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DEATHS in the COMMUNITY

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LONDON
BRITISH MEDICAL ASSOCIATION
TAVISTOCK SQUARE, W.C.1
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MEDICO-LEGAL INVESTIGATION OF DEATHS IN THE COMMUNITY

A report prepared by the
Private Practice Committee of the
British Medical Association

LONDON
BRITISH MEDICAL ASSOCIATION
TAVISTOCK SQUARE, W.C.1

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INTRODUCTION

1. Medico-legal investigation of deaths in the community became possible in this country only after 1836. Before that year there was no registration of deaths and no provision whereby the coroner could pay for necropsies to be performed. The returns under registration of burials had left almost one-third of the total deaths in England and Wales unaccounted for,[1] and the Bills of Mortality had depended upon the returns of the two old women "searchers" who were appointed in each parish to view dead bodies.[2] Their inflated returns of deaths from epidemic diseases such as cholera led to unnecessary states of panic in the population and provided one of the main reasons for the introduction of death registration in 1836.[3] A few years later the Registrar-General sent out books of death certificates to 10,000 doctors licensed to practise by the Royal Colleges and the Society of Apothecaries, and he invited them to certify the cause of death of patients they had been attending before death.[4] An unexpected result of the introduction of death certification and registration was a substantial increase in the number of deaths reported to the coroners.[5] However, the coroners, who were remunerated on the basis of the number of inquests they held, were actively prevented from holding their inquests by the justices in Quarter Sessions, whose authorization was necessary before the fees and expenses incurred in the holding of inquests could be recovered.[6] The justices took the view that no inquest should be held unless there was manifest evidence of felonious violence.[7] The legislation of 1836 was therefore relatively ineffective until 1860, when the remuneration of county coroners was placed on a salaried basis.[8] Meanwhile a public scandal had developed as a result of the failure to check widespread outbreaks of poisonings, in particular infanticide, and which had been due largely to obstruction of the coroners by the justices in Quarter

[1] Registrar-General, 1st Ann. Rep.; 1839 (187) xvi, 1 at p. 13.
[2] *Parochial Registration*, Sel. Cttee. Rep.; 1833 (669) xiv, 505 at p. 6.
[3] *Births and Deaths Registration Act*, 1836.
[4] Registrar-General, 4th Ann. Rep.; 1842 (423) xix, 440, Appendix, p. 51.
[5] Havard, J. D. J., *Detection of Secret Homicide*, 1960, p. 48. London.
[6] 25 Geo. II, c. 29 (1751) s. 3.
[7] Havard, J. D. J., *Op cit.*, 1960, pp. 38 ff.
[8] *County Coroners Act*, 1860.

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Sessions. Finally, in 1888, the coroners became completely independent of the justices when the administrative work of Quarter Sessions was transferred to the newly constituted local authorities.[1]

2. A few years previously, in 1874, it was made obligatory for any registered medical practitioner who had attended a deceased person before death to complete a certificate stating to the best of his knowledge and belief the cause of death.[2] But it still remained possible for a death to be registered without a certificate of death from natural causes having been given by a doctor who had been in attendance upon the deceased person before death, and it was not until 1926 that the principle finally became established that a death could not be registered without reference to the coroner unless such a certificate had been given.[3] The authority of the coroner to investigate all sudden deaths of unexplained cause, as well as violent or unnatural deaths, was confirmed in 1887,[4] but it was not until 1926 that he was able to dispense with an inquest in cases of sudden death where a necropsy showed that the death had not been violent or unnatural.[5] Until 1888 coroners, with certain exceptions, were elected by popular vote. In that year the election of coroners was abolished and was replaced with appointment by local authorities.[6] However, there remained no qualifications for office apart from the medieval requirement of an unspecified holding of freehold in land, and which occasionally had been satisfied by the purchase of a grave plot in the local cemetery.[7] In 1926 this obsolete condition was abolished and was replaced by the requirement that the candidate must be a duly qualified medical practitioner, solicitor, or barrister of at least five years' standing in his profession.[8] In the same year fees for necropsies and for attendance at inquests by medical practitioners were laid down by statute,[9] having previously been dependent upon scales drawn up by individual local authorities. In 1954 the Home Secretary was empowered to prescribe these fees by regulation.[10]

[1] *Local Government Act*, 1888, s. 3.
[2] *Births and Deaths Registration Act*, 1874, s. 20 (2).
[3] *Births and Deaths Registration Act*, 1926, s. 1.
[4] *Coroners Act*, 1887, s. 3 (1).
[5] *Coroners (Amendment) Act*, 1926, s. 21 (1).
[6] *Local Government Act*, 1888, s. 5.
[7] *Coroners*, Dept. Cttee. Rep.; 1910 (Cd. 5004) xxi, 561 at p. 3.
[8] *Coroners (Amendment) Act*, 1926, s. 1 (1).
[9] *Coroners (Amendment) Act*, 1926, s. 23.
[10] *Coroners Act*, 1954, s. 1.

CORONERS' JURISDICTION

Present Position

3. Since 1887 the coroner's jurisdiction has depended upon his receiving information which leads him to believe that a death is violent or unnatural, or a sudden death, the cause of which is unknown, or that the death comes within certain special statutory requirements (e.g., deaths in prisons).[1] The precise scope of the terms "sudden," "violent," and "unnatural" is uncertain, and has given rise to difficulties in deciding whether particular cases ought to be reported to the coroner.

Sudden Death

4. This has generally been held to mean "unexpected" death. A person may die "suddenly" without exhibiting any of the prolonged processes which are conventionally associated with dying, and yet the death need not attract medico-legal investigation. A person under treatment for coronary insufficiency may die "suddenly" from coronary thrombosis, but his death may not have been "unexpected." In the medieval period, when the coroner's jurisdiction was established, the state of medical knowledge and the available medical services were such that any sudden death was regarded as unexpected. Under modern conditions a distinction must be made and the word "sudden" should be replaced by "unexpected."

Violent Death

5. Here again all "violent" deaths attracted the coroner's notice in the medieval period, but under modern conditions they need not necessarily do so. Deaths associated with certain types of operative procedure are technically violent deaths yet need not necessarily attract medico-legal investigation. An example is the dramatic surgical intervention in advanced cases of cancer or where gross abnormalities are present, e.g., congenital heart defects, conjoined ("Siamese") twins, etc. Certain types of birth injury leading to neonatal death, e.g., tentorial tear, provide other examples. In some cases, of course, intervention by the coroner may satisfy the relatives that independent inquiries have been made.

Unnatural Death

6. Under modern conditions this is the most confusing term of all in establishing the coroner's jurisdiction. In the medieval period

[1] *Coroners Act*, 1887, s. 3 (1).

