HOME OFFICE

Report of the Committee on

DEATH CERTIFICATION AND CORONERS

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CHAPTER 19

APPEALS AGAINST INQUEST FINDINGS OR DECISION NOT TO HOLD AN INQUEST

19.01 The inquisition (the formal record of an inquest), the coroner's certificate after inquest which he sends to the Registrar of Deaths and the copy of the entry in the Register of Deaths all contain not only the " conclusion of the coroner/jury as to the death ", e.g. suicide, accidental death or misadventure—popularly known as the " verdict "—but also the findings of the Court as to the identity of the deceased person, the medical cause of death and the circumstantial causes. An alleged mistake in any of these matters may give understandable cause for concern to interested parties. At present, however, there is, in the strictest sense, no right of appeal against the findings of an inquest. The available remedy is in another form, namely application to the High Court (the Queen's Bench Divisional Court) for an order quashing the inquisition and ordering a fresh inquest to be held. The Court possesses ancient common law powers to make such an order and these powers are occasionally invoked, but, for the most part, the Court acts in accordance with the provisions of the Coroners Acts. Section 6 of the Coroners Act 1887 provides that an inquisition may be quashed and a fresh inquest ordered where the High Court is satisfied that:

> " by reason of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, or otherwise, it is necessary or desirable in the interest of justice, that another inquest should be held ".

In addition, section 19 of the Coroners (Amendment) Act 1926 makes it clear that the High Court's powers:

> " extend to and may be exercised in any case in which it is satisfied that it should act by reason of the discovery of new facts or evidence ".

Application must be made by or with the authority of the Attorney General; in practice it is usual for the application to be made by an individual with the Attorney General's consent. The application itself is heard in the Divisional Court, from whose decision an appeal lies to the Court of Appeal. When an application is granted, the court usually orders the fresh inquest to be held by a different coroner.

19.02 Very few applications are made to the High Court, although about 25,000 inquests are held annually in England and Wales. Six were received in the period 1966–1968 and half of these were refused as unmeritorious. From an analysis of the reported cases in the period from 1944–1968 (13 in number), it is apparent that nearly all the applications reaching the Divisional Court are made by relatives who are distressed at a verdict of suicide.

19.03 We were surprised that the number of applications should be so small and that they should have been almost totally confined to suicide cases; for we are satisfied that the real volume of dissatisfaction with inquest

results, though small, is a good deal higher than these figures would suggest and extends to cases other than suicide. We have little doubt that there are several different factors at work here. First, there must be a strong natural disposition among relatives of a deceased person to bring to a speedy conclusion what are usually known as " the formalities " consequent upon a death and to avoid any action, such as further legal proceedings, which would only protract matters. Second, there is little economic incentive to seek a new inquest because the result of an inquest has small effect in law on the determination of legal rights or interests. Third, there is a certain discouragement to would-be applicants for a new inquest, not only in the elaborate procedure itself, but much more, we think, in the working criterion which the High Court is known to apply to any application for quashing the result of a coroner's inquest, namely that the Court will be prepared to order a fresh inquest only if it can be shown that there is a probability of error as to the final overall " verdict " (see paragraph 19.01 above) or as to the identity of the deceased as recorded in the inquisition. There has been no case, so far as we are aware, in which a new inquest has been ordered on the ground that there is doubt as to the accuracy of the medical or circumstantial causes of death when there is not also an objection to the final conclusion or "verdict".

19.04 There are several reasons why we do not think the present situation is satisfactory. A number of witnesses made clear that, to those persons primarily affected, the medical and circumstantial causes of death as recorded by the coroner can be just as important, and a mistake in such matters just as injurious and deserving of remedy, as the final conclusion expressed in such terms as " death from misadventure " or " death from natural causes ". We have therefore made a number of proposals designed to improve the accurate certification of the medical causes of death; we have recommended that the powers of the coroner to enquire into the medical causes of deaths should be enlarged, and we want to encourage reference to the coroner of any cases where there is uncertainty about the causes of death. It would be absurd to offer these proposals for improving the ascertainment of the causes and circumstances of death if, at the same time, we neglect to improve the means of rectifying any errors which may have crept into the process of ascertainment.

19.05 At the heart of most of the criticisms directed against coroners we found the theme that they are, or are free to be, a law unto themselves and that, if they are guilty of conduct which indicates the lack of a proper judicial approach, redress is difficult or impossible to obtain. The occasions when such criticism is justified are rare and exceptional; but we are satisfied that they occur. They would be less likely to occur if the right of appeal was more explicit and accessible.

19.06 We are aware that it is sometimes argued that, since there are no parties to an inquest, the concept of an appeal is inappropriate. We have no sympathy with this view; there should be some legal form of redress for any person with a legitimate interest in a coroner's inquest who is aggrieved by his recorded findings. We have come to the conclusion that the present arrangements are too restrictive and that changes should be made.

19.07 As regards the basis for redress, we recommend that an error in any part of the record of the findings of a coroner's court (including the findings as to the medical and circumstantial causes of death) should constitute a ground for an application for a fresh inquest.

19.08 The other changes which we have in mind are rather more substantial. We recognise the value, and do not therefore recommend the abolition, of the present right of an individual aggrieved by the result of a coroner's inquest to apply to the Divisional Court for redress; but the High Court in London may sometimes seem rather remote and we believe that it might be feasible to provide for an alternative remedy to be available at a local level. What we have in mind is a process by which, without reference to the Attorney General, an application for leave to appeal against the findings of the coroner's inquest might be made to a High Court Judge sitting at one of the major centres outside London as provided for in the Courts Act 1971. In effect, it would become one of the functions of High Court Judges outside London to give " leave to appeal " against the findings of a coroner's inquest. Such leave would be discretionary and should be granted if it can be shown that there is *prima facie* evidence of substantial error in, or of some serious misconduct of the proceedings at, the inquest capable of having affected any part of the findings. Where a High Court Judge decides to grant leave, he should designate a judge not lower in status than a Circuit Judge to hear it as an " appeal by way of rehearing ". It would be for the Circuit Judge to decide whether the rehearing should be an oral rehearing of the witnesses or a rehearing of the transcript evidence (if one was available).

19.09 The introduction of such a procedure would bring the coroner's court closer in concept to the magistrates' courts (from which an appeal lies both to the Divisional Court (by case stated on a point of law) or to Quarter Sessions). We do not consider that there is any need to build into the new safeguards we propose any additional safeguards such as a right of appeal from a High Court Judge's decision to grant or refuse leave to appeal or from the decision of the Judge who hears the appeal.

19.10 Notwithstanding this new form of " rehearing ", cases may occur in which a new inquest rather than a rehearing would be appropriate, because there has been a plain and obvious error in the original proceedings. For example, a case occurred in which the body of a drowned person was identified at an inquest as that of one M, and a fortnight later a person claiming to be M walked into the coroner's office; the coroner successfully applied for a new inquest to be held. We think that the right to request a new inquest rather than a " rehearing " should be limited to the coroner who held the original inquest. This kind of application lies very much within the province of the Divisional Court and we hesitate to suggest any derogation from its powers. Nevertheless, we would hope that consideration could be given to the possibility of transferring the hearing of applications for a new inquest also to High Court Judges outside London.

19.11 We now consider the case where a coroner neglects or refuses to hold an inquest. The remedy here is also provided, at present, by section 6 of the Coroners Act 1887, which provides that where the High Court is

satisfied that a coroner neglects or refuses to hold an inquest which ought to be held, the court may order an inquest to be held. Applications on this ground are so rare that it is not possible to form any view as to how the procedure works in practice. In future, however, such applications may become more frequent, for we are recommending that the present mandatory classes of inquest should virtually be abolished and that, in future, the holding of an inquest should be left to the discretion of the coroner in the case of almost all the deaths reported to him.

19.12 We believe that a coroner's discretion not to hold an inquest on a death that has been reported to him should be open to rapid challenge and we recommend that the matter should be capable of determination by the High Court or any High Court Judge outside London. It should be for the Judge (if he is satisfied that an inquest should be held) to decide which coroner should be directed to hold it.

19.13 If our recommendations for giving the coroner wider discretion to hold an inquest are implemented, it is more likely than at present that cases will occur in which the coroner concludes his enquiries at too early a stage. If, in addition, our recommendations are implemented for assimilating the procedure for cremation with that for burial, it will be essential to provide a simple procedure for securing an order for an autopsy in cases where there is reason to believe that the coroner's decision not to hold an autopsy has been based on insufficient inquiry. Since speed will be essential in the hearing of such an application, we believe that it would be appropriate to give the power to make such an order to any High Court Judge. We therefore recommend that the High Court Judge should have power to order an autopsy and power to make an order suspending the operation of any burial or cremation order until the results of the autopsy are known. We appreciate that the introduction of this new procedure carries a risk of abuse by parties maliciously inclined with consequent distress to the near relatives of the deceased person. We doubt if attempts at such abuse would be likely to be widespread or successful, but in any event we attach greater weight to the dangers of not making any provision at all. If there were no procedure for an autopsy to be ordered, otherwise than by a coroner, cases could occur where, doubt having been cast on the sufficiency of the enquiry made by the coroner, it would prove impossible, because of cremation or burial of the body, to take effective steps either to dispel or vindicate such doubt. We believe that it is most important to forestall this danger as far as possible.

PART IV

DEVELOPMENT OF THE CORONERS' SERVICE

CHAPTER 20

ORGANISATION OF CORONERS' SERVICE

Introduction

20.01 In the preceding Parts of this Report we have recommended various measures to improve the accuracy of certification of causes and circumstances of deaths, to give coroners greater freedom to determine their own procedures, and to provide new rights of appeal against coroners' decisions. In Part V we shall suggest ways in which coroners could be helped by improved pathological and mortuary services. In this Part of our Report we present our views on the organisation and resources which coroners will need if they are to achieve the standards of efficiency dictated by the new responsibilities we have suggested.

20.02 This part of our review has been particularly difficult. Our witnesses did not paint a detailed picture of the whole coroners' system and the features they emphasised in evidence to us did little to help us establish such a picture for ourselves. A general assessment is hampered by the idiosyncratic behaviour of many coroners and by the fact that those coroners who have shown most " professionalism " have not exhibited a common pattern for others to emulate. The statistical data collected by the Home Office give little clue to local failures, deficiencies or anomalies, and expenditure by and for coroners is hard to identify. Much that coroners do makes little direct or lasting impact on the public; what coroners do or do not do causes little complaint. Earlier in this report (Chapter 11, paragraphs 42–46) we noted that many of our witnesses and many of those who responded to our surveys thought that there was not much wrong with the operation of the system as a whole. We stated there that " our own assessment is less favourable " and emphasised that archaic law, inadequate resources and lack of supervision or guidance could lead to inconsistency of practice and unsatisfactory attention to public needs. We also said:

> " We are satisfied that revolutionary change is not called for. At the same time we are strongly in favour of a speeding up of those evolutionary changes which are already taking place in the general orientation of purpose and performance of coroners. " (Paragraph 11.46.)

20.03 If we refer at this point to a coroners' " system " rather than a coroners' " service " it is not because our misgivings about the standard of service which a coroner gives to his community are acute or because we wish to put a lower value on the manner in which coroners do their work than on the results which we want them to achieve. It is rather that we prefer to keep in view certain unusual features of the coroners' system which might be obscured if we used the conventional concept of a " service " to examine current problems of structure, resources, co-ordination, support and supervision.

20.04 The first unusual feature to which we refer is the operational independence of the coroner. This has elements in common with the operational independence of the judge, the medical practitioner and the chief officer of police, and yet is in some measure different in its legal setting from any of these models. The coroner like the judge frequently reaches verdicts by a judicial procedure, but unlike the judge the coroner's decisions are by no means so directly subject to appeal. The coroner, like the medical practitioner, often has to take decisions, e.g. in the certification of death, which are personal judgments based sometimes on complicated evidence; but unlike the medical practitioner the coroner is not subject ultimately to the discipline of his own profession. The coroner, like the chief officer of police, is solely responsible under the law for the selection and execution of his operations; but, unlike the chief officer of police, he does not conduct his operations in association with a national system for training, inspection, support or public complaint. Nor has he the same degree of accountability for his actions.

20.05 The second unusual feature about the coroners' system is the importance of its local vitality. To a large extent the system amounts to a series of transient working relationships between a coroner and doctors, police, hospitals, pathologists and undertakers in his area. By reason of the long and special history of his office the coroner is usually described as Her Majesty's Coroner, but he is everywhere very clearly regarded not as an agent of central government or a member of a nationalised service but as an integral part of his local community. It is not easy to understand the nature and strength of this local interest in the coroner, but as many of our witnesses impressed upon us, there is an important inter-action between the confidence reposed in the coroner by his community and his independence of function.

20.06 The third unusual feature about the coroners' system is the relatively very small numbers involved. There are only 229 coroners; the total number of their staff is rather less than 2,000; purpose-built coroners' courts and offices are few and far between. The importance of the coroners' system does not depend very much on physical resources of any kind. When all is added together and whether it is called a " system " or a " service " it is minute compared with any of the medical, forensic or other services with which it collaborates. It would be misleading therefore to classify it either as a central or as a local service. No doubt it would be possible to reconstruct and elaborate the system so that it fell recognisably into one or other of these categories, but, as we shall show later, action of this kind would be disproportionate to the problems to be solved. The right course, in our view, is to preserve the obvious strengths of the present system and improve those features which are less satisfactory. In the rest of this chapter we deal accordingly with the basic and inter-related problems of coroners' areas and the appointment of coroners.

Coroners' areas

20.07 Every coroner holds an independent territorial jurisdiction by virtue of his appointment by a local authority. All county boroughs having a separate court of quarter sessions and municipal boroughs having both a separate court of quarter sessions and a population in August 1888 of more than 10,000 persons are entitled to appoint a borough coroner for their areas.

County councils are required to appoint a coroner or coroners for the whole of their area except for the parts for which a borough coroner is appointed. Altogether, coroners' jurisdictions (or districts) in England and Wales, including the Queen's Household and the three remaining franchise districts, number 261; there are only 229 coroners because some hold more than one appointment.

