twenty years.

Brodrick had recommended that the coroner jury be abolished. This recommendation was not acted on, although at the same time the jury for Fatal Accident Enquiries in Scotland was abolished.

When the above legislation was passed the coroners jury was omitted from the legislation - awaiting a convenient opportunity to abolish it altogether. This was attempted in 1977 in the Criminal Law Act[50], for all cases related to crime. It was acknowledged at the time that this Act could not alter the need for a jury in cases not under criminal law. But when the law was tested at the Court of Appeal in the case of Blair Peach the judgement implied that a jury can be required, at will, on the application of any person, or organisation, claiming to act for any person who is deemed to have a proper interest in the inquest.

The Coroners Juries Act 1983[51] did not resolve any of the uncertainty over the requirement for a jury, but merely amended the procedure for summoning one.

The Criminal Law Act 1977[50] required the coroner to adjourn cases of murder and manslaughter, and to refer the cases to the Director of Public Prosecution. The coroners power to commit for trial was abolished, and a jury was no longer needed in such cases.

The Coroners Rules Working Party amended the Coroners Rules in 1977[52] and again in 1980[35] to incorporate those recommendations of Brodrick which could be incorporated by Statutory Instrument. All these changes were than consolidated in the Coroners Rules 1984 which replaced the earlier rules.

Both the use of written evidence which is unlikely to be disputed, and the power to adjourn inquests where they might unreasonably influence later jury trials, were tremendous steps forward for the coroners system. Similarly the Coroners Act 1980[53] allowed the coroner to transfer the jurisdiction to another coroner without physically transferring the body, and indeed abolished the duty of the coroner to view the body.

These non-controversial reforms had been recommended 16 years earlier by the BMA and 9 years earlier by Brodrick.

NINE

THE CORONERS INQUEST

There has, over recent years, been increasing criticism of the inquest procedure. The majority of that criticism has come from lawyers whose training, in law, is in the adversarial trial procedure.

An inquest is *not* a trial. There are no "parties" to the proceedings. The family, professional witnesses and any other person whose conduct may be questioned - including insurers, employers and trade unions - may be legally represented.

In criminal trials, by contrast, the Crown proceeds, and the defendant is legally represented. In civil trials the whole of the case for both sides is put in the pleadings, and there is thus no element of surprise.

The judge in a criminal case has the power to protect the jury from threats and from intimidation. The coroner not only does not have this power, but many inquests are held outside a courtroom - for example in a town hall - and it may not be possible for the coroner to ensure that the jury is kept free from interference by pressure groups.

A Divisional Court may order the coroner to pay the costs of a successful appeal against the findings of an inquest.

The Legal Aid Act 1974[54] provided that legal aid should be available for persons who might be adversely affected by an inquest. Despite the demands of the Royal Commission, and the Working Party on Coroners Rules[35,55] , these recommendations remain unimplemented. It is, of course, worth noting that in some cases such representation might prove counter-productive; and might, in practice, encourage some pressure groups to prolong the inquest procedures at the expense of all the other, properly interested parties.

I. Advance Applications

When an application is made for judicial review in the High Court assertions may be made, and supported by affidavits, which are given considerable publicity before the Court hearing. This happened in the cases of Campbell[56] and of Helen Smith[57].

Even in cases which are less controversial than these, the coroner may have difficulty in dealing with certain assertions that are made in an application that is heard in advance of the inquest. The coroner cannot respond to the assertions until he has heard the evidence of the witnesses, and he cannot hear the evidence of the witnesses until the Divisional Court application has been determined.

The anomalies of the adversarial system arise again in the matter

of the representation of the coroner at these applications, and in the matter of costs. The coroner must look to his employing authority for support in paying for legal representation at the hearings. In some cases there may be a conflict of interests between the coroner and the local authority. This occurred in the Colin Roach[58] case, where the local authority wanted to hold the inquest in Hackney Town Hall, but the coroner wanted a proper court room with security for the jury. The coroner in this particular case was medically qualified, and his defence society assisted him. In the applications in respect of Helen Smith the coroner was a solicitor, and was given no assistance by his county council, who indeed publicly supported the applicant.