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the coroner's jurisdiction depended solely on the sudden nature of the death, and the inquest finding stated whether or not the death was " natural." A natural death was any death which was not caused by violence and the terms violent death and unnatural death were synonymous.[1] Hence deaths of prisoners from starvation and privation were recorded as " natural " deaths. No provision was made for the welfare of prisoners, and consequently death from starvation or privation was regarded as a natural sequel. But by the seventeenth century a change had occurred and prison deaths of this kind were no longer regarded as natural. As recently as 1933 the Court of Criminal Appeal[2] decided that the death of a child from pneumonia was not unnatural in circumstances where the child, although suffering from whooping-cough, had been taken from lodging-house to lodging-house, and had been denied medical attention by its parents who later concealed its body in a hedgerow. It seems likely that such a death would not be regarded as " natural " to-day, but the consequences of the child's treatment would have been far less apparent in 1933, when pneumonia was still the common killer and neither chemotherapy nor antibiotics were available for its treatment. It follows that in the historical sense " unnatural " death is a dynamic term which is determined by current trends and the attitude of the community. In these circumstances its inclusion in a statute is undesirable and it should be replaced by a more specific indication of the circumstances in which the coroner has jurisdiction. This will become all the more essential if a recommendation made later in the report is accepted concerning a statutory duty to notify the coroner of such deaths.

METHODS OF NOTIFICATION OF DEATHS TO THE CORONER

Notification through Death Certification and Registration Procedure

7. The report of the Departmental Committee on Coroners of 1936 stated that the machinery for the registration of deaths provides the most regular means of bringing cases to the notice of the coroner.[3] It is an offence to dispose of a body, by any means, without a registrar's certificate for disposal or a coroner's order,[4] and in this section we shall consider the procedure leading up to the issue of a registrar's certificate of disposal.

[1] Havard, J. D. J., *Op. cit.*, 1960, pp. 39–42.
[2] R. *v.* Purcy, *Criminal Appeal Reports*, 1933, **24**, 70.
[3] *Coroners*, Dept. Cttee. Rep.; 1936 (Cmd. 5070) viii, 1 at para. 29.
[4] *Births and Deaths Registration Act*, 1926, s. 1.

Necessary Period of Attendance

8. A registered medical practitioner who has been in attendance upon a deceased person during his last illness is required to issue a certificate stating " to the best of his knowledge and belief the cause of death " and " to deliver that certificate forthwith to the registrar."[1] Since the issue of a certificate of death from " natural causes " assures an uncomplicated passage through the registration formalities to the issue of a certificate of disposal, it is important to study the requirements which are necessary before such a certificate can be given. Unfortunately, the position is confused. In the first place it is nowhere laid down what constitutes " attended during his last illness." From the point of view of ensuring that deaths requiring medico-legal investigation do not escape notice it is essential that a death certificate should be founded on adequate knowledge of the case. In 1893 the Select Committee on Death Certification recommended that the requirement should be at least two attendances on the deceased, one of which must have been given within eight days before death,[2] and various attempts have been made to enforce this in subsequent legislation.[3] A " last illness " can last a very long time, and it seems that death certificates can be accepted without reference to the coroner in circumstances where the doctor has not seen the deceased person for several weeks. Many things may happen in the meantime without the knowledge of the certifying doctor, and the absence of any statutory definition of attendance during the last illness constitutes a serious loophole in our system of medico-legal investigation. The only safeguard is the duty of the local registrar to notify the coroner where it appears from the death certificate that the certifying doctor has neither attended the deceased within 14 days before death, nor seen the body after death.[4] But if the doctor *has* seen the body after death, the 14-day rule does not apply and the coroner need not be informed. In our opinion a death certificate should not be given without reference to the coroner unless the certifying doctor, or his partner or deputy, has seen the deceased person within a period of 14 days before death.

View after Death

9. The certifying doctor does not certify the *fact* of death, but the cause of death, and that only " to the best of his knowledge

[1] *Births and Deaths Registration Act*, 1953, s. 22 (1)
[2] *Death Certification*, Sel. Cttee. Rep; 1893–94 (492) xi, 195 at p. xvii.
[3] See e.g., *Deaths Registration and Burials Bill*, 1923 (129) i, 591, s. 3 (2).
[4] *Registration (Births, etc.) Consolidated Regulations*, 1954, S.I. No. 1596, Reg. 82 (i) (c).

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and belief." Accordingly, not only is he not required to examine the body but he need not even see the body after death. In other words the death certificate may be given on the basis of information supplied to him by another person. In these circumstances it is not surprising that the issue of a death certificate from "natural causes" is a fairly common finding in cases which are afterwards found to have been cases of homicide—e.g., on exhumation. There are even a number of cases on record in which the wrong person has been certified dead, because the doctor has received incorrect information, or in which persons certified as dead are later found to be alive, having procured a death certificate in order to disappear conveniently or to defraud insurance companies.[1]

10. According to the Registrar-General[2] 25.5% of death certificates indicate that the certifying doctor did not see the deceased person after death. This means that more than 100,000 persons were certified dead each year without being seen after death by the certifying doctor. It seems likely, however, that in some of these cases the body may be seen after death by a doctor, as when a decision is later made to have the body cremated. The accompanying table suggests that the recent increase in the

TABLE I[2]

(1) Year	(2) Total No. of Deaths	(3) Percentage Seen After Death	(4) Percentage Reported to Coroners	(5) Percentage of (4) Certified by Practitioners
1928	460,389	51·0	11·2	38·8
1933	496,465	53·7	11·2	42·5
1947	517,615	60·9	14·0	46·9
1950	510,301	66·8	19·0	47·8
1954	501,896	71·5	20·1	51·4
1959	527,651	74·5	21·4	53·1

proportion of bodies seen after death by certifying doctors may be associated with an increase in the number of cases reported to the coroner.

11. Since it became obligatory for doctors to give death certificates in 1874 there has been considerable agitation to make a view of the body after death a compulsory requirement, and

[1] Havard, J. D. J., *Op cit.*, 1960, pp. 98 ff.
[2] Registrar-General (1961) *Statistical Review of England and Wales for the Year* 1959, Part III (Commentary), p. 206, Table CXXIV.

this has been the subject of recommendations by nearly every governmental committee which has considered the matter. Attempts to introduce a compulsory view into legislation have generally been frustrated, possibly because the most active and vociferous group in favour of the requirement has been the Society for the Prevention of Premature Burial. The real need for a view of the body after death is to increase the accuracy of death certification, and not to counter the unlikely possibility of someone being buried alive. We consider that an examination of the body should always be carried out by the certifying doctor before a death certificate is given. The only possible objection to this requirement is in cases where patients live in relatively inaccessible places. When the Select Committee on Death Certification of 1893 recommended a compulsory view after death it grudgingly admitted that there might be cases of exceptional difficulty.[1] At that time horse-drawn traffic over indifferent roads was the rule. We consider there can be no objection to the requirement in England under present-day conditions of transport.