20.08 Of these 229 coroners 16 are whole-time coroners: seven are in Greater London, one each in the counties of Essex and Surrey and in the Cities of Birmingham, Manchester, Liverpool and Stoke-on-Trent and three in the West Riding of Yorkshire. These whole-time coroners investigate over one-third of the deaths reported to coroners in England and Wales (see Table O below). Their average case-load is about 3,000, but there is a wide variation between the heaviest and lightest case-loads.

20.09 The great majority of the remaining part-time coroners combine their duties with other work (usually they are solicitors in private practice). Some combine a coroner's post with some other part-time public appointment, such as county court registrar or clerk to the justices. One or two part-time coroners deal with more than 1,500 reported deaths in a year: nearly 50 deal with less than 100. The average case-load of a part-time coroner is about 350.[1]

20.10 All the non-county boroughs and nearly all county boroughs have part-time coroners; and in the counties too, where the areas are commonly large enough to justify the appointment of one whole-time coroner for each county, the organisation more often takes the form of a number of part-time coroners with comparatively small work-loads. Why are so many areas served by a part-time coroner? The factor most often emphasised by our witnesses was accessibility or—more loosely—" geography ". This factor is not easy to measure. There is obviously a minimum level of work-load before even part-time appointments are made. But there are many variables in the background. The number of deaths reported to coroners expressed as a proportion of all deaths varies considerably from place to place.[2] This may reflect different attitudes on the part of doctors and coroners, and different standards of facilities. If, for example, there are large general hospitals in his area the coroner's work-load may be significantly increased. Coroners and public alike have a common interest in the compactness of coroners' areas, but their interests are not identical or necessarily of the same weight. It is only in the minority of cases that members of the public are obliged to attend inquests; but in almost every investigation there is need for consultation and collaboration between coroners, doctors, pathologists and police. Looked at simply from the point of view of convenience to the public, it might have been expected that the profound changes in communication systems and travelling facilities which have occurred since 1945 would have led to substantial changes in the boundaries of coroners' areas. On the other hand, despite new urban developments and population shifts the main concentrations of population have not significantly changed, and the more populous coroners' areas have provided a static but seemingly satisfactory framework. That

[1] See Appendix 5 (Statistics of Work by Jurisdictions 1969).
[2] See Appendix 6 (Deaths Reported to Coroners as a Proportion of all Deaths 1965).

there have been few changes in the pattern of less populous coroners' areas is harder to explain, but our impression is that considerations of historical tradition, *laissez faire* and administrative convenience have all played a part.

TABLE O

Deaths Reported to Whole-time Coroners in England and Wales, 1968 and 1969
(Source: Coroners' Annual Return to the Home Office)

Jurisdiction	Number of Deaths Reported	
	1968	1969
Inner London North	3,043	3,116
Inner London South	4,571	4,596
Inner London West	3,826	3,865
Greater London Eastern	3,188	3,425
Greater London Western	3,960	4,063
Greater London Southern	2,883	2,969
Greater London—Northern and City of London ...	4,086	4,100
Essex	2,180	2,403
Surrey	1,984	2,327
Manchester	2,738	2,929
Birmingham	3,730	3,795
Liverpool	2,076	2,362
Stoke-on-Trent	1,720	1,850
Halifax Borough and District	1,144	1,239
Sheffield Borough and Rotherham District ...	1,479	1,632
Wakefield District	1,676	1,757
Total Whole-time Coroners	44,284	46,428
Remainder of England and Wales	80,136	85,211
Total	124,420	131,639

20.11 Are these small jurisdictions unsatisfactory? The evidence we received from all shades of opinion gave us no clear-cut answer to the question. Much depends on the calibre of the part-time coroner, his experience and facilities, and the standards he sets. In some areas, we were told, it has been possible to attract to a part-time post men with suitable experience and skills who would not feel able to undertake a whole-time coroner's duties. The small local jurisdiction has the advantage that the part-time coroner and his sometimes part-time staff are readily accessible. Good communication is possible between the coroner and the relatives of the deceased, doctors and other persons. Inquests can be held locally with convenience to relatives and witnesses; and the coroner's knowledge of the community may help him to address his enquiries to the origins of local disquiet and gossip in relation to particular deaths. The Law Society went so far as to say that:

> " the appointment of full-time coroners, except in places such as London . . . would have grave disadvantages since, in order to be economically practicable, they would have to serve a wide area and would therefore be less accessible to the public, to the local medical practitioners, undertakers, the police and local solicitors."

On the other side of the picture, we were told that in some areas the part-time coronership, passing from father to son or between partners in a firm of

solicitors, has tended to become a " family affair " and the local authority may have had little real choice of candidates. The part-time coroner with a busy professional practice may find himself unable to devote as much time as he would like to consideration of the deaths reported to him and, in consequence, may lean too heavily on the judgment of subordinates.[1] Office accommodation, interview rooms, mortuary and other facilities may be inadequate because demand is too small or infrequent.

20.12 There was little disagreement among our witnesses that a small jurisdiction may provide too small a work-load for a coroner to acquire a wide experience of his duties. Almost all our witnesses therefore expressed themselves in favour of the principle that the coroners' service should be based on whole-time appointments. With varying emphasis, however, such important organisations as the Coroners Society, the Law Society, the Association of Chief Police Officers, the National Association of Funeral Directors, the Association of Municipal Corporations and the County Councils Association were all agreed that in a number of areas " geographical " conditions would always make the continuance of some part-time jurisdictions unavoidable.

20.13 The concept of a pattern or whole-time coronerships throughout the country is not new. The Wright Committee, which reported in 1936, expressed the view that a system of whole-time appointments was:

> " a goal to be aimed at ".

The Committee reported that:

> " many part-time coroners because of the smallness of their districts, have little experience or prospect of experience in the conduct of their duties " (paragraph 222),

and recognised that:

> " the problem of the smaller coronerships can only be satisfactorily solved by a radical re-adjustment of coroners districts " (paragraph 225).

20.14 The Wright Committee produced no practical proposals for bringing about such a radical re-adjustment, but their Report contained two recommendations designed to encourage voluntary amalgamations. They proposed, first, that:

> " on each vacancy in a county coronership, the question should be specifically considered whether an enlargement of districts should not take place ",

and they argued that if this could not be effected by administrative arrangements between the Home Office and county councils, a statutory obligation should be placed on the county councils. Secondly, the Committee recommended that, as a provisional step, when a vacancy occurred in a non-county borough of less than 75,000 inhabitants, the area of the borough should be merged for coroners' purposes in the neighbouring county. Little notice was taken of either of these recommendations until 1952, when a Home Office circular was sent to local authorities responsible for the appointment of coroners urging them, wherever possible, to take the opportunity of a vacancy

[1] See Chapter 21 below, where we discuss the Report of an O and M Work Study on the Coroner's Officer.

in a county or borough coronership to amalgamate two county districts or to appoint the same person to both the county and a borough post.

20.15 The policy of piecemeal reform has been slow to achieve practical results[1] for a variety of reasons. Vacancies can occur at short notice by reason of death or sudden illness and the need for the post to be filled quickly can sometimes preclude consideration of a major reorganisation. It is not easy for a local authority to make a joint appointment when the key factor is the capacity of the existing part-time coroner to take on extra work. When a vacancy arises, and the responsible council wishes to make an appointment jointly to their own and another jurisdiction, it can only do so if the neighbouring coroner is willing to extend his duties or if he can be persuaded to resign his office and make way for a third person to take over both jurisdictions. The selection of districts for joint coronerships has been fortuitous, since it has depended upon the accident of a particular coronership falling vacant at a time when a neighbouring coroner is willing to undertake the extra work. The coroner available may not always be the most suitable and some joint appointments to an adjacent borough and county coronerships have not been a success.

20.16 Piecemeal amalgamation cannot always promise improvement of supporting services. While a joint appointment may sometimes secure an officer of adequate status and experience, it is not in itself likely to lead to the most efficient and economical use of resources. Local authorities may continue to maintain separate and inadequate public mortuaries within a few miles of each other and the arrangements for the provision of coroners' officers or secretarial assistance may differ in the two jurisdictions. At present, the scale of clerical and secretarial services at the disposal of each coroner depends partly on the generosity of the local authority and partly on his own professional circumstances, both of which vary widely. The provision of coroners' officers (who are usually police officers) differs markedly in different parts of the country, so that in one or two cities the coroner has the services of a considerable corps of policemen to assist him, while in other areas he is dependent upon the occasional services of a number of different police officers.

20.17 These difficulties by themselves have been sufficient to obstruct any serious attempt to rationalise the number and pattern of coroners' districts. But even if these difficulties did not still exist it would be no easy task to devise a better distribution of jurisdictions with a more appropriate blend of full-time and part-time appointments at coroner and deputy coroner levels. The concentration of so much of the population in comparatively small geographical areas and the remoteness, inaccessibility and lack of population in many large rural areas provide extremes of circumstance for which a simple pattern based exclusively on full-time coroners would be inappropriate.

Planning of new jurisdictions

20.18 With the aid of the statistical and other information provided by

[1] In 1900, there were 360 jurisdictions and 330 coroners, of whom 200 were county coroners, 76 borough coroners who were not also county coroners, and 54 franchise coroners who held no other jurisdiction. By 1936, the number had fallen to 309. (At this time there was still 44 franchise coronerships, but it is not clear how many of these were held by coroners who also held other jurisdiction.) In 1971, there are 261 jurisdictions (including 3 remaining franchise districts) and 229 coroners.

our witnesses, we made a number of studies on alternative bases for the determination of the boundaries of coroners' districts. We looked, for example, at the possibility of using the boundaries of police forces, Regional Hospital Boards, county courts, as well as the existing and projected local authority areas for this purpose. We used, as basic data, estimates of the numbers of deaths reported to coroners and numbers of inquests held derived from past trends rather than estimates based on a assessment of the effect of our own proposals. We sought to reconcile on a national scale two desirable features of a coroner's jurisdiction: a work-load sufficient to sustain a whole-time coroner and compactness sufficient to make the coroner reasonably accessible to the general public. Our studies showed that links between coroners, registrars, police and hospital authorities (each of whom have, at present, different territorial boundaries) are as important in determining the boundaries of coroners' areas as are the links of accessibility between coroners and members of the public or links of administration between coroners and their local authorities. The studies also helped us to decide that certain minimum numbers of reported deaths could be recommended as justifying the appointment of a part-time or full-time coroner as the case might be. We think that as guide lines for replanning coroners' areas, a total of 500 or more deaths reported annually to the coroner is the minimum that should require appointment of a part-time coroner, and a total of 1,500 or more deaths per year reported to the coroner is the lowest that should justify appointment of a whole-time coroner. Applying all these criteria and considerations we found that there was scope for a substantial reduction in the number of coroners' areas and a significant increase in the number of whole-time coroners, particularly if care were taken to make the boundaries of coroners' areas coincident, where they converged, with the boundaries of top-tier local authorities rather than with subordinate districts.

20.19 How is this potential for change, which nearly all our witnesses acknowledged and welcomed, to be best realised? Change of this kind cannot be planned without an adequate survey of local needs and conditions and agreement on pace. For these and other reasons it has been entirely outside our own competence to make a detailed plan. But we have been led by our studies to see that there is a major issue of public policy involved in the re-organisation of jurisdictions. The problem before the Wright Committee was the need to rationalise jurisdictions in a relatively static situation, the coroners' functions as well as local government structure remaining unchanged. Our problem is quite different. The general effect of our recommendations is to alter significantly the role of the coroner, by accelerating the present trend of his evolution into a principal agent in the certification of medical causes of death. At the same time the Government have proposed substantial reorganisation of the whole structure of local government, are considering changes in the pattern of local health services, and are implementing changes in the organisation of local social welfare services. Both the coroner and his context are changing; and whether or not our recommendations on the coroner's role in future are accepted in full two changes in prospect cannot fail to affect profoundly the present pattern of coroners' areas.

20.20 The most important single change will be the impending re-organisation of local government. The Government's decisions on a new structure of local government in England and Wales are due to take effect on 1st April 1974.

They involve the disappearance of all the existing councils of counties, county boroughs and boroughs (i.e. the authorities which, under the existing law, have a duty to appoint coroners). It follows that if separate provision for coroners is not made in the Bill to give legislative effect to these decisions there will no longer be a coroners' service after that date. It would be in line with our desire for larger jurisdictions to recommend that provision should be made in the Local Government Bill for coroners in England and Wales outside the Metropolitan areas to be appointed by the new county authorities and in the Metropolitan areas by the councils of the new Metropolitan areas.

20.21 The second important change is the proposed re-organisation of the National Health Service with the creation of new local health authorities linked closely with the new major units of local government. The effect of such a development will be to reinforce the present momentum towards more efficient operational groupings for the provision of local services in which larger areas are controlled by vigorous and responsible local bodies.

20.22 We do not think that it would be in the interest of the coroners' system for it to undergo, as a whole, a series of transitional changes in structure in step with changes in local government and the National Health Service. We have therefore looked for a permanent solution to the difficult problem of determining coroners' areas. We are satisfied that it would not be sufficient simply to recommend that the new major authorities should be responsible for appointing coroners, even if the legislation were to allow for combination of county areas for certain functions as contemplated in paragraph 30 of the Government's White Paper on the Reform of Local Government. Some external scrutiny will be necessary if the pattern of coroners' areas is to be properly co-ordinated in its new local government setting. Our own studies have shown how heavily dependent any central planning would have to be on local guidance and expertise. The question we have considered is how best to arrange a partnership in planning between local authorities and central government so that needs can be adequately surveyed, standards set and provision made.

20.23 The solution which we recommend is as follows. In future the new county and metropolitan authorities should be statutorily required to submit for approval by the Home Secretary proposals for the organisation of a coroner service in their area based on the scales suggested in paragraph 20.18 and giving detailed reasons to justify the creation of any part-time coroners' districts. Before submitting any proposal for a part-time jurisdiction the authority concerned should be statutorily required to consult the authority for any area bordering on the proposed part-time jurisdiction with a view to enlarging that jurisdiction if possible to whole-time status by inter-authority adjustment of the coroners' district boundaries. The authorities should be under a statutory obligation to keep the distribution of coroners' districts under review and to consider any proposals made by the Home Secretary for alterations of districts; and to facilitate central oversight they should be statutorily obliged to send to the Home Office such information or reports on the work in individual coroners' districts as the Home Secretary may from time to time request. On the central government side, the Home Secretary should have power to approve or reject proposals submitted to him; power, after consultation with the local authority or local authorities affected, to

amend the proposals for coroners' districts and power to propose and impose alterations from time to time to any coroners' districts that seem to him to be unsatisfactory in size for the efficient working of the service. We envisage that the boundaries of jurisdictions would be largely determined by:

(*a*) the desirability of creating a whole-time jurisdiction;
(*b*) the distribution of population and mortality trends;
(*c*) communication and transport facilities;
(*d*) the likely mobility of the coroner and his staff;
(*e*) the availability of mortuary, pathological and other relevant services; and
(*f*) the accessibility of registrars of deaths.