Where there are a number of applications before a Divisional Court they may not have either all the affidavits or all the judgements from previous applications unless the coroner is either there in person, or his legal representative is present. At the same time the Divisional Courts have stated that it is not the practice to make an order for costs against a coroner personally in determination of an application when the coroner is neither present nor represented. But unless the coroner is present to draw this to the attention of the court it will act upon the unopposed application from the applicant.

II. Court of Appeal Judgements

Two recent appeal court judgements have also had a significant impact on the work of the coroner.

In the case of Blair Peach[59] the Court of Appeal interpreted section 13 of the Coroners Amendment Act 1926 so that the word "circumstances" was extended to imply that a coroner was required to sit with a jury in any case where a situation might recur which could be avoided by action by some person, or body, in authority. Indeed this section is now drafted so widely that it applies to almost any situation at will.

This judgement makes no provision for the application of common sense in determining when it is appropriate for a jury to sit. Despite the fact that no more evidence is given in the presence of a jury there are increasing demands for the coroner to sit with a jury - for example on all cases of deaths in hospital.

In the case of Helen Smith[57] the majority decision of the Court of Appeal was that the coroner was obliged to hold an inquest on a body brought into the country from abroad for burial. All the surrounding legislation had been drafted on the assumption that no such obligation existed. There is therefore no provision for the registration of the death, for the summoning of witnesses, nor is there

any provision to financially assist families with difficulties in such cases.

It is essential following these cases that legislation be enacted to clarify those cases where the coroner must sit with a jury, and those which may be heard by the coroner alone. Similarly the position of the coroner in relation to bodies brought for burial from abroad needs further clarification.

III. Occasional Assistance for the Coroner

Judges have frequently acknowledged the difficulties they face in comparing the submissions put to them against the record of the original case. The coroner sits alone, and is required to listen to the case, to record the evidence of witnesses and to check the veracity of the witnesses' statements. In controversial inquests assistance is sorely needed. Here the assistant does not need to be senior, but to be "a spare pair of hands" to help record the details. In these difficult circumstances we feel that the coroner should be empowered to ask the Lord Chancellor to appoint an assistant coroner whenever the coroner feels a specific case merits such a provision.

TEN

NECROPSIES FOR THE CORONER

Currently necropsies performed for the coroner are divided into a "two-tier" system. In this the majority of "routine" necropsies - that is where there is no overt suspicion of a crime, but for example, where no doctor has attended the deceased in the 14 days before death - are performed by the consultant histopathologist at the local district general hospital. Only those necropsies where there is a particular suspicion of foul play, or a likelihood of extensive litigation, or indeed where for some other predictable reason the case is likely to require certian specialist knowledge, are invariably performed by specialist forensic pathologists.

Because all histopathologists are likely to perform coroners necropsies, and some of these "routine" cases may, in fact, turn out to be far from "routine", we recommend that all histopathologists in training should have some experience of forensic pathology. Those histopathologists who intend to specialise in this field will, of course, spend far more of their training in this specialised field.

The Brodrick Committee[3] considered the parlous state of academic departments of forensic pathology in the UK. In the 16 years since then nothing has been done to improve the situation. Since that committee's report the Wasserman Working Party[60] has been set up to investigate this area. Until they report nothing is being done to improve the situation.

Brodrick recommended that forensic pathology services should become part of the NHS. We are opposed to this for several reasons. The first is that the forensic pathology service primarily produces information for the police services. It does indeed offer some training for general pathologists but this is a minor part of its function. At the same time the NHS resources are increasingly stretched, and it would be wrong to further burden the service with a specialty which offers very little to the prevention and treatment of disease.