Cause of Death

12. The introduction to books of death certificates which are issued to doctors by the Registrar-General directs them to remember "that the international classification of causes of death is based, not upon terminal clinical states, but upon the antecedent and underlying pathological causes. . . ." On the bottom of each certificate form is printed the words "This (e.g., the cause of death) does not mean the mode of dying. . . ." The distinction made provides a good example of how the procedure adopted for providing statistics of mortality does not meet the needs of medico-legal investigation of death in the modern community. As a simple illustration the case may be taken of a person who has been attended for many years by her doctor for chronic bronchitis or for some other long-standing but potentially fatal disease. The doctor is informed of the patient's death and, without viewing her body, he gives a death certificate from chronic bronchitis. For all he knows the patient may have died from having a pillow held over her face until she suffocated. In this respect, it should be remembered that the proportion of deaths from violence amongst persons suffering from chronic disease has been shown to be greater than amongst the general population.[2] We recommend that the certifying doctor should be required to give information on the

[1] *Death Certification*, Sel. Cttee. Rep.; 1893–94 (492) xi, 195 at p. xiii.
[2] Turkel, H. W., *J. Amer. med. Ass.*, 1955, **158**, 1487.

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certificate concerning the terminal clinical state in addition to the antecedent and underlying pathological cause of death.

Notification of Coroner by Certifying Doctor

13. The normal practice of a certifying doctor upon becoming aware that the death is within the coroner's jurisdiction is to notify the coroner immediately. However, there is no statutory duty on him to do so, and there may be ethical reasons why he would prefer that the death is notified through the registrar upon receipt of the death certificate. There are several reasons why this is an unsatisfactory state of affairs. In the first place delay is inevitable as the normal process of "delivering" a death certificate is by post. In the second place the onus is placed on the registrar of checking from the certificate whether or not the cause of death is one which ought to be notified to the coroner. Although local registrars are provided with a list of certifiable causes of death, and with advice on the procedure to be followed in notifying the coroner under the Regulations, they are not qualified to act as final arbiters on the basis of the contents of a doctor's certificate. Finally, if, as frequently happens, the doctor hands the certificate to the qualified informant instead of posting it or handing it personally to the registrar, it may be some time before the registrar receives the certificate and notifies the coroner, as the qualified informant is allowed five days within which to register the death. Insufficient attention has been paid to the need to inform the coroner immediately it becomes apparent that a death has occurred which is within his jurisdiction. Failure to do so may seriously compromise the necropsy evidence, and the present method whereby the law relies on the machinery of death registration to ensure notification of deaths to the coroner cannot be regarded as satisfactory. We consider that a statutory duty should be placed on doctors to notify the coroner or his officer immediately they become aware that a death has occurred which ought to be investigated by the coroner.

Notification resulting from Registration Formalities

14. The duty of the local registrar to decide whether or not a death should be reported on the basis of the contents of the death certificate has already been discussed. In addition he is able to question the qualified informant in order to obtain the information necessary to register the death. Sometimes he may elicit information at this stage which indicates that the death should be reported to the coroner, even though a certificate of death from natural causes has been given.

Where a Death Certificate has not been Issued

15. This usually occurs because death has occurred in circumstances where no doctor has been "in attendance during the deceased person's last illness," or, less commonly, where the doctor who has been in attendance is unable to state the cause of death to the best of his knowledge and belief. With regard to the latter point the legal position is confused. A Home Office circular issued in 1927, which has since been withdrawn, but not replaced, advised that in such circumstances the doctor should not issue a certificate. This advice is perpetuated in the introduction to books of certificates of death which are issued to doctors. There are cases on record of doctors who have attended deceased persons being convicted under the Births and Deaths Registration Acts for not having given a certificate, and the defence that the doctor had suspicions concerning the circumstances surrounding the death has not been accepted by the courts as an excuse for not having given a certificate. A doctor who has been in attendance upon a deceased person and who can state the cause of death must give a death certificate, even if the cause of death is "cut throat." However, if he is unable to state the cause of death to the best of his knowledge and belief we consider that he is not required to give a certificate. This point is likely to arise only occasionally as there must be very few cases where a doctor has been in attendance upon a person during his last illness yet has no idea whatsoever as to its nature. Since the registrar is bound to notify the coroner if no death certificate is received[1] we consider that in such a case the doctor should be required to notify the coroner directly. This should also apply to any doctor who is called to a death and who has reason to believe that no other doctor has been in attendance on the deceased person during the last illness.

DUTY OF OTHER PERSONS TO NOTIFY THE CORONER

General

16. The doctor who has completed a death certificate is required to hand to the "qualified informant" a notice that he has done so.[2] This notice is in the form of a printed outer detachable part of the death certificate. As an additional safeguard we recommend that the qualified informant should be required, unless there is a reasonable excuse, to notify the coroner, coroner's officer, or police

[1] *Registration (Births, etc.) Consolidated Regulations*, 1954, S.I. No. 1596 Reg. 82 (i) (b).
[2] *Births and Deaths Registration Act*, 1953, s. 22 (2).

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immediately if he has been unable to obtain such a notice within 48 hours of death having taken place. Under the present law he is allowed 5 days within which to register the death[1] and it may be all of this time before the registrar becomes aware that no death certificate has been given and the coroner can be informed. Although statutes in some other countries have made it obligatory for all persons to notify the coroner or corresponding official of deaths coming within his jurisdiction, it is clearly impractical to expect the man in the street to possess the necessary knowledge to decide whether or not the coroner should be informed, and such a duty should not be imposed other than in general terms, e.g., suspicion of violence.

17. The heads of certain institutions—e.g., prisons, homes for inebriates, etc.—are at present required to notify the coroner of all deaths in such institutions. We consider this to be important in ensuring that such deaths have not resulted from neglect or other causes which ought to be investigated, bearing in mind that the inmates are generally deprived of some part of their civil rights. We deplore the recent abolition of this duty in connexion with foster children, particularly as the abolition was justified by the supposed existence of a common law duty of the community to notify the coroner of deaths coming within his jurisdiction.[2] Several centuries have passed since this duty fell into desuetude and it is no longer enforceable.

Persons with Special Knowledge

18. Certain persons may, by reason of their professional training and their opportunity to examine the body, be placed in an exceptionally favourable position to ascertain whether or not the death should be notified to the coroner. The professional nurses who may have attended the deceased person before death may often be in a better position than the medical practitioner to suspect the presence of foul play. In "laying out the body," a task which is rarely undertaken by the certifying doctor, they may also notice some previously unsuspected feature indicating that the case ought to be reported to the coroner. The undertaker will generally carry out a superficial examination of the body surfaces in preparing the body for disposal, and he may notice some feature which had escaped the notice of the certifying doctor. Under the present law any undertaker who notices suspicious features is

[1] *Births and Deaths Registration Act*, 1953, s. 16.
[2] *Parliamentary Debates* (*House of Lords*), **208**, col. 656.

unlikely to notify the coroner if he knows that a certificate of death from natural causes has been given by the attending doctor, but the doctor may not even have seen the body after death. Similar considerations apply to embalmers. We consider that a statutory duty should be placed on such persons to notify both the certifying doctor and the coroner where circumstances lead them to believe that a death may be within the jurisdiction of the coroner.

INTERFERENCE WITH THE BODY BEFORE THE CERTIFICATE OF DISPOSAL IS ISSUED

19. It is essential that the body should not be interfered with unnecessarily, otherwise, in the event of the death being reported to the coroner, necropsy evidence may be seriously compromised. Accordingly, interference with a body, other than (i) its reasonable removal from the place of death, or (ii) the removal of parts of the body under the provisions of the Human Tissues Act, should not be permitted until after the certificate for disposal has been issued.