20.24 The new powers should be used to secure a distribution of coroners to the best advantage of the service and to adjust that distribution to environmental, technical and other changes. We recommend that the statutory provisions should be formulated in such a way that, if at some future stage it were desired to deploy coroners more flexibly than by static jurisdictions, e.g. by creating panels of coroners for special enquiries wherever they might occur or by giving hard-pressed coroners temporary reinforcement by coroners from other areas, these possibilities would not be frustrated.

Appointment of coroners

20.25 Except for the few remaining franchise coronerships, coroners are appointed by local authorities. Every coroner is required to appoint a deputy coroner and may appoint assistant deputy coroners. These appointments must be made with the approval of the local authority which appoints the coroner. Once appointed a county coroner cannot be dismissed by his authority; a borough coroner can probably be dismissed by his local authority for misbehaviour because he holds office during " good behaviour "[1] (no such dismissal is known to the Home Office within the last 30 years). Where a coroner is found guilty of extortion, corruption or misbehaviour in the discharge of his duty, the court by whom he is convicted may remove him from office.[2]

20.26 The Lord Chancellor (or in the Duchy of Lancaster, the Chancellor of the Duchy) may, if he thinks fit, remove any coroner from his office for inability or misbehaviour in the discharge of his duties.[3] These powers are in practice extremely limited. In exercising them the Lord Chancellor acts judicially, that is to say, he acts only after he has heard evidence from those who are applying for the coroner to be removed from office and from the coroner as to the reason why he should be removed. There is no set procedure under which such evidence is collected and it is contrary to the traditions of English law that the same authority should both collect and present the evidence and then adjudicate upon it. The Lord Chancellor takes the view that he should not appear to act as both prosecutor and judge.

20.27 The Lord Chancellor's powers are limited because the law does not allow him to act where the coroner's misconduct does not relate to his office. Two examples (neither of them relating to recent events) will illustrate the

[1] Section 171 (2), Municipal Corporations Act 1882.
[2] Section 8 (2), Coroners Act 1887.
[3] Section 8 (1), Coroners Act 1887.

difficulties of this situation. In one case, the Lord Chancellor was told that a coroner who was also a solicitor had been found guilty by a Disciplinary Committee of the Law Society of having used clients' money for his own purposes but, because this misbehaviour did not relate to the conduct of his duties as a coroner, the Lord Chancellor had no power to remove him. In another case, the Lord Chancellor was reliably informed that a coroner was an alcoholic and mentally ill, but he was unable to act in the absence of proof of inability or misbehaviour on the part of the coroner in the conduct of his office.

20.28 The situation therefore is that one authority is responsible for appointing and paying the coroner, and another is responsible, within narrow limits, for control over his subsequent actions. Perhaps because the office of coroner is recognisably unique and the total numbers involved are very small this anomaly has not received critical attention in the past; the Departmental Committee of 1936 did not mention it. Historically the separation of responsibility appears to be rooted in the origin of the coroner as a locally appointed official with central government functions but it also reflects his position as an independent judicial officer (Chapter 10). Separation of responsibility has become more formalised in the past hundred years, not, so far as we can discover, because it was thought to be preferable to any other form of arrangement, but because central and local government have become more elaborate in structure and organisation. We believe that divided responsibility is seldom an aid to an efficient service, but we do see some advantages in the present arrangement. Local responsibility for appointment means that local factors can be taken into account in finding the right man. Central responsibility for dismissal means that the coroner is protected against the risk of local pressure in the proper performance of his office.

20.29 Our witnesses made very clear to us that the machinery for terminating the service of an unsatisfactory coroner required reform. They also recognised that the processes of selection and dismissal were not isolated technicalities but important elements in the organisation of the service for its increased responsibilities. The importance of these processes is all the greater because, as we have recognised, the future system must inevitably include a number of part-time coroners with the attendant disadvantages to which the Wright Committee drew attention. Full- and part-time coroners cannot be satisfactorily deployed in a common system without high standards of recruitment and coordination of performance.

20.30 We have already stressed (in paragraph 20.05) the strong community interest in the local coroner and we entirely accept that this must be taken into account in the process of appointing coroners. Local responsibility for appointment and local responsibility for determining the area of jurisdiction have gone naturally together. It was easy for us to understand why the Coroners Society and the County Councils Association suggested that the traditional arrangements should be maintained. Most of our witnesses, however, were in favour of placing responsibility for appointment as well as for dismissal of coroners in the hands of central government. They did not appear to expect that this might be damaging to the independence of the coroner or to the important local interest in him to which we have referred.

We concur with their general view. In face of the evidence we received about recruitment we do not think it would be to the general advantage to retain local government responsibility for appointment of coroners. What is wanted—as with the parallel problem of determining coroners' areas (paragraph 20.22)—is a partnership between local and general government. One approach might be to make local authority appointments contingent on the prior approval of the Lord Chancellor. Another might be for the Lord Chancellor to make appointments after appropriate consultations with local authorities. We recommend the second for several reasons. It should give a better assurance of uniform standards in selection. It should provide a better basis than exists now for a national salary structure for coroners and indirectly encourage recruitment. It would secure that the power of appointment lies with the authority having the power of removal.

20.31 The Lord Chancellor is already responsible for many appointments of legally qualified persons to public duty of a judicial character, and he is well placed to select for appointment as coroners persons who, as we recommend in paragraph 20.41 below, should have minimum legal qualifications and experience. It would be inappropriate that his power of appointment should be fettered by any *statutory* requirement to consult particular individuals or authorities, but we assume that before making any appointment he would consult the Home Secretary, local authorities and such other presons as he might think fit. As far as possible whole-time appointments should be to permanent and pensionable posts with entitlement to compensation in the event of abolition of office following re-organisation of the areas of jurisdiction. Part-time appointments should be made on a contractual basis for periods of, say five years at a time, renewable at the discretion of the Lord Chancellor. We recommend that the Lord Chancellor should also be responsible for the appointment of deputy coroners to whole-time posts. Appointments of deputy coroners to part-time posts and of assistant deputy coroners (who may be called upon in emergencies) should be made by the coroner with the approval of the Lord Chancellor.

Removal from office of centrally appointed coroners and deputy coroners

20.32 We see no advantage in the existence of the several powers of removal described in paragraphs 20.25 and 20.26 above and consider that it would be more satisfactory if the power of removal lay solely with the authority having the power of appointment. We recommend accordingly. We also recommend that the power should be exercisable only for incapacity or misbehaviour: this limitation will ensure that the independence of the coroner in the proper exercise of his duty is, and is seen to be, protected. Because, however, it would be inappropriate for the Lord Chancellor, acting judicially, both to investigate the grounds for removal and to adjudicate upon the issue, responsibility for investigation (which at present is not imposed on anyone) should be allocated to another Minister—most appropriately, we think, to the Home Secretary. It would be the Home Secretary's duty to arrange for the facts to be presented in the fairest and most suitable way to the Lord Chancellor.

20.33 As to the Lord Chancellor's present inability to act when a coroner's misconduct does not relate to his office, we recommend that the present limitations on his statutory powers be removed so as to permit him to remove a

coroner for *any* incapacity or misbehaviour, which in his judgment, renders the coroner unfit to continue in office. This would bring the Lord Chancellor's power to dismiss a coroner into line with the power to dismiss a Circuit Judge.[1]

CONDITIONS OF SERVICE AND SALARIES

20.34 At this point it will be convenient to mention several other matters closely related to the organisation of recruitment and to indicate our proposals for central government policy.

Qualifications for appointments

20.35 The existing law requires that a coroner should be " a barrister, solicitor, or legally qualified medical practitioner, of not less than five years standing in his profession ".[2] The great majority of coroners today (almost 90 per cent) are solicitors in private practice who hold the office of coroner in a part-time capacity. Of the 16 full-time coroners, on the other hand, four are solicitors, two are barristers, two have a medical qualification, and eight are qualified in both law and medicine.

20.36 We concur with those of our witnesses (including coroners themselves) who argue that too much emphasis can be placed upon formal qualifications to the exclusion of personal qualities. In their 1962 Memorandum on the Coroners System, the Coroner's society said:

> " Profound legal learning is not required, and the qualities of simplicity, sympathy, firmness and dignity are to be preferred to high academic distinction."

We agree that the man is more important than the qualification. In view, however, of the enhanced status and powers which we wish to see given to coroners, we think that it would be a retrograde step to abandon the principle of a minimum professional requirement.

20.37 There was no clear consensus of opinion among our witnesses as to what qualifications should be possessed by coroners. Some (including the Royal College of Physicians, the British Medical Association and the Association of Chief Police Officers) suggested that all coroners should in future be qualified in both law and medicine. In theory this might be the perfect arrangement, but there cannot be many medical practitioners who subsequently qualify as barristers or solicitors or who have qualified in medicine after first taking a legal qualification and we doubt if there would ever be enough to make such appointments possible in every case. Since we accept that a coroner should possess some professional qualification, that law and medicine are the two most appropriate, and that it is unlikely that it will be possible to demand both, we considered what choice should be made between the two.

20.38 In favour of the medically-qualified coroner it can be said that the largest part of the coroner's task consists in establishing the medical cause of death. If, as the result of the increased discretion for coroners which we propose in Chapter 14, the number of inquests is reduced, the proportion of coroners' work which is concerned primarily with questions of medical certifi-

[1] Courts Act 1971, section 17 (4).
[2] Section 1, Coroners (Amendment) Act 1926. Until 1926 the only qualification for appointment to the office was an unspecified holding of land in fee.

cation will increase still further. Every coroner needs to have some understanding of medical terms in order critically to examine medical certificates of the cause of death, to assess the reports of autopsies and to appreciate the significance of medical evidence at an inquest. A coroner qualified in medicine may be better able to discuss the details of cases with medical practitioners and this could be particularly important if our proposal is accepted that a coroner should still be able to dispose of a case without an autopsy even when no doctor has issued a medical certificate of the cause of death.

20.39 However, there are weighty arguments on the other side. A coroner takes his decisions judicially even when he is making enquiries outside the formal context of an inquest. He has to decide between the competing claims of society for information and of relatives for privacy. He must be able to assess the value of diverse and sometimes conflicting evidence. For these tasks we have no doubt that legal rather than medical training provides the better qualification because of the attitudes towards evidence and the performance of judicial and administrative responsibilities which legal training ordinarily inculcates. A coroner who is a lawyer is more likely to command the confidence of the public by virtue of his independence from the medical profession, on whose evidence he will so often have to rely.

20.40 Some of the argument which at first appears to favour a medically-qualified coroner has, in fact, a reverse thrust. The medically-qualified coroner may be credited by the public, if not by himself, with a detailed and up-to-date knowledge of developments in many fields of specialised medicine which he does not possess. A coroner whose training has been in the law is the more likely to rely on expert medical evidence if this is made available to him and to elicit statements from medical witnesses in a form which is comprehensible to the public.

20.41 Our conclusion is the same as that reached by the Departmental Committee on Coroners in 1936, i.e. that possession of a legal rather than a medical qualification is to be preferred. Accordingly, we recommend that only barristers or solicitors of at least five years' standing in their profession should be eligible for future appointment as coroners, deputy coroners and assistant coroners. In order to preserve flexibility for the future, this new qualification should be prescribed by regulation rather than by statute.

20.42 It is desirable that before appointment to a full-time post a coroner should have had previous experience as a deputy or assistant coroner, but there should be no absolute bar to the appointment of a coroner who appears to the Lord Chancellor to be sufficiently qualified in other respects to compensate for lack of previous experience.

Residential requirements

20.43 Under the existing law, coroners who are appointed to county jurisdictions are required[1] to reside within the district to which they are assigned, or within two miles of it. We understand why this provision was

[1] Section 5, Coroners Act 1884 (there is no decided view as to whether this provision applies also to deputy coroners).

once considered necessary, but improved facilities for communication since 1884 have removed any justification for a residence requirement. We recommend, therefore, that this be abolished. Instead, it should be a condition of appointment that a coroner, or in his absence his deputy or his assistant, should be readily available at all times to undertake coroners' duties.

Retirement

20.44 There is no statutory retiring age for coroners and there are examples of coroners continuing to serve well after their 80th birthday. However, if a coroner belongs to a local authority pension scheme and he has served in one office for fifteen years and attained the age of 65, he must vacate his office if he is called upon to do so by the local authority from which he receives his salary.[1]

20.45 We consider it undesirable that coroners should, in practice, be able to postpone their retirement indefinitely, but because any age limit can only be an arbitrary one we found it difficult to suggest what the upper limit should be. The office of coroner is at present unlike any other in the fabric of English life and there is no other office which suggests itself as a useful guide in determining a sensible retiring age. In the end we thought it sensible to be guided in part by the rules applicable to National Health Service appointments and in part by the rules applicable to members of the lower judiciary. Accordingly we recommend that unless special circumstances necessitate an earlier retirement, a coroner should normally retire at the age of 65, but that the Lord Chancellor should have power to extend the coroner's tenure of office annually in appropriate cases up to the age of 72. These conditions should also apply to deputy coroners and assistant deputy coroners.

Coroners' salaries

20.46 Coroners' salaries are paid by the local authority which appoints them. The sum is determined by agreement between the authority and the coroner, but either may appeal against the suggested revision of the salary to the Home Secretary, who has power to fix the salary at such rate as he thinks proper.[2] Since 1967, most part-time coroners have been paid in accordance with a national agreement reached between the local authority associations and the Coroners' Society of England and Wales, which establishes a scale of salary according to the number of deaths reported and provides for an addition of 10 per cent for rural areas to cover the extra cost of travelling. The current scale of recommended salaries for part-time coroners runs from £384 per annum in areas where 100 deaths are reported to £3,231 where the coroner has upwards of 1,700 deaths reported to him. The seven whole-time London coroners each receive £5,500 per annum, although the number of deaths reported to them is from about 3,000 to upwards of 4,500. In addition, nearly all coroners receive a sum of money for expenses, out of which sum they pay their deputies and assistant deputies.