When the coroners necropsy is performed in NHS hospitals, and especially when a full forensic pathology service is provided for the police from a university department of forensic medicine, the police service is being heavily subsidised from limited University or NHS funding. Therefore we strongly support the Brodrick recommendation that all the University-based services should immediately receive adequate funding from the Home Office to support their activities.

The current system of "Home Office Appointed Pathologists", who work on a regional basis, is essential to the proper running of

the service. At the same time the remuneration of these pathologists has been unreasonably low for many years. Considerable pressure from, and negotiation by, the British Medical Association over the last few years has improved the situation to some extent, but the rewards are still very poor for an onerous, and frequently unpleasant occupation.

In some areas, especially those which are geographically remote, it is not always possible for a "Home Office" pathologist to be involved in a case. In these circumstances we recommend that pathologists from academic units, university departments and hospital consultant staff with appropriate motivation and experience, preferably after a period of training in a forensic pathology department and perhaps such extra qualifications as the Diploma in Medical Jurisprudence, should be recruited in to the system.

At the same time we are aware that the decline in the state of academic forensic medicine has meant that the quality and quantity of teaching to undergraduates of the legal aspects of medical practice has at best deteriorated, and at worse ground to a complete halt. This has had a parlous effect on the standard of death certification, and will worsen, until the funding for the academic departments is established on a firm footing, allowing the delivery not only of a comprehensive forensic medicine service but also the establishment of teaching for undergraduates, and of postgraduate training courses.

ELEVEN

THE CORONER AND THE GENERAL PRACTITIONER

The Coroners Rules have, since 1953, required the coroner to inform the patient's general practitioner of both the place and time of the necropsy "unless it is impracticable .... or to do so would cause the examination to be unduly delayed"[21&20].

This rule, which is rarely followed, was introduced so that the practitioner would have every opportunity of clearing himself of a charge of malpractice. Although this is an important reason, in the view of the Association it is essential to have the general practitioner present, whenever possible, so that he can consult with the pathologist performing the necropsy on the many points which may arise during that procedure and which help him in his immediate dealings with the bereaved family.

We recommend, therefore, that, where the identity of the deceased's general medical practitioner is known, every effort should be made to inform him of the place and time of the necropsy, and the GP should be encouraged to attend and to consult with the pathologist during the performance of the necropsy.

Although the present agreement between the BMA and the Coroners Society[61] provides that the GP can obtain a copy of the necropsy report upon payment of the statutory fee, or by arrangement with the pathologist, the BMA considers that the GP should receive a copy free of charge and without payment in every case.

TWELVE

DISPOSAL OF THE DEAD

I. Certificate of Disposal

This certificate allows the disposal of the body by earth burial. This has long been the traditional form of disposal of the dead in the country, and as far as the detection of homicide is concerned , and bearing in mind the concerns expressed in the section of interference with the dead, remains the form of disposal most likely to allow a satisfactory later examination of the body, should this be required.

At the same time it must be remembered that the issuing of a certificate of disposal indicates that the death has been satisfactorily registered and that there is, at that time, no evidence to suppose that a further examination of the body may be needed.

Further examinations are rare, but sometimes occur where there is a dispute arising from claims by relatives to pension or insurance rights. Similarly, although rarely, a death which has been certified and registered with no suspicion attaching to it, may later arouse suspicions of foul play.

Certain methods of disposal of the dead - especially cremation and burial at sea - render later examination either useless or impossible, and it is therefore essential to restrict the access to these methods.

II. Cremation

With the possible exception of radioactivity and the detection of certain metallic poisons such as thallium, cremation destroys all evidence of the cause of death. Because of the finality of this method of disposal in destroying any possibility of further investigation of the cause of death, the disposal must only be authorised with great care.

When the Cremation Acts were devised cremation was thought of as an eccentric method of disposing of the dead. But in 1982[62], 66.5% of deaths were disposed of in this way, the earth burial is fast becoming the "eccentric" method of disposal.