Laying Out

20. We consider that many of the conventional procedures such as the stuffing of body orifices with cotton-wool must be delayed until after the certificate of disposal has been issued.

Embalming

21. Two kinds of embalming appear to be practised in this country. Firstly, a temporary process aimed at delaying the onset of putrefactive changes to cover the period the body is lying in a Chapel of Rest. For this purpose it is unusual for more than one injection point to be used. A representative of a leading firm of London undertakers has stated that such an injection is carried out in nearly every one of his cases. Secondly, a full process of embalming aimed at permanent preservation, when about six injection points are needed : if a 1% solution is used about 3 to 4 gallons of preserving fluid may be required. The process of embalming renders ineffectual the majority of tests for poisons. It completely nullifies the tests for volatile poisons, and interferes with the isolation processes for all the non-volatile organic compounds. The formaldehyde in the embalming fluid undergoes condensation with cyanide and many other compounds so that even where poisons are isolated the material does not respond characteristically in the identifying reactions. Recoveries of organic compounds from embalmed bodies are invariably low

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because of the resistance to solvents of tissues fixed in formaldehyde, and if methyl alcohol is used in the embalming fluid it will interfere with the identification of ethyl alcohol. Modification of the constituents of embalming fluid may lead to further interference with toxicological analysis. We consider that no embalming process should be permitted until the certificate for disposal has been issued.

Registration Formalities

22. The time within which a death must be registered is five days. There is no reason why this period should not be reduced to forty-eight hours, provided facilities for registration are made more readily available than at present. Under the existing arrangements many local registrars' offices are open only for a few hours each week and it is not always possible to register a death even when the office is open, as the period concerned may be restricted to other forms of registration such as births or marriages. If, as we recommend, interference with the body such as embalming is to be made conditional upon the issue of a certificate of disposal, it must be possible for the relatives to obtain a certificate with the minimum of delay. Accordingly we recommend that the days and times during which it is possible to register a death should be greatly extended.

THE PROCEDURE AFTER THE CERTIFICATE OF DISPOSAL HAS BEEN ISSUED

23. The certificate of disposal authorizes disposal of the body by earth burial, which is the conventional form of disposal in this country. But it may happen that events occur following disposal which indicate that a further examination of the body is necessary. This usually occurs because suspicion is later attached to a death which aroused no particular interest at the time so that the body was disposed of on the basis of a death certificate and registration in the normal manner. It may happen that the death was notified to the coroner but insufficient examination of the body was made. It may also happen where a dispute arises out of claims by the relatives to pension or insurance rights. This makes it essential to restrict any method of disposal that destroys evidence which would otherwise be available.

24. The most destructive method of all is cremation, which destroys all evidence of the cause of death with the possible exception of radioactive poison. The Association has recently published a report on the medical aspects of cremation in which the safeguards necessary to the community are considered fully.[1] The main safeguard is the rule that cremation cannot be authorized until the cause of death is "definitely ascertained." We would again emphasize the importance of this rule together with that of the requirement of an independent investigation into the death by a doctor who has not been concerned with treatment of the case. Whilst welcoming the sanitary and economic advantages which accrue from disposal by cremation we deplore the attempts by cremation authorities to make cremation "easier" by reducing the safeguards at present in existence. There is no evidence to support their allegation that the essential safeguards at present attached to cremation discourage its use as a method of disposal. Over the past ten years the proportion of deaths in the community in which cremation had been chosen as the method of disposal has more than doubled, and now represents more than a third of the deaths in England and Wales.

25. Removal of the body out of England and Wales presents another obstruction to further investigation of the death, but we regard the existing safeguards, whereby the coroner must be informed not less than four clear days before the body is removed, as sufficient.[2]

26. The position with regard to burial at sea is less satisfactory. As a method of concealing evidence of crime it is just as efficient as cremation, but there is no statutory requirement which governs the procedure, apart from the normal requirement of a certificate of disposal. Disposal outside the three-mile limit might come within the Removal out of England Regulations, but the position is uncertain and confused. We recommend that any method of disposal other than cremation or burial in a registered burial ground should be subject to authorization by the coroner, who must be given adequate notice by the person intending to dispose of the body.

STILLBIRTHS

27. The law relating to succession of property and the substantive criminal law do not permit stillbirths to be regarded as deaths. The law requires a newborn child to have been completely extruded from its mother (although the umbilical cord need not have been severed), in addition to having shown signs of life, and to have breathed, before it can be regarded as having

[1] *Brit. med. J. Suppl.*, 1959, **1**, 173.
[2] *Removal Out of England Regulations*, 1954, S.I. No. 448, Reg. 6.

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been " born alive."[1] A child which has not been born alive cannot, of course, die. It follows that if a child is destroyed whilst so much as a foot remains in the maternal passages, it cannot be homicide, even though the child may have shown signs of life and have breathed. The need to protect the child in such a situation was recognized by introduction of the statutory offence of child destruction,[2] but the security of the newborn child, whether or not technically born alive, will not be complete until stillbirths are treated as deaths for the purpose of registration and notification to the coroner. The newborn child can be destroyed with the minimum of signs of external violence, and its surreptitious disposal as a stillbirth does not present any serious difficulty under the existing law.

28. Although most European countries had enforced registration of stillbirths by the middle of the 19th century, it was not until 1926 that it was made compulsory in this country.[3] For registration purposes a stillbirth is defined 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."[4] Having provided a statutory definition the Registration Acts do little more than extend to stillbirths the provisions already existing in respect of registration of live births. The same " qualified informants " are required to register the birth and the same period is allowed within which the birth must be registered. Since this period is six weeks[5] it follows that the requirement is of little practical value in ensuring that doubtful cases are notified promptly to the coroner. Although the registrar is required to notify the coroner if he has reason to suppose that an alleged stillbirth may have been born alive,[6] he will not necessarily become aware of the event until the birth is registered, and even if he does hear about it he is not empowered to compel the appearance of a qualified informant until six weeks after the birth took place.[7]

29. The Registration Acts do, however, make one important exception in the case of stillbirths. The qualified informant, upon

[1] *Births and Deaths Registration Act*, 1953, s. 41.
[2] *Infant Life Protection Act*, 1929, s. 1.
[3] *Births and Deaths Registration Act*, 1926, s. 7 (2).
[4] *Births and Deaths Registration Act*, 1953, s. 41.
[5] *Births and Deaths Registration Act*, 1953, s. 3.
[6] *Registration (Births, etc.) Consolidated Regulations*, 1954, S.I. No. 1596, Reg. 63.
[7] *Births and Deaths Registration Act*, 1953, s. 4.

registering the death, is required to produce a certificate signed either by the doctor or midwife in attendance at the birth, or who had examined the body of the child, stating that the child had not been born alive.[1] If no such certificate is produced the qualified informant must make a statutory declaration that no doctor or midwife had attended or examined the child, or that he had been unable to obtain a certificate.[2] Since 1960 it has become mandatory upon the doctor or midwife, successively, who has attended the birth or examined the child, to give such a certificate and to state, to the best of knowledge and belief, the cause of " death " and the estimated duration of the pregnancy.[3] But it is still possible for a stillbirth to be registered without reference to the coroner on the basis of a certificate signed by a doctor or midwife who was not in attendance at the birth, or, if a statutory declaration is completed, where neither a doctor nor a midwife has examined the body.