20.47 If our proposals for rationalising coroners' areas are accepted, there should be many more whole-time coroners posts and the machinery for altering

[1] See section 6, Coroners (Amendment) Act 1926.
[2] Section 5, Coroners (Amendment) Act 1926.

the boundaries of their areas should be more responsive to altered circumstances. Both of these developments should make it easier to create and maintain a uniform structure of salaries. We understand that, at present, it is usual for the salary of a whole-time coroner to be related to the salary of the third grade in a major department of a local authority, e.g. assistant chief education officer. But this does not produce uniformity of salary, since the same titular appointment may carry a different salary according to the size of the local authority area. Thus, whole-time coroners' salaries at present range from £2,900 in the smallest county borough to £5,500 in Greater London.

20.48 If our recommendations aimed at giving coroners more discretion to choose the form of their enquiry and greater flexibility of approach during these enquiries are to be satisfactorily implemented, men (or women) of high calibre will be required and the salary level must be one that will attract and retain such people. This is another reason why we favour a uniform salary structure for whole-time coroners. We therefore recommend that whole-time coroners should be paid standard salaries and we suggest that an appropriate analogy to follow might be the salary of a stipendiary magistrate.

20.49 As regards the salaries of part-time coroners, we can see no alternative to the use of a work-load citerion, along the lines of that used at present by the local authority associations in their negotiations with the Coroners Society of England and Wales.

CHAPTER 21

SUPPORTING SERVICES FOR CORONERS

A. STAFF

THE CORONER'S OFFICER

21.01 In many areas the coroner's only help comes from his " officer ". The duties of a coroner's officer are old, important and obscure. He is the descendant of the parish constable who, from the end of the mediaeval period until about the middle of the last century, assisted the coroner by informing him of sudden deaths, carrying out preliminary enquiries and making arrangements for the inquest. When the parish constable disappeared, coroners commonly appointed officers of their own; but in recent years, the post has generally been filled by serving police officers seconded for duty with the coroner. Police officers have been serving as coroners' officers since the inception of police forces in the nineteenth century.

Use of serving policemen

21.02 The importance of the post of coroner's officer was well understood by the Select Committee on Death Certification, which reported in 1893. The Committee's remarks have a surprising topicality. They said:

> " The preliminary enquiries in a case referred to a coroner are usually made by his officer, who frequently is a parish beadle or police officer. In practice it is not unusual for it to be left to this official to decide after his own personal inquiries in the matter, whether an inquest is necessary. He also, in some cases, has the selection of the witnesses to be called, and it sometimes happens that a coroner does not know what witnesses are coming before him until they are called. It may be doubted whether this important part of the work connected with a coroner's inquiry should be entrusted to an official who cannot be expected to possess the requisite qualifications for its proper performance. "[1]

By 1910, when a Departmental Committee on Coroners published its report[2] a coroner's officer was nearly always either a serving police officer or a police pensioner. The Committee recommended that serving rather than retired police officers should be employed on this duty, justifying this view partly on the practical ground that it was easier for the coroner to exercise discipline over a man who could be punished by another authority for carelessness or misconduct and whose pension was at stake as well as his post. Similarly, the Wright Committee,[3] which made no attempt to explore the role of the coroner's officer in depth, felt able to comment in its report of 1936 that " the present system of serving police officers acting as coroners' officers . . . appears to us to work very well, and to have considerable advantage over

[1] Second Report from the Select Committee on Death Certification, House of Commons, page viii.
[2] Second Report of the Departmental Committee on Coroners. Cd. 5004 (1910).
[3] Report of the Departmental Committee on Coroners 1936, Cmnd. 5070.

any other arrangement." The Committee's Report contains no indication that any other arrangement was considered. Conscious of a long-standing and general ignorance of the duties and influence of the coroner's officer, we asked the Organisation and Methods Branch of the Home Office to make a study on our behalf of the work done by coroners' officers and their methods of operation in various parts of the country. Their report, which covered eight cities and boroughs in addition to London, together with seven country jurisdictions, was not prepared with a view to publication, but we have included in the annex to this chapter our own summary of the situation which it revealed.

21.03 We found diversity of view about the involvement of the police in this work. Coroners are strongly in favour of continuation of the present arrangement; and in their evidence to us placed particular emphasis on the need for a close association with the police force and access to their scientific departments. Other witnesses with an interest in the "detection of crime" aspect of the coroner's work, stressed the value of the attendance at the scene of death of an officer who might have some detective experience. On the other hand medical staff in some hospitals made known to us their concern that routine investigations by police officers acting as coroners' officers into deaths in hospital which *prima facie* did not appear in any way to be unusual or suspicious had disrupted the work of large sections of the hospital staff. The Commissioner of Police put to us in evidence the view he had been pressing on the Home Office for several years past, namely that it is most undesirable for active police officers to be tied down to duty[1] as coroners' officers.

The case for change

21.04 It is clear that there are considerable advantages to coroners in the existing arrangements. Generally, it may be said that the coroner has the services of a man who is conveniently subject to the disciplinary sanctions of another service, who possesses stipulated standards of physical fitness and intelligence, who is accustomed to irregular hours of duty and work which not everyone would find agreeable, who has been trained to exercise initiative and who has a close link with the whole resources of the local police force. In some areas indeed, the coroner's officer relieves the coroner of all his duties save those of actually making the decision on the final disposal of each case as it is presented to him and of holding an inquest where this is necessary.

21.05 We can appreciate the reasons why many coroners place so much reliance on their officers. It is to the general convenience of coroners, police and public that the officer, rather than the coroner, should be the first point of reference when a death is reported for investigation; and it is a natural consequence that the officer should be involved in all the successive aspects of the coroner's enquiries. It would not, however, be right for coroners to allow these considerations of convenience to erode their own personal and positive control of the decisions and acts for which in law they are solely responsible. The Home Office O and M Survey left us in no doubt that a number of

[1] Over 50 police officers are regularly employed full-time on coroner's officer duties in the Greater London area.

coroners have delegated so much responsibility that they cannot exercise close supervision of the detailed stages of the case demanding fuller enquiry than usual. It is particularly unsatisfactory that many coroners do not themselves discuss the details of reported cases with the doctors concerned, or consult with and advise relatives.

21.06 The coroner's officer occupies the position of general factotum in the coroner service. As we make clear in various parts of this Report, this service has undergone a marked change of emphasis in this century, away from its former concentration on crime towards a wider medical and social function. Consequently, the coroner's officer now finds himself much less involved with his original function of investigating sudden deaths from the viewpoint of possible homicide and much more concerned with tasks which *prima facie* appear to have little connection with what is generally understood to be police work. In particular, it is often the police officer serving as coroner's officer who has the responsibility of co-ordinating the specialist services upon which the coroner's enquiries now depend. It is a tribute to the modern training and personal qualities of police officers that many have been able to adapt themselves to the altered range of duties of coroners' officers.

21.07 But for all the many conveniences (to the public as well as to coroners) which flow from these appointments we think that the use of police officers as coroners' officers is a misuse of trained police manpower. The report of the Working Party on Police Manpower, which was presented in 1966 to the Police Advisory Board, recommended that police officers should:

> ' ordinarily undertake only those duties which require the combination of:
>
> (*a*) the special qualifications and personal qualities demanded on entry to the service;
>
> (*b*) the particular training provided within the police, with special emphasis on crime prevention and detection, and the maintenance of public order; and
>
> (*c*) the exercise of authority, i.e. police powers ".[1]

The post of coroner's officer, as it exists at present, may confidently be said to require the first of these attributes. It may, over a very narrow range of duties, possibly require the second; it certainly does not demand the third. It has been cogently argued in evidence to us that many tasks performed by the coroner and his officer have no real police interest and need not be performed by police officers. In view of the situation revealed by the Home Office O & M Report, we accept this argument.

21.08 If the service were being created today we very much doubt whether the police would be first choice for supplying coroners' officers. Much of the coroner's officer's work today is not appropriate for the police. We have in mind, in particular, such routine matters as the recording of medical histories, the discussion of clinical histories with doctors and the inspection of case

[1] Police Manpower, Equipment and Efficiency (Reports of Three Working Parties) London, HMSO, para. 60.

notes—matters for which a police officer has no particular aptitude and in which his uninformed involvement can be unproductive, troublesome to hospital staffs and unhelpful to coroners. In this context we were told that it is not unknown for doctors occasionally to omit material from their case notes deliberately in case it is misinterpreted by a coroner's officer.

21.09 Similarly, we are aware that some members of the public are aggrieved by the fact that it is a police officer who calls on them to take particulars of a death to which absolutely no suspicion attaches. Few coroners explain that their officer is acting as an assistant to them rather than as a police officer and, although in most areas a coroner's officer carries out his investigative functions in plain clothes, some coroners consider it entirely appropriate that their officers' visit should have the additional authority provided by a police uniform. Where the report of an autopsy performed for the coroner indicates that there is a straightforward medical explanation for the death and that no suspicion attaches to it, there should be no need for anyone to take a statement from the relatives and, certainly, no need for a visit from a police officer either in or out of uniform.

21.10 From the point of view of a chief officer of police the sole justification for employing a policeman as a coroner's officer would appear to lie in the possibility that he may notice features in an apparently innocent death which may be of police interest. But such a contingency is remote. The vast majority of " suspicious " deaths (including *prima facie* suicide cases and all road accident deaths) are reported directly to the police and investigated by the appropriate officers in the force. We doubt whether a policeman acting as coroner's officer is any more likely than a properly trained civilian working for a coroner to discover an unsuspected factor in a death which has been reported to the coroner by a doctor or informant but was not reported to the police immediately.

21.11 Our conclusion is that there are few duties of a coroner's officer which could not be effectively performed by properly trained civilian employees in the coroner's office and that there is no sufficient case for the continuation of the post in its present form. We therefore recommend that police officers should no longer serve in the capacity of coroner's officer.

21.12 We accept that an abrupt withdrawal of the services of the police officers who have hitherto been acting as coroner's officers would put coroners in a very difficult position. We envisage therefore, that police officers would be " phased out " gradually and we recommend that a chief officer of police should withdraw his man only after the closest consultation with the coroner, local authorities, hospital and, where appropriate, other bodies.

21.13 Subject to what we have to say later on about general responsibility for the provision of support for coroners, we propose that the coroner himself should continue to be responsible for recruiting staff for administrative work and help with investigation into the circumstances of deaths. This will remove any possibility of confusion about the independence of the coroner's staff (or, indirectly, about the independence of the coroner).

21.14 We recommend that every coroner should be provided with the services of a civilian coroner's officer and where necessary the services of a secretary. The functions of these two persons may to some extent overlap and, depending upon the size of the coroner's area and the number of deaths reported to him, it may be necessary for the coroner to employ one, two or more persons.

Administration

21.15 The new civilian coroner's officer should be responsible for such matters as collating medical and police reports; preparing cases for the coroner's decisions; arranging for the removal of bodies, for autopsies and for inquests; communicating with witnesses and relatives; paying expenses to witnesses; and liaison with the Press. The secretary's functions should include the normal range of office tasks, but might also extend to taking down particulars of deaths as they are reported, giving the simpler kind of advice to relatives and making enquiries of doctors on the coroner's behalf. It might also be possible to utilise the services of a coroner's secretary to provide an inquest transcript—the need for which is considered in Chapter 15 above.

" *Field enquiries* "

21.16 A coroner requires administrative (including clerical) assistance whenever a death is reported to him, e.g. in the recording of his enquiries, making arrangements for an autopsy and preparing the papers which he will send out at the close of his enquiries; but it is not always necessary for detailed " field enquiries " to be made.

21.17 At present, most deaths reported to the coroner (about 80 per cent in 1969) are dealt with without inquests by means of the Pink Form[1] procedure. In most of the whole-time jurisdictions (and in some other areas as well), a coroner's officer makes a brief visit to the relatives, but it is unusual for detailed enquiries to be made into the circumstantial, as opposed to the medical, cause of death. On the other hand, it is usual for a coroner to obtain some information about the deceased person's medical history for the information of the pathologist who carries out the autopsy on his behalf. This information is obtained either from the deceased person's general practitioner or from a hospital doctor (and sometimes from both sources). The necessary information can often be provided on the telephone and it is only rarely necessary for a member of the coroner's staff to visit the hospital or the general practitioner's surgery.

21.18 In consequence of our recommendations in Part I of this Report, the need for " field " visits should be still further diminished in the future. In Chapter 6, we have recommended that doctors should be under a statutory obligation to report certain deaths to the coroner and that, whenever possible, an initial telephone report should be supplemented by a written notification. In Chapter 7, we have also proposed that a new form of certificate of the fact and cause of death should be used by doctors both for notifying a death to the registrar and for reporting it to the coroner (see Figure 2). When

[1] See paragraph 14.02 above.

completed by a doctor this certificate would contain much of the information basic to the coroner's enquiry and where he required more information than was supplied to him in this way it should be possible for him to telephone the doctor concerned or, in suitable cases, for his secretary to ask the doctor for additional information.

21.19 It follows that for the great majority of all cases reported to him, it would be possible for the coroner to investigate the death without the need to send one of his staff " into the field " to enquire into the circumstances and to take statements. But there would remain a need for this type of investigation in some cases. Even now it is necessary for statements to be taken sometimes in " non-inquest " cases in order to establish that an inquest is unnecessary and if, as we propose in Chapter 14 a coroner has a much greater discretion to decide whether or not he should proceed to an inquest when a death was reported to him, it is likely that there would be an increased need for statements to be taken in a number of " non-inquest " cases. Some of these deaths into which the coroner would be enquiring would also be the subject of investigation by the police and, where this was the case, the coroner's needs should be met if the statements given to the police which were also relevant to his own enquiries were made available to him. In the minority of cases in which the police have no direct interest but in which it would be desirable that the circumstances should be investigated to the extent of taking statements from witnesses to establish how or why the death occurred, we suggest that the task of taking statements should fall to the new civilian coroner's officer. We should like to see coroners appointing to these posts men (or women) of the calibre of a good solicitor's clerk; such persons are accustomed to taking statements for a variety of purposes.