Appendix A to this document is a copy of the information sheet produced by the British Medical Association in 1985 to explain some of the recent changes in the certification of the dead for disposal by cremation.

Over a number of years, as this form of disposal has become more popular, there has been considerable pressure from funeral directors and from the public via Parliament, to reduce the cost of the certification procedure to the public, and to generally simplify the procedure.

Brodrick recommended that the cremation certification should

be abolished, and that the single death certificate should be sufficient for all methods of disposal. Again the evidence upon which the Brodrick report claimed that the previous edition of this BMA report[1] was being "unduly alarmist" in warning on the dangers of relaxing the procedures for certification for cremation, was never published. The Brodrick Report's recommendation inspired a number of further reviews of this area, and Horner[63], Cameron and McGoogan[29], and Joint Report of the Royal Colleges of Physicians and Pathologists[30] have all asserted that Brodrick was over-complacent.

The confirmatory certificate in form "C" has always been regarded as a further safeguard requiring a second, and independent, professonal to examine the body. The Strutt Inter-Departmental Committee[24] which reported in 1950 examined the need for this confirmatory certificate and recommended that it be retained. We agreed with that recommendation then, and have seen no evidence to alter that opinion.

From 1985 confirmatory certificate "C" is no longer required where a necropsy has been performed[64]. The results of that necropsy will lead to the recording of accurate information on the cause of death, reducing, according to the Home Office, the need for a second and independent professional's opinion.

When the coroner has been notified of the death the cremation is authorised by coroners certificate "E", usually issued subsequent to necropsy. The crematorium referee also has the option of ordering a necropsy - and then authorisation for the cremation is via form "D"[65].

III. Removal of the body out of England and Wales

Removal of the body will also prevent the further investigation of the death. There are however existing safeguards - namely the requirement for the coroner to be informed of the intention to remove the body at least four days before the removal is effected[66]. These safeguards are sufficient. This applies to removal to parts of the United Kingdom other then England and Wales (eg Scotland and Northern Ireland) as well as to removal of the body out of the United Kingdom.

IV. Death on Board Ship

When a death occurs on board ship the body can be disposed of by burial at sea with this being considered part of the "normal working" of that ship.

V. Burial at Sea

Where a person dies in the UK, and is to be buried at sea, there are few statutory requirements to govern the procedure. A certificate of disposal is required, and under the Dumping at Sea Act[67] the Ministry of Agriculture Fisheries and Food must be informed.

Disposal outside the three-mile limit might come within the Removal of Bodies Regulations[66], but the position here is uncertain.

Because of the finality of this method of disposal in concealing the evidence of any crime we recommend, in keeping with the other final and destructive method of cremation, that disposal of the body should be the subject of authorisation by the coroner who must be given adequate notice of intent by the person intending to dispose of the body.