30. It is not possible to decide whether or not a newborn child has been born alive by means of external examination of the body alone, as there is no reliable external sign of live birth prior to healing of the umbilical cord stump, an event which does not take place until several days after birth. We consider that no stillbirth should be registered without reference to the coroner unless a registered medical practitioner or certified midwife was present at the birth and has given a certificate stating that the child was not born alive. We also recommend that any doctor or midwife called to a stillbirth and who is unable to give such a certificate should notify the coroner, his officer, or the police as should any qualified informant (excepting, of course, the mother) who has been unable to obtain such a certificate within twenty-four hours of the birth.

31. Finally, the law relating to the disposal of stillbirths should be brought into line with the laws relating to disposal of the dead. Apart from burial in a registered burial ground or disposal by cremation there are, at present, no restrictions on the disposal of stillbirths. Subject to the statutory requirements of the Public Health Acts and the law relating to public nuisance, stillbirths may be disposed of anywhere. Nor is there any record of where disposal has been effected, as the person receiving the certificate of disposal is not required to notify the registrar of the details of disposal, as is the case with deaths.[4] We consider that the procedure for

[1] *Births and Deaths Registration Act*, 1953, s. 11 (a).
[2] *Births and Deaths Registration Act*, 1953, s. 11 (b).
[3] *Population Statistics Act*, 1960, s. 1.
[4] *Births and Deaths Registration Act*, 1926, s. 3 (1).

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disposing of stillbirths should be the same as that for disposal of the dead.

THE CORONER

32. The present division of the country into coroners' districts is based on the medieval pattern which existed when coroners were elected by the local community, when paramount importance was attached to communal responsibility for presenting deaths to the coroner, when inquests had to be held on every death reported to the coroner, and when both the coroner and his jury had to view the body of the deceased person. Relatively few cases could be dealt with by each coroner under these circumstances, and coroners' districts were, accordingly, small in extent. The main duty of the coroner was to discover whether the many formalities, now obsolete, in presenting deaths had been properly observed. The duties of the present-day coroner are very different, as the main purpose of his investigation is to determine scientifically the cause of death and the nature of the surrounding circumstances. The trained personnel and specialized techniques essential to efficient medico-legal investigation cannot be provided satisfactorily unless the coroner's district is based on a much larger unit. It is on the assumption that there will have to be reorganization of existing coroners' districts that most of the recommendations in this section of the report are made.

Personnel

33. Until 1926 coroners needed no qualification for office apart from an unspecified holding of freehold in land. In 1926 it was enacted that a coroner must be a duly qualified medical practitioner, solicitor or barrister of five years' standing in his profession before he could be appointed.[1] At present the great majority of coroners are solicitors occupying the office of coroner on a part-time basis, but there are a few coroners who are both medically and legally qualified, most of whom are employed as coroners on a full-time basis. The need for coroners to be medically qualified was recognized by the Registrar-General as long ago as 1857,[2] and in the following year he suggested that coroners should be required to take a course in medical jurisprudence.[3] However, a Departmental Committee on coroners reported in 1936 that only solicitors or barristers should be appointed coroners and it would go no

[1] *Coroners (Amendment) Act*, 1926, s. 1 (i).
[2] Registrar-General, 19th Ann. Rep.; 1857–58 (2431) xxiii, 1 at p. 204.
[3] Registrar-General, *Observations on Coroners' Inquests*, 1858, p. 3.

further than to suggest that coroners "should have some training in forensic medicine."[1] The reason for this recommendation appears to have been the increasing pre-occupation of lawyers with the inquisitorial nature of the coroner's inquest.

34. The coroner's inquest provides a notable exception to conventional English court procedure, which in criminal cases is accusatorial in nature. The coroner may compel witnesses to give evidence on oath, and every person, whether suspected or not, of having committed an offence in connexion with the death, is regarded as a competent witness. All statements made before the coroner are admissible in subsequent proceedings. Under these circumstances, in which the coroner enjoys relative freedom from the rules of evidence, particular care has to be exercised by him to ensure that persons are not placed unjustifiably in jeopardy. Accordingly a legal qualification is felt to be an essential condition for holding the post of coroner. However, this must not be allowed to obscure the paramount necessity for the modern coroner to be medically qualified also. The great majority of the coroner's work is concerned with deciding which deaths ought to be subject to medico-legal investigation and with ascertaining the cause of death in those cases which are investigated. In London and Middlesex more than 80% of cases reported to coroners are disposed of without inquest, and in those cases where an inquest is held the conduct of persons in connexion with the death is called into question in only a small proportion.

35. The coroner must have complete control over the investigation of each case, and we do not accept that he can delegate responsibility to a pathologist. The coroner must be able to discuss the medical aspects of the case with any doctor who has been in attendance upon the deceased person and to direct what further investigations should be carried out. He must be able to discuss critically the necropsy and other findings with pathologists, anaesthetists, etc., and to decide which further examinations should be undertaken. This aspect of the work occupies a large proportion of the coroner's working day and is of an executive or administrative character.

36. The coroner is in a unique position to appreciate hazards to the community which might otherwise remain unsuspected, but he cannot carry out this work properly unless he is medically qualified. This is particularly true in the field of therapeutics,

[1] *Coroners*, Dept. Cttee. Rep.; 1936 (Cmd. 5070) viii, 1, paras. 221, 226.

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where the association between the use of certain drugs and the death of the patient may be recognized for the first time by coroners whose approach to the case is disciplined by medical training and clinical experience. The requirement of a medical qualification is well recognized in other countries. In those parts of the United States where coroners have been replaced by medical examiners, a medical qualification is an essential requirement for holding office. In some other parts the laws relating to coroners have been altered to make the possession of a medical qualification a condition of holding office. The Departmental Committee of 1936 did not, however, attempt to obtain any evidence of the medical examiner system notwithstanding the fact that it represents the most important development in the medico-legal investigation of deaths which has taken place in the twentieth century. For reasons which will be considered later we do not support the replacement of the coroner system by the medical examiner system in this country, but we do support the recommendations of recent United States' Committees on the necessary qualifications for holding office as a coroner or medical examiner. For example, the Model Post-Mortems Examinations Act adopted by the National Conference on Uniform State Laws at Chicago in 1954 recommended that coroners should have " the best obtainable professional training in medicine and pathology. . . . Wherever possible he and his principal assistants should keep abreast of medical advances by affiliation with medical schools and should, to the extent of their abilities, aid in the development of their professional field by contributions to medical literature, and by teaching medical and law students in their special medico-legal field."[1]

37. At present coroners in England and Wales are appointed by local authorities, and, although legislation has enabled them since 1926 to merge existing coroners' districts into more efficient and larger units, there has been little improvement in the position.[2] At present almost half of the coroners in England and Wales receive less than 200 cases reported to them annually, whereas 5% of coroners, mostly full-time coroners, receive more than a third of the country's total number of cases. A Home Office circular to local authorities in 1952 pointed out that more than half the coroners in England and Wales held less than 50 inquests a year and reminded them that statutory powers could be exercised to merge existing districts upon the death or retirement of the coroner in office.[3]

[1] *Model Post-Mortems Examinations Act*, Chicago, 1954.
[2] *Coroners (Amendment) Act*, 1926, s. 12.
[3] *Home Office Circular*, No. 52/1952.