Police assistance

21.20 By recommending an end to the employment of police officers as full-time coroners' officers, we do not intend to suggest that coroners should be inhibited from asking for the assistance of the police in the investigation of any unusual death whenever they feel that this would be appropriate. The working relationship between a coroner and his local police force is likely to remain close because of the necessary interest of the police in a substantial minority of the deaths reported to a coroner. The police will always have an interest in deaths from accidental violence, and if the accident is a major one, e.g. a rail or flying accident, the police are likely to be in charge of the investigation. If the total demand from coroners for police assistance is reduced (and this should be the effect of our proposals), chief officers of police should be willing to make available for the coroner an officer with the rank and experience commensurate with the difficulty of the particular investigation.

Other forms of assistance

21.21 Nor is assistance from the police the only kind of specialist assistance which a coroner may need for the effective carrying out of his functions. There are situations in which a coroner's enquiries may be materially helped by the information provided for him by a local authority social work department or by the welfare department of a hospital. In those cases in which the social work department already has contact with the family of someone

into whose death the coroner is enquiring we believe that it would be entirely appropriate for him to ask to be informed of any relevant information known to that Department. As the coroner's work becomes more and more medico-social in character the need for close liaison with other agencies working in this field will become more and more apparent and we hope that coroners will not be slow to ask for information from these sources whenever they feel that this would be appropriate. Indeed, the fact that a substantial minority of deaths reported to coroners are deaths that may be ascribable to social breakdown in one form or another leads us to believe that there may be advantage (particularly in the larger urban areas) in the coroner having on his staff someone who is trained or experienced in social work who could, where appropriate, conduct field enquiries and, if necessary, take statements.

B. ACCOMMODATION

Office

21.22 At present, the responsibility for providing office accommodation for coroners varies throughout the country. Most full-time coroners are provided with permanent office accommodation by the authorities who appointed them; on the other hand, part-time coroners often use their own private accommodation, in some cases without any financial contribution from their authorities for this purpose. Our impression is that the general standard of provision is not high. A number of organisations laid stress on the need for adequate accommodation not only for the coroner, his officer and other staff, but also for interviews, public waiting, and storage of documents. Several suggested that administrative offices, court premises, post-mortem facilities and the offices of the registrar of deaths should be associated in a single complex.

Courtroom

21.23 The cost of providing this accommodation is at present met by local authorities. The place where an inquest is to be held rests in the discretion of the coroner and the quality of the accommodation used varies considerably. In London, the Greater London Council is obliged by statute to " provide and maintain proper accommodation for the holding of inquests ", but no similar obligation rests on local authorities in other parts of the country. In most districts, where there is no regular courtroom available, it is usual for a coroner to use a magistrates' court, council office, or a room in some public institution or even in a private house (if this is convenient to everyone concerned). Payment for the use of such premises, if necessary, is made by the coroner, who is then reimbursed by his local authority.[1] In choosing the place in which he will hold an inquest, a coroner has to balance the possible inconvenience to himself, to bereaved relatives and to witnesses. Many coroners are prepared to travel to different areas within their jurisdiction if this is to the convenience of the other persons involved in the investigation of a death. We were told that it is not unusual

[1] Under section 25 of the Coroners Act 1887 a local authority may include provision for such payments in the Schedule of Fees and Disbursements which that section empowers them to make.

in a large rural area for a coroner to use as many as 15 different places in the course of as many weeks.

21.24 One of the advantages claimed for the present arrangements is their flexibility, but it seemed to us from the evidence that there are in practice serious limitations to what a busy full- or part-time coroner can achieve in securing good office or court accommodation, whether on his own initiative or by representations to the local authority. Except in large conurbations there is little incentive to establish permanent and adequate office and other facilities. It is unsatisfactory that, occupying as he does a pivotal position between the public, the police, the medical profession and scientific services, the coroner should have to cope often single-handed with problems of his own administration and other facilities. The present situation should be changed.

C. CENTRAL GOVERNMENT RESPONSIBILITY

21.25 As we mentioned in the preceding chapter (paragraph 20.6 above), the physical needs of the coroners' service are relatively small. Their scale indeed invites improvisation with all its defects and disadvantages. We want to secure a better standard of provision in future based on a sensible use of existing resources and planned extensions where they are needed. We therefore propose a framework of responsibility on the following lines. The Home Secretary should be placed under a statutory duty to secure the provision of make available suitable and sufficient staff and accommodation for the performance by coroners of their statutory functions (including the holding of inquests). In carrying out this duty the Home Secretary should be statutorily empowered to make arrangements with other persons to act as his agents and to pay for expenditure incurred by them as his agents. This would allow the Home Secretary discretion, as seemed to him best, to authorise coroners to recruit certain groups of staff, or local authorities to provide staff, office and other accommodation or to come to some arrangement with those responsible, under the Courts Act 1971,[1] for the provision of staff and accommodation for the Higher Courts. In the case of staff, this would be the new administrative court service and in the case of office and court accommodation the Department of the Environment (formerly the Ministry of Public Building and Works). We envisage that there would be a procedure for any of these agents to make known their estimated financial requirements to the Home Office; and we would expect the Home Office to keep under review general and particular standards of facilities provided and to encourage improvements where necessary.

[1] See in particular sections 27 and 28.

ANNEX TO CHAPTER 21

THE WORK AND METHODS OF CORONERS' OFFICERS

A summary account based on a survey made by the Organisation and Methods Branch of the Home Office (1967)

Appointment

1. Although retired policemen and other civilians are occasionally employed in this duty, the overwhelming majority of coroners' officers are serving policemen, seconded for a period to assist the coroner. In London, the Home Counties and many large provincial towns, one or more police officers may be employed full-time in the post. In one or two cities, the coroner has the full-time assistance of a number of men, including quite senior officers, who comprise what might almost be described as a private police force. Elsewhere, the arrangements vary: an officer may combine the work of coroner's officer with other police duties (e.g. serving warrants) or, as happens frequently in rural jurisdictions, the police officer who is originally called to the scene of the death may act as a temporary coroner's officer for the duration of the particular enquiry.

Control

2. The formal position of the police officer seconded for duty with the coroner is a curious one. As a member of a police force, he is nominally subject to the direction and control of his Chief Constable, who, since the passing of the Police Act 1964, also bears in law the vicarious responsibility for his wrongful acts. The coroner's officer enjoys the same conditions of pay, discipline and nominal hours of duty as his police colleagues; he is often attached to his force for the purposes of reporting each day for duty and may in fact occupy the same rooms as his police colleagues. Nevertheless, insofar as he acts as the representative of the coroner, it is the coroner who is really responsible for his actions and who is in effective control of his working day. We are not aware that this ambiguity of role has given rise to any difficulties, but it is not difficult to envisage the kind of problems that could arise. For example, it is difficult to determine whether the coroner or the Chief Constable should bear the actual, as distinct from the legal, responsibility for a complaint against the actions of a coroner's officer, especially if he has been conducting enquiries on behalf of the police and the coroner simultaneously.

General Duties

3. In most districts, nearly all initial reports and enquiries, whether from doctors, hospitals, registrars of death or the police, are received by the coroner's officer and not by the coroner himself, although he may sometimes be available to speak direct if required. Only where there is no permanent coroner's officer is it the usual practice for reports and inquiries to be received at the coroner's own office or, more rarely, at his home. It is usual for the initial record of the particulars of a death to be kept for the use of the police as well as the coroner, especially where the coroner's officer works in the local police headquarters.

4. An important difference in the method of working of individual coroners' officers lies in the extent to which the enquiry for the coroner and certain parts of the follow-up action are undertaken by the local police rather than the coroner's officer. Often, it is the police officer on beat patrol who visits the scene of death, investigates the circumstances, obtains statements and passes on the details to the coroner's officer. In effect the beat policeman relieves the coroner's officer of the initial investigation. Elsewhere, especially in the towns, the coroner's officer makes

less use of the beat police and himself undertakes the investigation. Even in the towns, however, it is still usual for the beat police to take the preliminary action when the coroner's officer is off duty.

5. Although the degree of discretion given to coroners' officers can vary widely, in general coroners do not expect to be continually consulted; they rely on their officers, as experienced and responsible members of the police force, to make all necessary inquiries into reports of sudden deaths and to submit a well-prepared case for final decision. It seems that most officers visit their coroner (or telephone if they are widely separated) at least once each day, when they keep him informed of the progress of current cases and seek guidance and instructions where necessary. However, most coroners do not expect to see anything in writing about a case at least until a decision is required about its disposal, i.e. a decision as to whether a Pink Form A or B should be issued or whether an inquest should be held. Supplies of pink forms are normally held in the coroner's office, to be released individually to his officer for use in a particular case, but in some jurisdictions the coroners' officers hold a supply of blank pink forms which may even be already signed, and which they complete on the verbal authorisation of the coroner.

Removal of the body

6. It is usually the coroner's officer who decides that a body should be removed to the mortuary and who arranges the removal, although this function may be performed by the local police when the coroner's officer is off duty and the body cannot remain where it is until morning. Sometimes the local authority has a standing arrangement with a single firm of undertakers who contract to do this work, usually on the basis of a tender which is revised annually. More often an undertaker is selected by the coroner's officer himself for each individual case, perhaps after checking whether the relatives have any preferences. Occasionally a body may be removed in an ambulance or even in a police van. Where the mortuary to which the body is removed is in a detached building, which has no staff, or is owned by the police authority itself, or is situated in a hospital where there is no mortuary attendant available to deal with coroners' cases, the coroner's officer or beat officer has to be there to admit the body and put it into the refrigerator. It is normal for the officer to examine the body and to be responsible for the custody of the clothing and the property. Sometimes when a statement of identification has not been obtained prior to the removal of the body to the mortuary, the coroner's officer may be involved in the cleaning of a body to make it presentable for identification and may occasionally help to remove it to the mortuary chapel for this purpose.

Autopsies

7. Most coroners do not see the case papers before an autopsy is carried out; they rely on their officers to give them an adequate verbal account of the relevant details. But very often such an account is only given after the autopsy has been performed. The extent to which the coroner's authorisation may be regarded as a mere formality or a real decision depends largely on the individual habits of the coroner concerned, which may often be deduced from his general approach to the question of autopsies. Where it is the coroner's general policy to order an autopsy in virtually every case it would be wrong to criticise the coroner's officer for assuming that the coroner's approval would be forthcoming and making arrangements accordingly. It seems that in districts which have no permanent coroner's officer, it is the rule for the police to obtain the prior and express authorisation of the coroner in every case, but there is no doubt that in other areas it is, in effect, the coroner's officer who decides whether or not an autopsy should be performed. Where this happens the coroner is normally informed before the autopsy is performed, but there are some areas in which he is not usually given prior indication

unless the coroner's officer believes that the case has a suspicious or criminal element, or that it is so simple that it may be disposed of without autopsy by the issue of a Pink Form A.

8. The arrangements for the autopsy are usually made by the coroner's officer. The pathologist is sometimes selected by the coroner for the particular case and sometimes works on a rota basis with other pathologists in the district. When he telephones the pathologist to arrange the time and date of the autopsy, the officer usually relates to him preliminary information about the circumstances of the death.

9. The practice of coroners' officers with regard to attendance at autopsies varies widely. In the large towns, they normally attend only if the case has a possible criminal element; elsewhere it is customary for them to attend every autopsy with an exception sometimes in the case of deaths which have occurred in hospital. Some officers merely identify the body to the pathologist and then leave. Others remain throughout in order to be able to supplement, if necessary, the information which they may already have given to the pathologist. In country districts, up to 4 hours may be spent in travelling to and from a mortuary and in attending the whole of the autopsy.

10. Some coroners' officers give active assistance to the pathologist in performing the autopsy, especially if it takes place in an unstaffed public mortuary. The officer may assist the pathologist by removing the body from the refrigerator, providing hot water, writing notes for the pathologist and even participating in the actual physical examination.

Inquests

11. When the pathologist's report is received, or, as often happens, the coroner's officer is told the cause of death by the pathologist in advance of receiving the full report, the officer normally submits the case to the coroner for his decision as to whether the case may be disposed of by means of the Pink Form B procedure. In some districts the coroner's officer may go ahead on his own initiative with arrangements for an inquest in appropriate cases and merely hand the case papers to the coroner immediately before it commences. The more normal practice is for the officer to discuss with the coroner beforehand which witnesses should be called and in what sequence. Where a jury is required the coroner's officer normally takes responsibility for summoning the jurors.

12. It appears to be the universal practice for the coroner's officer to attend the inquest, accompanied on occasion by a more senior officer. His functions, at least where there is no court usher, are to supervise the inquest generally in the sense of marshalling the witnesses and of keeping order; to administer the oath to the witnesses and jury if there is one; to fill in as much as possible of the inquisition and the form of certificate after inquest; and afterwards, to obtain the signature of the jurors on the inquisition and to pay the expenses of the jurors and witnesses. Some coroners, however, prefer to administer the oaths themselves and in some jurisdictions the payment of witnesses and jurors may be performed by a representative of the local authority who attends the inquest for that purpose. It is the usual practice for the coroner's officer to make up a copy of the case papers for retention by the police as well as by the coroner.

Liaison between the police and the coroner

13. In cases of suspected or known murder, manslaughter or infanticide there is always an effective liaison between permanent coroners' officers and the Criminal

Investigation Department of the police. If the coroner's officer has his desk in the C.I.D. office, he notifies his senior officer as soon as any report reaches him about a death which seems to be suspicious, including all deaths involving poison, drugs or gas, and he may be accompanied to the scene by another officer, often a detective. In addition, the coroner's officer may assist the detective officers at the scene by carrying out such duties as arranging for the fact of death to be established by a doctor. It is unusual for the coroner's officer to become a part either of the chain of identification or of the investigating team in criminal cases, since this would involve his subsequently spending a considerable time in court.

14. All road traffic deaths, which in 1968 accounted for 24 per cent of all cases in which inquests were held, are investigated by the regular police. In these cases, it is unusual for the permanent coroner's officer to attend at the scene, but he will visit the relatives to make arrangements for the opening of an inquest. There is often a delay of some weeks before the coroner is informed whether proceedings are to be instituted under the Road Traffic Act or whether he can proceed with a full inquest.