SUMMARY OF RECOMMENDATIONS

(1) There should be a clear definition as to what constitutes attendance on a patient for the purposes of death certification. (Section Three, I.)
(2) Inspection of the body by the certifying doctor should become mandatory. (Section Three, II.)
(3) Where the attending doctor has seen the patient within 7 days before death, the certificate may be given by a partner or member of the same group practice, subject to certain safeguards. Conversely where the patient has been seen in hospital within the same period, but not by the general practitioner, the latter may give a certificate after contacting the hospital doctor concerned with the case. (Section Three, III.)
(4) There should be no obligation to issue a death certificate when the doctor is required to notify the coroner, removing the uncertainties which currently exist. (Section Three, IV & V.)
(5) There should be a statutory requirement for doctors to notify the coroner of certain categories of deaths. (Section Three, VII, Section Four,I)
(6) All deaths of foster children and those who are the subject of care orders should be reported to the coroner. (Section Four, I.)
(7) The qualified informant should have an obligation to inform the coroner's officer, or a police officer, within two working days of the death if he has been unable to obtain a death certificate. (Section Four, III.)
(8) Any person who has a professional involvement with the disposal of the dead, such as nurses, embalmers, and funeral directors, should have a statutory obligation to inform both the coroner and the medical attendant if they notice anything suspicious about the body. (Section Four, III.)
(9) Any interference with the body other than normal laying-out procedures, removal of the body from the place of death or removal of parts of the body under the Human Tissue Act 1961, must await the issuing of the disposal certificate. (Section Five.)
(10) Deaths of British subjects which occur overseas should be the subject of enquiries by the relevant consular department on behalf of the Foreign and Commonwealth Office. Such enquiries should not be affected by the removal of the body to any other place, including all parts of England and Wales. (Section Four, III(3).)
(11) Any stillbirth at which neither a doctor nor a midwife was present should be reported to the coroner. (Section Six.)
(12) The disposal of the bodies of stillborn infants should be recorded in the same manner as that of other bodies. (Section Six.)

(13) The terms of service of coroners should be improved to attract the most able people to these posts. (Section Seven.)
(14) The existing multiple small coroners districts should be replaced with larger regional offices, each of which should have adequate mortuary accommodation and the necessary aids to scientific investigation.(Section Seven, II.)
(15) A system of training for coroners should be established, based on the new regional offices, with each coroner training a number of assistants. (Section Seven, III.)
(16) The regional offices should each be controlled by a coroner who is qualified in both medicine and law. The coroner should be encouraged to maintain his professional knowledge and expertise, and to impart it to others by participation in the teaching of medical and law students. (Section Seven, IV.)
(17) Each coroner should have an attached coroner's officer of equivalent seniority to an officer of the criminal investigation department. (Section Seven, VI.)
(18) The power of appointment for coroners should be nominally vested in the Office of Lord Chancellor or by the Secretary of State upon such conditions as the Minister shall determine and no coroner should be removed from office except by reason of inability or misbehaviour. (Section Seven, VII.)
(19) The appointment of both coroner and coroner's officer should be seen to be apolitical (Section Seven, VII.)
(20) Legislation should be enacted to clarify those cases where a coroner must sit with a jury. (Section Eight.)
(21) Where a coroner has any reason to believe that the inquest can be best achieved by the appointment of an assistant coroner to aid him, or by the appointment of another lawyer to similarly aid him, the Lord Chancellor should be empowered to make that temporary appointment. (Section Nine, III.)
(22) Coroners necropsies should be performed by histopathologists or forensic pathologists only. The remaining power for the coroner to direct any medical practioner to perform a coroner's necropsy should be abolished. (Section Ten.)
(23) Where there is a suspicion of criminal or litiginous death the necropsy should be performed by a forensic pathologist or by a histopathologist with training and experience in this field. (Section Ten.)
(24) The NHS should not be expected to fund coroner's necropsies. (Section Ten.)
(25) Because the forensic medicine service is of direct benefit to

the police, and because of the need to train further pathologists in this field, central government money should by used to support training in all university departments of forensic medicine. Such departments would also offer a necropsy service to the police. (Section Ten.)

(26) The remuneration of the "Home Office" pathologists should be reviewed, with the intention of rewarding the specialists suitably for an onerous and often unpleasant occupation. (Section Ten.)

(27) Consideration must be given to means of improving the provision of under and postgraduate teaching in the legal aspects of medical practice, not least in an attempt to improve the accuracy of death certification. (Section Three, VIII, and Section Ten.)

(28) The deceased's general medical practitioner should always be informed of the time and place of a coroner's necropsy, and should be encouraged to attend whenever possible. (Section Eleven.)

(29) Unless there is a reason why it is inadvisable in that particular case the general practitioner should be sent a copy of the necropsy report. (Section Eleven.)

(30) The cremation certification procedure should be retained. (Section Twelve, II.)