Little progress has been made towards this end, probably because of vested interests. In some districts the office of coroner has been linked with a particular firm of solicitors or has been handed down from father to son for generations. The great majority of coroners, having so little coroner's work to do, occupy the office in their spare time from the practice of their profession, usually that of solicitor. The prior demands of professional practice have led to the appointment of an army of deputy coroners and assistant coroners so that the part-time post may be continuously manned. This is because a coroner is required to hold himself ready at all times to undertake, either by himself or by his deputy, any duties in connexion with inquests and necropsies.[1]

38. We recommend that the power of appointment of coroners should be taken away from local authorities and vested nominally in the Lord Chancellor, who would make appointments on the recommendations of a suitably constituted advisory body. The number of existing coroners' districts should be greatly reduced and regional coroners' offices set up to deal with approximately 3,000 cases reported annually. These larger jurisdictions should have the use of mortuary accommodation and all necessary scientific aids to investigation, even if such facilities lie within another coroner's district. Wherever possible the coroner's office should be located near a forensic science laboratory, or research unit so that the excellent material for teaching, research, and statistical purposes which can be provided by coroners' cases may be fully exploited. Each office would employ coroners' officers on a full time basis. We recommend that each office should be under the overall control of one coroner, who is qualified in both law and medicine, with one or more assistant coroners acting under his supervision. This would ensure that there is a constant supply of coroners undergoing training for this most responsible work, and will lead to a discontinuance of the present practice whereby many coroners are appointed with no experience whatsoever of the duties they will be expected to carry out. Coroners should be encouraged to maintain contact with the active practice of their professions, and to keep abreast of medical advances by some participation in the teaching of medical and law students. Geographical considerations and in particular density of population, which is reflected in the number of cases reported to the coroner, will play an important part in deciding the boundaries of each regional office. A possible disadvantage to such a scheme would be the need in rural areas to

[1] *Coroners Rules*, 1953, S.I. No. 205, Rule 1.

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transport the body a considerable distance for the purpose of medico-legal investigation. However, the advantages to be gained from carrying out the investigation under optimal conditions will be adequate compensation for the additional cost of transport, and cannot fail to be an improvement over the present practice of carrying out highly skilled necropsies in the squalid and badly-lit mortuaries which so many local authorities maintain.

Preliminary Investigation

39. The coroner's jurisdiction over a dead body depends initially upon whether or not the body is lying within his district.[1] The existence of a large number of small coroners' districts sometimes gives rise to difficulty in this respect because death may not have occurred in the same district as did the incident which caused the death, or the body may have been moved after death to another coroner's district. Statutory machinery exists to transfer the case to the coroner in whose district the relevant events took place[2] but the most satisfactory way of dealing with the problem is to get rid of small coroners' districts and fuse them into larger and more efficient units of jurisdiction.

40. Upon receiving information that a dead body is lying within his district the coroner must decide whether the circumstances surrounding the death give him reasonable cause to believe that it is within his jurisdiction. If he does so decide the next step is to institute preliminary investigation into the case, and this is usually carried out by the coroner's officer. The post of coroner's officer is very important and should be regarded as being on the same level as that of a police officer of the criminal investigation department. Not only does great care have to be exercised in assessing the evidence at the scene of death and in preserving all necessary specimens, but considerable tact has to be exercised in dealing with relatives of the deceased person and other witnesses who may be under considerable emotional stress as a result of the unexpected nature of the death. The coroner should be able to call upon all necessary scientific aids to investigation at the scene of death, including colour photography.

41. Unfortunately the existence of multiple small coroners' districts generally makes it impractical to appoint a specially trained coroner's officer. In most districts the coroner's officer is any police officer who can be spared from what is regarded as

[1] *Coroners Act*, 1887, s. 3 (1).
[2] *Coroners (Amendment) Act*, 1926, s. 16.

more important routine police work, or, alternatively, the first police officer to reach the scene of death is automatically appointed coroner's officer for that case. If our recommendation concerning larger coroner's districts is accepted it will be possible to appoint specially qualified coroner's officers who have received training in police methods.

Necropsy

42. The most important single factor in the medico-legal investigation of deaths in the community is the scientific determination of the cause of death. The dangers of relying on circumstantial evidence in cases of unexpected death have long been realized, and more recently have been confirmed by statistical studies in which the findings of doctors who have diagnosed the cause of death on the basis of external examination of the body, the past history, and other relevant circumstances have been compared with the findings of pathologists who have conducted necropsies afterwards. Not only have deaths thought to have been due to illness been shown to have been due to violence, but the converse has also been shown to be true. Unless a coroner orders a necropsy by a pathologist with suitable qualifications and experience the probability is that the cause of death will be wrongly given in at least one-third of his cases.[1]

43. In a recent series of 9,501 deaths in various hospitals in England and Wales the diagnosis of the certifying doctor was compared with that of the pathologist who conducted the necropsy.[2] The clinical diagnosis was found to be in disagreement with the necropsy findings in 54.7% of cases, and in approximately half of these the disagreement was as to fact and not merely as to opinion. Even where the certifying doctor stated that the diagnosis was "fairly certain"—i.e., more than "probable"—the pathologist disagreed in 44.3% of cases. Within the series it was noted that 18.7% of the deaths due to carcinoma of the bronchus were certified as deaths from other causes and that 25% of deaths certified as due to cardiovascular disease were not due to this cause. 43% of deaths certified as from cerebral haemorrhage were not caused by cerebral haemorrhage. The clinical diagnosis and certification in these cases were made under optimal conditions in hospitals. It is unlikely that certification by general practitioners under domiciliary conditions would be any more accurate.

[1] Turkel, H. W., *J. Amer. med. Ass.*, 1953, **153**, 1086.
[2] Heasman, M. A., *Proc. roy. soc. Med.*, 1962, **55**, 733.

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44. In cases of unexpected, violent, or unexplained deaths the margin for error in clinical diagnosis without necropsy becomes even greater. Although no adequately reported series has been published in this country, Turkel[1] has reported that the doctor in attendance upon the deceased person was in disagreement with the pathologist in 45% of cases notified to the San Francisco coroner's office. Subsequently he analysed the necropsy findings in 400 consecutive cases reported to the coroner's office and he found that eight deaths had been caused by previously unsuspected violence which might never have been discovered if a necropsy had not been carried out. An even more surprising finding was that 51 of the 154 deaths attributed to violence when reported to the coroner were not in fact caused by violence.[2] The findings of an inquest in circumstances where no necropsy has been carried out are therefore little more than inspired guess-work. The failure of many coroners to order routine necropsies on cases reported to them means that in many cases domestic, industrial, and public health hazards remain undetected and unsuspected, whilst in other cases not a few deaths attributed by the coroner to accidental violence will have been caused in fact by natural illness.