Contact with relatives

15. Permanent coroners' officers spend a large proportion of their time in visiting relatives and other potential witnesses, in order to establish the identity of the deceased, obtain a case history and explain the coroner's procedure to them. It is usual for the coroner's officer to undertake this task even if the beat police undertook the preliminary enquiries. Where there is no permanent coroner's officer, the coroner's own office staff or the local police station deals with any enquiries from relatives.

Contact with the Press

16. It is generally the coroner's officer, or, if not, a more senior police officer, who deals with enquiries from the Press and responds to any request to be kept informed of inquest arrangements. Occasionally, the officer gives to the Press a copy of each time-table of inquests, with a list of the names of witnesses, at the same time as he gives it to the coroner. Where there is no permanent coroner's officer, the Press telephone or call at the coroner's office, usually each day, to see if there is any news.

PART V

PATHOLOGICAL AND RELATED SERVICES

CHAPTER 22

GENERAL ORGANISATION OF PATHOLOGICAL SERVICES AND EXISTING SUPPORT FOR CORONERS AND THE POLICE

Introduction

22.01 At present, autopsies are performed on the bodies of over one quarter of all persons who die in England and Wales and on a third of all persons who die in hospitals. In 1969, there were about 153,000 autopsies carried out in England and Wales, of which about 110,000 were requested by coroners. If effect is given to our recommendations for improving the law and practice in relation to the certification of the medical causes of death (see Part I), there will be an increase in the number of deaths reported to coroners. It is to be expected therefore that there will be a consequential increase in the number of autopsies performed for coroners and that there will be increasing demands on the services of pathologists and pathology departments. Before considering what, if anything, needs to be done to meet such demands, it will be convenient to look first at the existing organisation of pathology services.

Organisation of pathology

22.02 Pathology is the oldest, and in many respects the fundamental, branch of medical science; it has increased rapidly in importance and in complexity since the last war. No major hospital is now without its own Pathology Division or Department, and each has at least one consultant pathologist on its staff. Several have consultants in each of the four major sub-divisions of pathology, *viz*; morbid anatomy, chemical pathology, haematology and microbiology. The Department of Health and Social Security has supplied us with some figures (see Tables P and Q below) which illustrate both the growth of pathology as a specialty and the modern tendency towards increased specialisation within the pathology service.

22.03 Our expert witnesses were at one in emphasising that pathologists are heavily dependent upon good ancillary services, especially laboratories. Fortunately, these, too, have developed both in number and in the range of facilities which they can provide. There are few parts of the country in which it is now impossible for a detailed pathological examination to be carried out in a conveniently situated National Health Service hospital.[1] Hospital

[1] The policy of the Department of Health and the Welsh Office is now to concentrate pathology services into Area Laboratories attached to particular hospitals with only a minimum number of satellite laboratories in individual hospitals. Until Area Laboratories can be built, hospital authorities have been asked to re-organise their services on an area basis in as few laboratories as necessary (HM(70)50—August 1970).

TABLE P

Hospital Pathologists by Grade

Source: The Department of Health and Social Security

	Consultant	Senior Registrar	Registrar
1949–50	468	93	102
1960	(at 31/12/60) 725	(at 1/7/60) 69	(March 1960) 124
At 30th September 1966 ...	997	133	231
At 30th September 1968 ...	1,057	126	231
At 30th September 1970 ...	1,120	148	215

TABLE Q

Hospital Pathologists by Grade and Specialty 1966–1970

Source: The Department of Health and Social Security

	Consultant			Senior Registrar			Registrar		
	1966	1968	1970	1966	1968	1970	1966	1968	1970
General Pathology *	644	614	607	64	51	55	174	179	163
Morbid Anatomy and Histology	109	145	175	26	21	29	16	13	15
Chemical Pathology ...	54	66	77	19	18	10	12	8	13
Haematology	59	86	101	14	20	36	17	16	17
Blood Transfusion ...	25	24	27	1	2	—	1	5	3
Microbiology	106	122	133	9	14	18	11	10	4
TOTAL	997	1,057	1,120	133	126	148	231	231	215

* Most General Pathologists have received a basic training in Morbid Anatomy, but some now do most of their work in one of the other divisions of pathology.

pathologists and laboratory services are supported by reference laboratory services for specialised investigation. The Public Health Laboratory Service, for example, provides a country-wide service in bacteriology and virology; and an extensive range of specialist investigations can be conducted in university departments or in the Forensic Science Laboratories maintained by the Home Office.

22.04 The organisation of a pathology department varies according to whether it is located in a university (where it will have close links with a medical school and a teaching hospital) or in a non-teaching hospital responsible to a Regional Hospital Board.

22.05 A university medical school usually has a Division of Pathology, which is sub-divided into at least four departments:—

(i) Morbid anatomy, histopathology and cytology

(ii) Chemical pathology including toxicological, metabolic and endocrine analyses

(iii) Haematology and blood transfusion

(iv) Microbiology including virology.

It is not unusual for separate professorial chairs to be held by the heads of each of these departments and one of these professors may be designated as administrative " Chief of Division ". It is usual for university pathologists working in teaching hospitals (whether they are professors, readers, senior lecturers or lecturers) to hold honorary contracts with the National Health Service. These are in the consultant grade if the university teacher is in the senior lecturer grade or above. A university lecturer working in a teaching hospital has the honorary National Health Service grade of senior registrar. It is often the case in a teaching hospital that one or more of the divisions of pathology are staffed by pathologists who are employed by the National Health Service and hold honorary university rank in the appropriate grade of professor or lecturer. This mixture of reciprocal relationships results, on the whole, in a satisfactory unity of purpose in the provision of a service to patients, teaching and research.

22.06 In hospitals administered by Regional Hospital Boards (as distinct from the Board of Governors who are responsible for the teaching hospitals), pathology departments are staffed by consultants, medical assistants, senior registrars, registrars and senior house officers. In some hospitals, there is still a " consultant-in-administrative-charge " responsible for all the pathology in the hospital or hospital group, but it is more usual for every consultant to act, in effect, as his own head of department. Large non-teaching hospitals have consultants in the four major specialties or sub-divisions (see paragraph 22.05 above). Where there is more than one consultant in any field, each is the equal of the other in clinical matters.

22.07 Consultant pathologists in the National Health Service, whether they work in teaching or non-teaching hospitals, may be in whole-time or part-time posts. Time spent working in hospitals is calculated on a sessional basis—usually with eleven sessions a week constituting a whole-time appointment. But the concept of a whole-time contract consisting of eleven sessions a week is purely notional, since it is usual for whole-time consultants to spend more hours in a hospital than the sum of their clinical sessions. A consultant pathologist may work part-time in more than one hospital and achieve full-time status in this way, or he may choose to devote the time when he is not in hospital employment to private practice. Whether he has a part-time or whole-time contract with the hospital service he may undertake work for coroners and retain the fees for this work (see paragraph 22.14 below) provided that this does not interfere with the proper discharge of his hospital duties.

22.08 There is an agreement between the universities and the National Health Service under which no full-time employee of a university may receive any remuneration, other than a distinction award, for work done in the National Health Service. All consultants, whether they hold NHS contracts or are honorary consultants, are eligible for NHS distinction awards as supplements to their salaries. In the case of a consultant remunerated directly by the National Health Service, the proportion of an award paid is determined by the number of his sessions,—a whole-time consultant receives the maximum award. However, to receive the maximum, a pathologist holding a whole-time honorary consultant contract must spend a minimum of 21 hours a week on clinical work. If less time is spent, the distinction award is reduced proportionately. A consultant who spends a considerable part of his time on coroners' work is thereby precluded from achieving a full distinction award.

Support for the coroner

22.09 In both teaching and non-teaching hospitals it is common for most members of Morbid Anatomy Departments to carry out post-mortem examinations, sometimes exclusively as a National Health Service duty (to correlate the diagnosis before death with autopsy observations) and sometimes, in addition, to find the medical cause of death for coroners. Both types of post-mortem examination can also serve the purposes of teaching, training, or medical research. Coroners usually request individual members of Morbid Anatomy Departments to conduct post-mortem examinations on their behalf.

22.10 The Home Office collects statistics of the number of autopsies performed for coroners, but it has, no information to indicate who performs them or where they are performed. The evidence of our witnesses on this point did not provide us with a consistent picture. In order to clarify this situation, we decided to obtain for ourselves some factual information about coroners' practice. Our secretary therefore wrote to every coroner in England and Wales requesting information about autopsies performed on his authority in the last quarter of 1968. We asked to be informed of the names of medical practitioners who had carried out the autopsies on the coroner's behalf and the number which each doctor had performed, together with a list of places in which the autopsies were carried out and the number of autopsies performed in each place. We received almost 100 per cent response to this invitation and we are most grateful to coroners for their co-operation.

22.11 When the information was received, the doctors whose names were sent to us were classified according to their status as whole-time forensic pathologists, consultants with specialist forensic experience or interests, other hospital pathologists and general practitioners. We were left with a small residual category of doctors whose status we were not able to determine. We also separately identified the work done by so-called " Home Office pathologists " (see paragraph 22.20 below).

22.12 The results of this survey are summarised at Tables R and S below. They showed that 688 doctors carried out a total of 27,447 autopsies for coroners in this period. The following features may be noted:

(i) the overwhelming majority of coroners' autopsies were carried out by hospital pathologists employed in the National Health Service at the level of registrar and upwards;

(ii) in a number of areas coroners were employing consultant pathologists who were not morbid anatomists and whose background and training did not obviously fit them to conduct coroners' autopsies;[1]

(iii) outside London and the Home Counties, the number of deaths investigated by persons with a specialist forensic qualification was remarkably small;

(iv) out of 5,062 autopsies carried out in this quarter by whole-time forensic pathologists, no less than 3,905 (or about 77 per cent) were performed in Greater London; forensic pathologists were responsible for about 62 per cent of all autopsies carried out on behalf of the seven Greater London coroners;

(v) only fourteen doctors (and these were all forensic pathologists) carried out over 200 post-mortem examinations in the quarter but over 250 performed less than 25 and over 400 less than 50;

(vi) about 65 per cent of autopsies were carried out in hospital mortuaries, the remainder in public mortuaries.

22.13 In assessing the implications of this picture it is important to bear in mind the results obtained from coroners' autopsies. Table D (Chapter 1) shows that the largest single group of deaths certified by coroners in 1969 comprised deaths from heart disease (45 per cent of all deaths certified by coroners); this is also the most common cause of death in the community generally. Coroners also certified large numbers of other common causes of death like cancer and vascular diseases of the central nervous system. Violent deaths (predominantly accidents and suicide) provided in 1969 only a minority (4·2 per cent) of the total number of deaths certified by coroners. This pattern reflects the trend since 1926 (to which we drew attention in Chapter 10) towards an increased proportion of deaths reported to coroners because the *medical cause* was in doubt by contrast with those that are reported because of the *circumstances* in which the death occurred. The present position is that the large majority of deaths which are reported to the coroner are deaths in which a doctor feels that he cannot *accurately* certify the cause and reports for this reason alone.

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(1) In one area, roughly corresponding to a Regional Hospital Board Area, the specialties of the doctors carrying out the autopsies for coroners were:—

consultants in general pathology or morbid anatomy	27 doctors,	1,180 autopsies
lecturer or senior registrar in morbid anatomy	6 doctors,	30 autopsies
consultant in neuropathology	1 doctor,	13 autopsies
consultant haematologist	4 doctors,	146 autopsies
consultant chemical pathologist	1 doctor,	138 autopsies
consultant bacteriologist	4 doctors,	182 autopsies
Home Office pathologist	1 doctor,	174 autopsies
General Practitioners	8 doctors,	145 autopsies
	52 doctors,	2,008 autopsies

TABLE R

Number of Post-mortems Carried Out for Coroners by Different Types of Practitioner 1st October 1968—31st December 1968

Source: Information provided by Coroners to the Home Office

	Whole-Time Forensic Pathologist	Consultant Pathologist with special Forensic experience and interest	Consultant Pathologist, Senior Lecturer etc.	Assistant Pathologist, Lecturer or Registrar in Pathology	General Practitioner etc.	Position not known	TOTAL
	1	2	3	4	5	6	7
Bedfordshire ...	6	86	97	26			215
Berkshire ...		96	64				160
Buckinghamshire...		13	221	17			251
Cambridgeshire ...		39	42				81
Cheshire ...		37	589	1	97		724
Cornwall		272	24				296
Cumberland ...		4	119	6			129
Derbyshire ...	5	30	354		42		431
Devon	1		417	23	1		442
Dorset			174	1			175
Durham		49	563			35	647
Essex	2	100	582	5			689
Gloucestershire ...	6		491	14			511
Hampshire ...		387	250	119	33		789
Herefordshire ...	3	27	20		1		51
Hertfordshire ...	5	102	238			1	346
Huntingdonshire ...		41					41
Isle of Wight ...			58				58
Kent	73	37	687				797
Lancashire ...	45	408	2,009	317	318	26	3,123
Leicestershire ...		138	157				295
Lincolnshire ...	1		318				319
LONDON ...	3,905	984	1,276	66		43	6,274
Monmouthshire ...		152	56				208
Norfolk		60	180		28		268
Northamptonshire		90	162	2			254
Northumberland		1	204	108	23	17	353
Nottinghamshire	3	171	370		71		615
Oxfordshire ...		22	167	3	2		194
Rutland		7					7
Shropshire ...			130				130
Somerset	2		354				356
Staffordshire ...	69	418	463	5	77	59	1,091
Suffolk			274				274

TABLE R—Continued

Number of Post-mortems Carried Out for Coroners by Different Types of Practitioner 1st October 1968—31st December 1968

Source: Information provided by Coroners to the Home Office

	Whole-Time Forensic Pathologist	Consultant Pathologist with special Forensic experience and interest	Consultant Pathologist, Senior Lecturer etc.	Assistant Pathologist, Lecturer or Registrar in Pathology	General Practitioner etc.	Position not known	TOTAL
	1	2	3	4	5	6	7
Surrey	162	358	44				564
Sussex	5	138	348		77		568
Warwickshire ...	49	71	724	273	17		1,134
Westmorland ...		20	12	1			33
Wiltshire		69	131				200
Worcestershire ...	63	2	196		40		301
Yorkshire ...	416	334	1,826	112	237	43	2,968
WALES	241	122	720			2	1,085
TOTAL ...	5,062	4,885	15,101	1,099	1,064	236	27,447

TABLE S

Coroners' Post-mortem Examinations Performed During Period October–December 1968

(1) Numbers of post-mortem examinations performed	(2) Number of doctors
600–700	2
500–599	0
400–499	2
300–399	5
200–299	5
100–199	39
50–99	128
25–49	152
10–24	132
5–9	89
1–4	134
Total	688

Payment for autopsies and related work carried out for coroners

22.14 A pathologist who performs an autopsy on behalf of a coroner is entitled to a fee, the amount of which is prescribed in Rules made by the Home Secretary (currently the Coroners (Fees and Allowances) Rules 1971). At present, a pathologist is paid £7.50 for an autopsy in a case which does not proceed to an inquest. He may be paid £12 if he performs an autopsy and subsequently gives evidence at an inquest. In addition, a pathologist working for a coroner may be entitled to receive payment in respect of " special examinations ".[1]

22.15 The responsibility for all aspects of an autopsy performed for a coroner rests solely with the pathologist whom he has requested to perform it. This doctor, however, may be assisted by hospital porters or mortuary technicians; and he may sometimes request specialist examinations (e.g. a detailed toxicological analysis), which may be performed by National Health Service personnel. These assistants may or may not themselves receive a separate payment. Fees are never paid to the staff of the Public Health Laboratory Service for their bacteriological or virological examinations. On the other hand, we were informed that some hospital bacteriologists will do coroner's work only if they receive a special fee for it. The coroner is entitled to pay fees for special examinations if he is empowered to do so by the local authority which appoints him.[2] To some extent, the scales of fees allowed by local authorities follow recommendations made by the British Medical Association[3] and the recommended fees are sometimes also charged when the local authority has authorised payment of a fee but has not specified the amount.