(31) Methods of disposal, other than cremation or earth burial in a registered place, should be subject to authorisation by the coroner, who must be given adequate notice by the person intending to dispose of the body. (Section Twelve, III, IV & V.)

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BMA GUIDANCE ON CREMATION CERTIFICATION IN HOSPITALS (England & Wales)

PART I: INTRODUCTION

1. Changes to the regulations governing cremation certification were introduced earlier this year: "The Cremation (Amendment) Regulations* 1985". They relate to the need for a confirmatory certificate (Form C) where death has occurred in hospital and a post-mortem has been carried out.

2. The Association's Forensic Medicine Sub-committee have considered the new regulations and have prepared these notes of guidance for members.

3. The notes give the background to cremation certification and the BMA's advice on the administration of the new regulations. It is intended to include them as an appendix to an up-dated version of "Deaths in the Community", which is scheduled for publication in 1986. "Deaths in the Community" was first published by the Association in 1964 in response to increasing concern in the medical profession about the laws relating to the disposal of the dead.

PART II: BACKGROUND TO THE NEW REGULATIONS

Certification of Death

4. Death registration and the certification procedure which accompanies it, were introduced for the purposes of providing epidemiological information and for this reason the Office of Population Censuses and Surveys (OPCS) is responsible for this administration.

5. The OPCS compiles mortality and morbidity statistics important in preventive medicine. For many years OPCS relied exclusively on information contained in the certificate of causes of death, despite the existence of more accurate information elsewhere.

6. Legislation affecting coroners and disposal of dead bodies by cremation, was introduced for the purposes of detecting crime. Cremation destroys almost all forensic evidence. It is difficult to assess the frequency with which this aids the concealment of homicide and the responsible government department is the Home Office.

Cremation Certification

7. Cremation is controlled by the Cremation Acts of 1902 and 1952 and by regulations (as amended) made under the 1902 Act.

8. The Regulations were substantially redrafted in 1930** to bring

S.I. 1985 No. 153

**Statutory Rules and Orders 1930 No. 1016

them into line with revised Coroners legislation. The changes in 1952 were introduced following the report from the Inter-departmental Committee on Cremation (Strutt Report). Further amendments followed in 1965 and 1979. The most recent amending regulations came into effect in April 1985.

9. These amended Cremation Regulations prescribe the minimum content of all cremation certificates. There are now eight forms as follows:

Form A - Application for Cremation

Either a near relative or the excutor completes Form A, giving details concerning the deceased. Anyone else must explain why they, and not the afore-mentioned, are making the application. Most commonly a representative of the Local Authority or the Health Authority makes the application in these exceptional cases.

Form B - Certificate of Medical Attendant

The doctor in attendance on the deceased during the last illness completes this form. This is normally the doctor who gave the medical certificate of cause of death.

Form C - Confirmatory Medical Certificate

This certificate, the purpose of which is to confirm the information given in Form B, may be issued by a medical practitioner who has been fully registered for at least five years with the General Medical Council, and who is neither a relative or partner or the practitioner who has issued Form B (Regulation 9).

Home Office advice also precludes two doctors on the same hospital firm completing Forms B and C. When a pathologist has performed a routine post-mortem he or she usually completed Form C.

Under the new (1985) regulations this form is not required in certain circumstances (see para 20 below).

Form D - Certificate after Post-Mortem Examination

This certificate is used after a post-mortem examination has been ordered by the medical referee. Either the referee or the doctor who carried out the post-mortem certifies the cause of death and confirms that there is no reason for making any toxicological analysis or for holding an inquest.

Form E - Coroner's Certificate

This certificate may only be supplied by the coroner either after he has opened an inquest or following post-mortem examination without inquest. The coroner must be satisfied that further examination of the remains will be unnecessary.

Form F - Authority to Cremate

This may be issued only by the medical referee (or deputy) apointed by the Home Secretary on the nomination of the Cremation