45. The proportion of forensic necropsies carried out on the total deaths in the community will therefore provide a useful index of the efficiency of the medico-legal system of investigation. This index should be fairly constant, as it would be expected that the proportion of deaths requiring medico-legal investigation would not vary in different communities to any marked extent, though due allowance should be made for the widely different pattern of life in rural as opposed to urban communities. Table II shows that a wide variation does exist in the index between the counties of England and Wales, and it seems clear from this table that the main reason for the difference is the variation of practice between individual coroners in ordering necropsies on reported cases.

46. In some counties more than 90% of the cases reported to the coroner in 1960 were subjected to necropsy, in others less than half were so examined. Table II also shows that those counties holding a low proportion of necropsies on reported cases held proportionately a larger number of inquests. Counties holding a high proportion of necropsies in 1960 were generally those where full-time coroners with medical qualifications are in office.

[1] Turkel, H. W., *J. Amer. med. Ass.*, 1953, **153**, 1086.
[2] Turkel, H. W., *Ibid.*, 1955, **158**, 1485.

TABLE II.—*English Counties with Highest and Lowest Medico-legal Necropsy Rates on Total Deaths*, 1960[1]

County	Total Deaths Including Still-births 1	Coroners' Necropsies as % of Total Deaths 2	Deaths Reported to Coroner as % of Total Deaths 3	Coroners' Necropsies as % of Reported Cases 4	Inquests as % of Reported Cases 5
England					
1. London	37,573	26·85	28·22	95·17	16·35
2. Middlesex	23,676	22·12	23·28	95·03	17·59
3. Surrey	19,501	20·96	24·21	86·58	20·04
4. Cambridge	2,005	16·75	21·44	78·13	30·00
39. Durham	17,938	7·47	16·01	46·62	37·79
40. Northumberland	10,046	6·18	14·65	42·19	30·57
41. Westmorland	912	4·94	13·92	35·43	44·10
42. Wiltshire	4,436	4·31	13·55	31·77	25·95

Quality of Necropsy

47. It is the usual practice of full-time coroners with large districts to employ exclusively pathologists experienced in forensic work, and this practice is recommended in the Coroners Rules.[2] However, in some parts of the country practitioners inexperienced in forensic work are instructed by part-time coroners to carry out necropsies on coroners' cases. It was inevitable that this should have been the case while there were insufficient pathologists to carry out coroners' work, but it is inexcusable that this state of affairs should continue now that a regional pathologists' service has been developed. There is evidence that in spite of the Home Secretary's advice ("the post-mortem examination (necropsy) should be made, whenever practicable, by a pathologist with suitable qualifications and experience, and having access to laboratory facilities"[3]) some coroners still do not understand the importance of necropsies being conducted by experienced pathologists. Coroners have statutory power to order any medically qualified practitioner to carry out a necropsy, and we recommend strongly that this power should be withdrawn as being no longer necessary.[4] In one large city with adequate pathological services the coroner has ordered a general practitioner inexperienced in

[1] Figures calculated from the Home Office Returns of Coroners and the Registrar-General's Returns of Deaths and Stillbirths.
[2] *Coroners Rules*, 1953, S.I. No. 205, Rule 3 (a).
[3] *Loc. cit.*
[4] *Coroners (Amendment) Act*, 1926, s. 21 (i).

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medico-legal work to carry out a necropsy on the body of a patient he had been attending, and the excuse that the necropsy ought to be carried out by an experienced pathologist who was available was not accepted by the coroner, who threatened the general practitioner concerned with proceedings if his orders were not carried out. Coroners' necropsies should ordinarily be performed by experienced general pathologists; experience in forensic pathology is always desirable. Some cases demand the services of a specialist in forensic pathology.

48. Once the scene of the death has been assessed by an experienced coroner's officer and any problems of identity established there is no reason why the body should not be removed to a properly equipped centre. Accordingly, there should be no excuse for providing inferior facilities for the conduct of the necropsy. At present the provision of mortuaries is the responsibility of local authorities and the body will be moved to the mortuary provided by the authority in whose district the coroner works, or in some cases to the mortuary of the local hospital. The mortuaries maintained by local authorities are very rarely equipped adequately for the purpose of carrying out a forensic necropsy. The lighting is often bad, there is usually no refrigeration unit, and the ancillary staff may be untrained. The removal of the body to the mortuary, which has to be carefully supervised if essential evidence is to be preserved, is under the control of the local authority and not of the coroner. The mortuary attendants are under the control of the local authority and neither the coroner nor the pathologist can direct them. To a certain extent this state of affairs is the result of multiple small coroners' districts whose administrative expenses are the responsibility of the local authorities concerned. The conditions under which the necropsy is carried out will therefore depend on the mortuary facilities of the local authority in whose district the death took place. If our recommendations concerning larger coroners' districts are accepted it should be possible, and would in fact be necessary, to give the coroner independent mortuary accommodation, and the number of cases received by each coroner would justify such a provision being made.

Consultation with the Deceased Person's Medical Practitioner

49. The Home Secretary has recommended that local authorities should exercise their statutory powers to assist the coroner in calling for a written medical report from the deceased person's medical practitioner for the purpose of deciding whether to hold an

inquest or necropsy.[1] Both the coroner and the pathologist can be assisted materially by such reports, and we recommend that more use should be made of them.

50. Although coroners are required to notify the deceased person's medical practitioner of the time and place of the necropsy " unless it is impracticable . . . or to do so would cause the examination to be unduly delayed "[2] there is evidence that this rule is widely disregarded by coroners. We recommend that every effort should be made to notify the medical practitioner concerned and that he should be encouraged to be present in order that consultation between himself and the pathologist may be effected in the course of the necropsy. Notification of the medical practitioner was made obligatory so that he could have every opportunity of clearing himself against possible charges of malpractice. It does not appear to have been appreciated by coroners that the main reason for having the medical practitioner present is so that consultation can take place with the pathologist conducting the necropsy on the various points which arise in the course of the examination.

51. In all cases where the deceased person's medical practitioner is known he should be informed of the cause of death where a coroner's necropsy is ordered and, if the deceased person's medical practitioner so requests, he should be sent a copy of the necropsy report unless there is an important reason why this should not be done.

Inquest Procedure

52. The inquest on unexpected, violent, or unexplained deaths is an institution peculiar to common law countries. It is not found in civil law countries nor in those parts of the United States which have adopted the Medical Examiner system of investigation. For reasons which have already been mentioned the coroner's inquest has been criticized because it fails to conform with conventional English court procedure and because much of its original purpose has ceased to exist. On the other hand, we consider that it is particularly suited to the unique problems which are associated with such cases. If it were not for the coroner's inquest there would be no method of examining witnesses under oath in connexion with the death, unless, of course, a criminal charge is brought. In addition it is particularly effective as a method of dispersing the unfounded criticisms and rumours which are so often associated with the occurrence of unexpected death in the community.