Forensic pathology

22.16 Within the general framework of pathology services, arrangements of a limited and loosely organised character have been made—or have developed—to provide assistance to coroners and the police. Our specialist witnesses found it natural to talk about these arrangements in terms of the expression " forensic pathology ". There is no accepted definition of this term. On occasions it was clear, from the context, that our witnesses intended that the expression should cover every autopsy and special investigation carried out on behalf of a coroner. At other times, it was equally obvious that they were using the expression in the more limited sense of pathology which was of direct relevance to the police or to the criminal courts.

22.17 Before 1926, when the coroner was chiefly concerned with the investigation of unnatural death, the relationship between coroners' pathology and pathology which might be relevant to the criminal courts was plain to see;

[1] Under section 22 of the Coroners (Amendment) Act 1926 a coroner is entitled to request " a special examination by way of analysis, test or otherwise of such parts or contents of the body or such other substances or things as ought in the opinion of the coroner to be submitted to analyses, tests or other special examination with a view to ascertaining how the deceased came by his death ".

[2] Under section 25 of the Coroners Act 1887, a local authority may make a " schedule of fees, allowances and disbursements which may lawfully be paid and made by a coroner in the course of his duties ".

[3] Most recently in the BMA booklet " Fees for Part-time Medical Services". (London) 1971.

but the situation has changed as we have demonstrated earlier in this Report. Only a small part of " coroners pathology " now has any forensic implication.

Pathology and the police—the existing situation

22.18 According to the evidence we received, the basis of forensic pathology is the small amount of work which, although it is carried out on behalf of the coroner, is particularly the concern of the police. The special interest of the police is recognised in Rule 2 (1) (*b*) of the Coroners Rules 1953, which provides that " if the coroner is informed by the Chief Officer of Police that a person may be charged with the murder, manslaughter or infanticide of the deceased the coroner should consult the Chief Officer of Police regarding the legally qualified medical practitioner who is to make the post-mortem examination ". Every police force needs to be able to call on the services of a specially experienced pathologist to help in the investigation of murder and other serious crimes against the person. Ideally, this person should be a pathologist with a sound training in morbid anatomy who has added to this general knowledge some additional skills, most notably the ability to detect, and give authoritative testimony about, unusual features of a dead body and the surrounding circumstances which may be of evidential value. He should be able to command the facilities of a well-equipped pathological laboratory, be readily available on call to police and courts, and be prepared to travel at short notice anywhere in the area which he serves.

22.19 The number of pathologists who are qualified and willing to provide this service to the police is limited. The majority have part-time consultant posts in the National Health Service, while some of them hold professorships or less senior university appointments. In London the police are well served by a number of forensic pathologists (including 3 professors)[1] based on university departments, but in the provinces the representation of forensic pathology in the universities is small (both in terms of university departments and numbers of individuals involved). This is one of the reasons why the Home Office has made alternative provision for the police in the provinces by a procedure of appointments to what has become known as the " Home Office list ".

22.20 Outside London, the Home Secretary has nominated suitably qualified pathologists to provide a service to police forces on a part-time basis. They are known as " Home Office pathologists " and, at present, there are 25 persons holding such appointments. Each of these is associated with one of the regional Home Office Forensic Science Laboratories and is encouraged to co-operate with the forensic scientists there. Of those at present on the Home Office list, five hold university appointments in departments of pathology, or of forensic pathology and the remainder hold consultant appointments in the National Health Service. In selecting pathologists for inclusion on the Home Office list, we understand that the Home Office has relied largely on the advice of a senior pathologist in the area and the Director of the appropriate Home Office Forensic Science Laboratory. It has been the practice, before any formal appointment is made, for the Home Office to find out from the university

[1] One has retired but still does some coroner's work.

or hospital board concerned whether or not it has any objection to the appointment of one of its pathologists.

22.21 In recent years, it has sometimes been difficult to attract to these posts suitably qualified pathologists with the necessary experience. It was suggested to us that the inconvenient nature of some of the work provided the main disincentive to recruitment to the list: the hours are uncertain, working conditions in the field can be uncomfortable and dirty, and court appearances can be unpredictable, time-consuming and irksome to an employing authority —as well as to the individual. The physical location of the men at present on the list sometimes means that a pathologist may have to travel up to 200 miles to examine a body or perform an autopsy and, later, spend a whole day or even days attending criminal proceedings. When this happens, a university may be deprived of a valuable teacher, or a hospital of a badly needed consultant and there may be no cover if, for any reason, there is more than one demand for the services of the forensic specialist at the same time. It is unusual for a forensic pathologist (whether he is based on a university or in a hospital) to have a deputy. The total number of forensic pathologists[1] in England and Wales is about 40. These circumstances render the service particularly vulnerable to death, illness, retirement or withdrawal of any one of the men on the current Home Office list.

22.22 The pathologists on the Home Office list are variously paid for their services to the police. The majority receive retaining fees from the Common Police Service Fund (the amount varies according to the area served and the density of its population) and make their services available to the police without further charge. Others receive a fee for each case from the police authority concerned. The amount of this fee is settled between the pathologist and the police authority or, where appropriate, between the pathologist and the Director of Public Prosecutions. In addition, all Home Office pathologists receive from coroners (or sometimes a local authority acting on their behalf) separate fees for the autopsies which they perform for coroners. Most pathologists undertaking work for the police retain coroners' fees and other fees on a personal basis, but a few are required, by the terms of their engagement with their employing authority, to pay over all or part of their earnings to their employers.

Mortuaries and facilities for post-mortem examinations

22.23 Responsibility for the provision of mortuaries (including post-mortem rooms), their staff and their equipment is divided between hospital authorities and local authorities. So far as we are aware there is no statutory obligation on a hospital authority to provide either a mortuary or facilities for carrying out post-mortem examinations but it is a fact that arrangements exist for post-mortem examinations to be carried out at convenient National Health Service hospitals throughout the country. Under the Public Health Act 1936 and the London Government Act 1963, the council of a county borough, London borough, urban or rural district or a parish council may, and if required by the Secretary of State (for the Environment), must provide;

(*a*) a mortuary for the reception of dead bodies before interment; and

(*b*) a post-mortem room for the reception of dead bodies during the time

[1] By which we mean pathologists with a recognised " forensic " qualification or with a number of years of " forensic " experience.

required to conduct any post-mortem examination ordered by a coroner or other duly authorised authority.

County councils have no power or duty to provide this accommodation;[1] indeed they often find themselves paying one of the smaller authorities for the use which a county coroner makes of the mortuary accommodation which they provide. Guidance on the accommodation and equipment of hospital mortuaries and public mortuaries is provided respectively by the Department of Health and Social Security and the Department of the Environment.

22.24 Traditionally, coroner's autopsies have been performed in public mortuaries rather than in hospitals but, in recent years, the trend has been in the other direction. This is partly because the majority of deaths reported to coroners now occur in hospitals and the hospital mortuary provides the most convenient place for the autopsy to be performed; and partly it is a consequence of the fact that local authorities have now largely ceased to build public mortuaries. A few mortuaries have been built and paid for jointly by hospital authorities and local authorities and their running costs have thereafter been shared in agreed proportions. It is the policy of the Department of Health and Social Security and the Department of the Environment to encourage these " joint-user " arrangements. Regional Hospital Boards planning new accommodation have been asked to consult with local authorities so that future hospital provision can take account also of coroner's needs.

22.25 Adequate facilities for the storage of bodies and the performance of post-mortem examinations are essential to the proper functioning of the coroner's service. Accordingly, we have looked closely at the existing situation and some of us have made personal visits to a representative sample of the best and worst examples of both hospital and public mortuaries. The standard of provision varies enormously in both categories of mortuary. In many hospitals mortuary facilities are first-class, but in several the facilities, including post-mortem facilities, are totally inadequate by modern standards—isolated, in every sense, from the rest of the hospital and often with poor access to the services of a pathological laboratory. Similarly, there are a few large and well-equipped public mortuaries. But the situation in some of the smaller mortuaries provided by local authorities, and still used for coroners autopsies in some areas, leaves a lot to be desired. Indeed, we have no hesitation in saying that the physical accommodation in some of the worst public mortuaries is so bad as to be little short of scandalous. Six years ago, Dr. Alan Usher, a forensic pathologist at the University of Sheffield wrote in these terms of the mortuaries and some smaller urban districts;

> " Small, poorly lit, wretchedly ventilated, freezingly cold in winter, malodorously warm in summer, often without refrigeration or proper working surfaces and with their woefully inadequate Victorian plumbing in a permanent state of semi-occlusion from the anatomical debris of decades, these buildings still stand in council yards, by sewage works and rubbish tips all over the land, the subject of the prying curiosity of agile children and awkward silences at local council meetings. Next to public conveniences, to which many of them bear a curious and revealing architectural resemblance, they are usually the smallest buildings erected and

[1] Nor has the Greater London Council.

maintained by the local authority and one cannot help but feel that their size accurately reflects the interest taken in them."[1]

We are quite satisfied that, in certain areas, Dr. Usher's description is as valid today as it was in 1965.

22.26 Some of the pathologists who have given evidence to us have described how they have performed autopsies, sometimes on the bodies of murder victims, on some primitive slab in an outhouse attached to a police station, which in some areas is the place designated as the public mortuary. Nor is it only the pathologist who is troubled by these conditions or who has to suffer the indignities which they create. It is sometimes necessary for relatives to visit a mortuary in order to identify a body and, in those small mortuaries which have only one table, it must be most distressing for relatives to see the body of someone whom they have loved dearly lying on the very table on which he will later be dissected, complete with its channels for blood disposal and possibly, too, with dissecting instruments lying to hand.

22.27 Our description of conditions to be found in some public mortuaries has emphasised the poor quality of much of the accommodation and facilities. It cannot, however, be said that there are too few public mortuaries in existence: indeed, our witnesses were agreed that there were in fact too many for present day requirements. In the late nineteenth century and early twentieth century, before motor transport came into common use, it was reasonable for local authorities individually to provide mortuaries for their own areas. Since then, some authorities have continued to operate such mortuaries in spite of the need for more modern accommodation which they might have provided jointly with neighbouring authorities or hospitals. Moreover, some authorities have continued to maintain existing, but inadequate, facilities although more modern and better accommodation had become available in an adjoining local authority area. More recently some authorities have provided new mortuaries of their own, when they could, with greater public advantage, have combined their resources with a neighbouring local authority or hospital. In the case of some authorities, financial considerations have discouraged substantial progress in modifications, re-equipping and rebuilding which have become necessary as conditions have changed.

22.28 We were helped in putting the evidence of our witnesses and our own experiences into a national context by the survey of all autopsies performed for coroners in the last quarter of 1968 (to which we refer in more detail in paragraphs 22.12 and 13 above). As part of this survey, we asked coroners to tell us where their autopsies were carried out and to indicate how many autopsies were performed in each place. The results show that, of the nearly 28,000 autopsies which were carried out in this period, over 18,000 (or about 65 per cent) were performed in hospital mortuaries. The remainder were performed in public mortuaries. Public mortuaries were used proportionately more frequently in the large towns (especially London) than in the counties. It is in the large towns that there is often a public mortuary which has facilities at least as good as those in the average hospital. The relative use

[1] Usher, A., Journal of the Forensic Science Society, Volume 5, No. 4, Oct. 1965.

of hospital and public mortuary provision in different regions can be examined in more detail in Appendix 7.

22.29 The evidence of our witnesses and the evidence of our own observations has convinced us that radical improvements are necessary in the general standard of mortuary and post-mortem facilities provided for coroners and for those who carry out pathological work on their behalf. In future, every mortuary used by a coroner should be a suitably equipped building of adequate size placed in proximity to a main department of pathology. This means that it must usually be part of a major hospital. We give further consideration to the place in which autopsies should be performed in Chapter 23 below in the general context of our discussion of how to improve pathological services for coroners.

CHAPTER 23

MEETING THE CORONER'S NEEDS IN FUTURE

23.01 In recent years, as we have already mentioned, coroners have been calling for increasing numbers of post-mortem examinations for the purpose of discharging what is now the major one of their two functions: the certification of the medical cause of death. In recent years, also, pathological services have been growing in scale and specialism. The statutory links between coroners and these services were fashioned a relatively long time ago. It is timely to consider whether they require reform.