[1] *Home Office Circular*, No. 176/55 (1955), para. 10.
[2] *Coroners Rules*, 1953, S.I. No. 205, Rule 4 (b).

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The surreptitious and private disposal of these cases under some foreign systems of medico-legal investigation is not nearly so effective in this respect as the verdict of a coroner's jury that it has heard all the evidence and is satisfied. This is particularly true of those few cases where even the best available medical evidence is unable to state the cause of death definitely and can only exclude the possibility of foul play. The utility of the inquest in this respect has been recognized by its introduction earlier in the century into the Scottish system of medico-legal investigation[1] which is based primarily on the European pattern.

53. The coroner has to hold an inquest where the death has occurred in prison or where it appears to have been due to violence or unnatural cause.[2] In other cases it is within the discretion of the coroner whether or not an inquest is held. Table II shows that there is a marked variation in practice between coroners over the holding of inquests. We agree with the report of the Departmental Committee on Coroners of 1936 that the discretion of coroners not to hold an inquest might be further extended to include "simple accidents,"[3] and that the fact that the death was associated with violence should not necessarily require an inquest to be held. This is particularly important with regard to deaths which may follow surgical operations.

54. The question whether or not a death associated with a surgical operation should be regarded as "unnatural" for the purpose of notifying the coroner has already been discussed (para. 5). The further question whether such deaths, when notified, should be the subject of an inquest is a matter which should be left to the discretion of the coroner after he has reviewed the necropsy findings and other relevant circumstances. It is particularly important that the coroner should obtain expert anaesthetic opinion before any finding is reached that an anaesthetic procedure has been responsible in whole or in part for death having occurred. It is both unnecessary and undesirable that an inquest should be held in every case where death has occurred within a certain period after a surgical operation. We do consider, however, that an inquest should be held whenever the conduct of any person has been called into question.

55. Finally, we recommend that the ancient requirement that an inquest should be held "super visu corporis" should be

[1] *Fatal Accidents and Sudden Death Inquiry (Scotland) Act*, 1906, s. 2.
[2] *Coroners Act*, 1887, s. 3 (1), Coroners (Amendment) Act, 1926, s. 21 (1).
[3] *Coroners*, Dept. Cttee. Rep.; 1936 (Cmd. 5070), viii, 1, para. 141.

abolished. In our view it is neither desirable nor necessary that the coroner should be required to view the body personally in every case.

SUMMARY OF RECOMMENDATIONS

1. The classes of death which the coroner is required to investigate should be more clearly defined. (Paras. 3–6.)

2. A death certificate should not be given without reference to the coroner unless the certifying doctor, or his partner or deputy, has seen the deceased person within a period of 14 days before death. (Para. 8.)

3. The certifying doctor should be required to make an examination of the body before certifying death. (Paras. 9–11.)

4. The certifying doctor should be required to give on the certificate information concerning the terminal clinical state, in addition to the antecedant and underlying pathological cause of death. (Para. 12.)

5. Medical practitioners should be required to notify the coroner or his officer immediately they become aware that a death has occurred which ought to be investigated by the coroner. (Paras. 13–15.)

6. The qualified informant should be required to notify the coroner, coroner's officer, or police, immediately if it has not been possible to obtain a death certificate within 48 hours of death taking place. (Para. 16.)

7. All deaths of foster children should be reported to the coroner. (Para. 17.)

8. Professional nurses who have been in attendance upon the deceased, or who have assisted in laying out the body, should be required to notify the certifying practitioner and the coroner, or his officer, if they have reason to believe that the death ought to be investigated by the coroner. (Para. 18.)

9. The same obligation should apply to funeral directors, embalmers, and their assistants. (Para. 18.)

10. Interference with a body, other than (i) its reasonable removal from the place of death, or (ii) the removal of parts of the body under the provisions of the Human Tissues Act, should not

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be permitted until after the certificate for disposal has been issued. (Paras. 19–21.)

11. The days and times during which it is possible to register a death should be greatly extended, and the time within which a death must be registered should be reduced to 48 hours. (Para. 22.)

12. The existing safeguards to disposal by cremation should be preserved, in particular the requirements that the cause of death must be " definitely ascertained," and that an examination of the body by an independent doctor takes place, before cremation is permitted. (Para. 24.)

13. Methods of disposal other than by cremation or burial in a registered burial ground should be subject to authorization by the coroner, who must be given adequate notice by the person intending to dispose of the body. (Para. 26.)

14. Any stillbirth at which a registered medical practitioner or certified midwife has not been present should be reported to the coroner or his officer. (Para. 30.)

15. Any registered medical practitioner or certified midwife who has been called to a stillbirth and is unable to give a certificate should notify the coroner or his officer. (Para. 30.)

16. The qualified informant should be required to notify the coroner, his officer, or the police, if the certificate has not been obtained within 24 hours of the stillbirth. (Para. 30.)

17. The procedure for the registration and disposal of stillbirths should be the same as that for registration and disposal of the dead. (Para. 31.)

18. The existing multiple small coroner's districts should be replaced by larger jurisdictions with the use of mortuary accommodation and all necessary scientific aids to investigation, even if such facilities lie within another coroner's jurisdiction. For this purpose use should be made of hospital pathological facilities together with those of research units and forensic science laboratories. (Paras. 32, 37–38.)

19. Each regional office should be under the control of a coroner who is qualified in medicine and law. Coroners should be encouraged to maintain contact with the active practice of their professions, and to keep abreast of medical advances by some participation in the teaching of medical and law students. (Paras. 33–36.)

20. Powers of appointment of coroners should be taken from local authorities and vested in the Lord Chancellor. (Para. 38.)

21. The statutory power of a coroner to direct any registered medical practitioner to perform a medico-legal necropsy should be abolished. Coroners' necropsies should ordinarily be performed by experienced general pathologists; experience in forensic pathology is always desirable. Some cases demand the services of a specialist in forensic pathology. (Para. 47.)

22. The coroner should obtain a written medical report from the deceased person's medical practitioner whenever possible. (Para. 49.)

23. The deceased person's medical practitioner should always be informed of the time and place of the necropsy. (Para. 50.)

24. In all cases where the deceased person's medical practitioner is known he should be informed of the cause of death where a coroner's necropsy is ordered and, if the deceased person's medical practitioner so requests, he should be sent a copy of the necropsy report unless there is an important reason why this should not be done. (Para. 51.)

25. The discretion of a coroner not to hold an inquest should be extended to include " simple accidents." (Para. 53.)

26. Inquests should not be held automatically in cases where death is associated with medical or surgical procedures. (Para. 54.)

27. The coroner should always obtain expert anaesthetic opinion before deciding that an anaesthetic procedure has been implicated in a death. (Para. 54.)

28. The coroner should not be required to view the body personally in every case. (Para. 55.)

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