23.02 The responsibility for arranging an autopsy at present rests with the coroner himself. In choosing the doctor whom he will direct or request to perform the examination he is required by the Coroners Rules 1953 to have regard to the following considerations:

(*a*) "the post-mortem examination should be made, whenever practicable, by a pathologist with suitable qualifications and experience and having access to laboratory facilities;

(*b*) if the coroner is informed by the Chief Officer of Police that a person may be charged with the murder, manslaughter or infanticide of the deceased, the coroner should consult the Chief Officer of Police regarding the legally qualified[1] medical practitioner who is to make the post-mortem examination;

(*c*) if the deceased died in a hospital, the coroner should not direct or request a pathologist on the staff of, or associated with, that hospital to make a post-mortem examination if—

(i) that pathologist does not desire to make the examination, or

(ii) the conduct of any member of the hospital staff is likely to be called in question, or

(iii) any relative of the deceased asks the coroner that the examination be not made by such a pathologist

unless the obtaining of another pathologist with suitable qualifications and experience would cause the examination to be unduly delayed;

(*d*) if the death of the deceased may have been caused by pneumoconiosis, the coroner should not direct or request a legally qualified medical practitioner who is a member of a pneumoconiosis medical panel to make a post-mortem examination. "[2]

23.03 It should be noted that the coroner's power is to select an *individual* doctor to perform the autopsy; he has no power to refer a death for investigation by a hospital or university department. But a coroner who is not medically qualified (and only a handful of coroners are doctors) is seldom likely to

[1] Means " duly qualified ", i.e. registered by the General Medical Council.
[2] Coroners Rules 1953, Rule 3.

be able to judge for himself exactly what examinations or tests are required, or to understand the growing complexity of the pathological services, Moreover, some of our witnesses told us, and the Home Office O and M study of the coroner's officer demonstrated, that the arrangements for an autopsy are frequently left in the hands of a coroner's officer. The officer calls upon any pathologist who has made a standing arrangement with the coroner to carry out post-mortem examinations on his behalf. It is not surprising, therefore, that, as our own survey of post-mortem examinations carried out for coroners indicated, some coroners seem to have exercised their discretion in such a way that the doctor selected to perform an autopsy, so far from being a morbid anatomist, has not even had a qualification in pathology or access to facilities for detailed examinations.

23.04 Some of our witnesses were not slow to dispute the wisdom of coroners' choices even when they fell upon qualified pathologists. Clinical pathologists, for example, criticised the diversion of autopsies to specialist forensic pathologists where the death was of purely medical interest, because, they said, this was usually at the expense of the medical value of the autopsy and forensic pathologists had been known to reach the wrong conclusion as to the exact medical reasons for a death from natural causes. Forensic pathologists, on the other hand, criticised the involvement of clinical pathologists, arguing that the latter might overlook such matters as carbon monoxide poisoning or ligatures. (We were not given any specific examples of these alleged failures by either set of protagonists.) Most of our witnesses expressed their dissatisfaction with the present situation and there was much support for the view that the situation was aggravated by the artificial, yet well established, " isolation " of coroners' work even in the major pathological units. Thus, we were told, that even when an autopsy requested by a coroner is performed in a National Health Service hospital by a pathologist who is contractually employed in the National Health Service, the tendency is for the pathologist selected by the coroner to deal with the case entirely on his own because both he and the hospital regard the work which he does for coroners as completely separate from hospital employment. The concept of total reliance on an individual specialist ceased to be the practice of the best hospitals before the last war, but it still lingers on in the coroner's practice of nominating one man to perform an autopsy on his behalf.

23.05 The relevant financial arrangements[1] also play a part in shaping how existing resources are used. The single fee system, for example, restrains the coroner from seeking or encouraging a composite investigation by a team of specialists. It also has other effects, some good, some bad. The differing practice of authorities who employ pathologists in allowing them to retain their fees for coroners' work or insisting on their surrender has encouraged some and discouraged others from doing work for coroners. Where the fee has been there for pathologists to keep, the opportunity for earning as many fees as possible has certainly led some pathologists to concentrate on work for coroners to the detriment of their other responsibilities. It has also led to some individuals taking on a daily work-load of investigations and reports for coroners, which is hard to reconcile with the narrow specialism character-

[1] See Chapter 22, paragraphs 14 and 15.

istic of present day pathology and suggestive of undesirably limited exploration in the general run of cases.

23.06 There are at present about 800 pathologists in England and Wales who on paper seem to be adequately qualified to perform autopsies for coroners. Not all of these may have the inclination to take up such work, and it is no part of our thinking to suggest that there should be any compulsion upon these specialists. But the number is large enough to demonstrate the absurdity of continuing to require the coroner (who we have recommended should be legally, not medically, qualified) to select the pathologist suited to the needs of the particular case, even though in some cases the information provided to the coroner by the deceased's doctor will itself indicate the nature of any specialist pathological investigation required. We recommend, therefore, that responsibility for selecting the appropriate pathologist or pathologists to investigate a particular death, should cease to rest with the coroner; instead it should be entrusted to another authority familiar with the services and resources which could be made available to assist the coroner and familiar also with the needs of coroners and the circumstances of their work. The practical effect would be to allow the coroner to refer his requirement for an autopsy to a *service* rather than to an individual. How that service should be organised we consider in the following paragraphs.

A specially created service?

23.07 It is important to remember that the nation's pathological resources are limited, and that the diversion of any part of them to one special activity means the loss of their availability for other purposes. The strategic question we have had to consider is whether, in the national as well as the coroner's interest, it would be more satisfactory to propose the creation of a special pathology service for the more or less exclusive support of coroners—and the police. Such a proposal was put to us by some of our witnesses, who argued that forensic pathology was of such considerable importance to coroners and the police that the Home Office should establish a separate comprehensive Forensic Pathology Service based on Universities but in close association with the existing Forensic Science Laboratories. Only such a service, it was claimed, could provide the expertise required to detect any possible indications of foul play in cases brought to the attention of police or coroners. After careful review we decided that this approach was neither realistic nor acceptable. For many years to come it would be quite impracticable to confine coroners' pathology work to those qualified in forensic pathology, even if a major expansion of recruitment and training were launched at once. If that were not the considerable obstacle it is, even if, perhaps ," qualification " were initially waived, we see as much more compelling the objections that coroners' work cannot and should not be arranged in such a way as to separate it from hospital pathology with all its resources. Much the larger part of coroners' pathology belongs to the body of applied pathology and should nourish and be nourished by it.

A National Health Service responsibility?

23.08 If coroners' pathology is to be provided as a service integral with the general provision for pathology, we are convinced that the best solution would

be for coroners' autopsies to be performed in National Health Service hospitals by pathologists employed by the NHS and *as part of* the National Health Service. This would remove any risk of isolating coroners' pathology from the ordinary pathology work in hospitals, it would allow existing resources to be used to best advantage and permit extended provision to be sensibly planned and co-ordinated, and it would also avoid the need to duplicate facilities, e.g., mortuary provision, which would be a great disadvantage if the alternative proposition for a special forensic pathology service for coroners (paragraph 23.07 above) was adopted. Accordingly, we recommend that the provision of a pathology service for coroners should become the responsibliity of the National Health Service.

23.09 The proposition is not as revolutionary as it sounds. The National Health Service is a principal beneficiary of the results of applied research into the medical causes of death, which is, in part, made possible by the statistical material produced by enquiries undertaken for the coroner. The Service provides the framework within which most deaths reported to the coroner are now investigated and persons employed whole-time or part-time within the National Health Service carry out most of the work on the coroner's behalf. But, as we have indicated earlier (see paragraphs 22.01, 12 and 13 above), the present arrangements sometimes fail to provide the coroner with the best possible service and the National Health Service itself does not get the full benefits of the work which its members do on the coroner's behalf. Although the first objective of a coroner's autopsy should be to elicit the cause of death for certification purposes, there is no reason why it should not also subserve attempts to discover and understand how the disease or accident originated and affected the whole body and the manner in which it led to death. The National Health Service exists to improve the health of the nation and we believe that the investigation of the medical causes of death, which can have such a fundamental importance in the prevention of future deaths, is an entirely appropriate function for this Service to undertake.

Forensic pathology in the universities and the National Health Service

23.10 We have already described (in Chapter 22) the present very limited provision for pathology that is purposefully oriented towards the interest of coroners and the police. That provision is, if anything, declining. The number of specialist forensic pathologists is dwindling and the existence of some and the status of other university departments has been in jeopardy. Anomalies of remuneration, imperfectly organised training, the absence of a standard professional qualification and lack of a career structure have no doubt discouraged many experienced pathologists from offering part of their services to coroners and the police. We think, however, that there have been more fundamental reasons, of which perhaps the most important is the continuing controversy about the real strength of the case for a separate specialised branch of forensic pathology. Our specialist witnesses gave us a clear picture of the opposing points of view.

23.11 On the one side, it was argued that for nearly every kind of death there was likely to be some specialist with greater experience than the forensic pathologist of the particular condition which required investigation; a surgeon,

for example, might know more about wounds and could teach this better than forensic pathologists; similarly, a physician might know more about poisons and the treatment of poisoning. If in the course of medical training there was any need for a deliberate emphasis on the needs of coroners and the police, this could be met within the context of forensic medicine. To dispense with the formal features of forensic pathology, e.g., a forensic pathology department or the services of a forensic pathologist, did not mean that forensic medicine was not taught at all in the university in question; forensic medicine, if not taught as a specific topic, was featured as a significant aspect of other specialities such as surgery, medicine (including toxicology, obstetrics, gynaecology and ethics). Forensic pathology in the specialist vocational sense advocated by its most enthusiastic adherents inevitably involved a very substantial " service " element which frequently took those concerned away from the more conventional university duties of teaching and research; if the discipline was needed at all, it should not be organised in a university setting.

23.12 On the other side of the controversy it was argued that, where forensic pathology was properly organised in a medical school, its value had been amply demonstrated both as an academic discipline and as a service. The advancement of knowledge in forensic pathology could best be accomplished by training in an academic environment. Forensic medicine was a speciality entitled like other specialities to university representation; and forensic pathology, as a sub-speciality, also had its rightful place there.

23.13 We prefer not to involve ourselves in the controversy over whether or not forensic pathology is a speciality in its own right. It seems to us that there are two more important problems to which we should address ourselves: Do the police need the services of a special kind of pathologist who can for the most part be distinguished from a clinical pathologist in a hospital? Do coroners need the services of the same kind of pathologist as the police?

23.14 Our answer to the first question is an unequivocal " yes ". We accept the view that while every forensic pathologist needs to be a competent morbid anatomist the reverse statement does not follow: many morbid anatomists will never have the inclination to undertake forensic work, i.e. work for the police or the criminal courts. The nature of the problems most often encountered in criminal investigation is different from that most often encountered in clinical work. So are the circumstances in which the two kinds of pathologists are called upon to work. The forensic pathologist may be required to do field work literally! There is also a difference between writing an opinion for a colleague and giving evidence based on that opinion or being cross-examined on that opinion in the criminal court. There are pathologists who feel attracted to this particular kind of challenge and also have the ability to cope with it and there are pathologists who do not feel this urge and who may not have the right attributes. We conclude that the difference between a clinical pathologist and a forensic pathologist is as much in the nature of the man as the nature of the work.

23.15 Our answer to the second question ("Do coroners need the services of the same kind of pathologist as the police? ") is an unequivocal " no ". Much the greater part of coroners pathology has no forensic implication. What

the coroner requires in most cases is an adequate *written*[1] statement of the findings of a pathologist whose qualifications, experience and skill make him best fitted to carry out that particular examination. We do not accept the argument advanced by some forensic pathologists that the pathologist without forensic training or experience has a lower "index of suspicion" than a forensic pathologist for the potential case of homicide. In our review (Chapter 4) of the danger of secret homicide, we found no significant evidence that routine autopsies were failing to disclose evidence of homicide where it was there for the finding.

23.16 If our conclusions are correct there are three main organisational problems:—

(i) how to co-ordinate the pathological services in the coroner's area so that coroners' work is undertaken by the appropriate pathologists;

(ii) how to construct a convenient working link between the coroner and his local pathological services;

(iii) how to provide the special assistance required by the police.

Co-ordination of pathological support for coroners

23.17 When we recommend that the National Health Service should assume responsibility for providing a pathological service for coroners, we visualise that measures would be taken by the appropriate Service authorities—encouraged and guided as necessary by the Secretary of State for the Social Services, his expert advisers and his advisory committees—to secure that a sufficiency of pathologists in contractual employment with them would be available for the work and, further, that they would review and try to make good any significant deficiencies in the availability and accessibility of pathological assistance to the coroner in consultation with him. In other words there would be a purposeful effort by all concerned to make systematic arrangements to provide pathologists willing to help coroners when requested to do so, to measure the gross work-load likely to be placed on this group, to look for reinforcement of the group when this seemed necessary, and to place on a suitably recognisable formal basis the obligation accepted by each individual pathologist to carry out examinations for a coroner if so requested.

23.18 It would be outside our competence to proceed beyond these general propositions to more detailed proposals for the structure of what might be described as "the coroners' component" in National Health Service pathology; but we certainly would not wish any of the broad measures mentioned in the previous paragraph to have the effect of isolating coroners' work from pathology in general. Essentially, what we want to see is an appropriate recognition in the National Health Service of the importance of coroners' work and a matching familiarity in the National Health Service with the day-to-day needs of coroners for assistance. How these two objectives are to be achieved in terms of organisation and co-ordination will best be considered by those closest to the problems. From their considerable experience of handling coroners' work the authorities concerned will need no reminding that coroners'

[1] We have already recommended that coroners should be able to accept written evidence for purposes of inquests as well as of less formal enquiries.

needs are always urgent, indeed imperative; a pathologist and supporting facilities must be available as quickly as possible for the individual case.

23.19 We should be wrong, however, not to express the hope that the relevant authorities, in mapping out the capability and availability of pathologists to do coroners' work in their area, should pay regard to the possible contribution of forensic pathologists. A large number of our witnesses made proposals, differing in detail but hardly in substance, for combining hospital pathology and forensic pathology in a co-ordinated scheme for coroners. The basic concept was for a two-branch scheme. Designated pathologists in National Health Service district hospitals would take responsibility for the large non-criminal element of coroners' work. Specialist forensic pathologists in universities would be available to deal with cases where crime is known or suspected to have taken place, to undertake research and training, and to provide specialist advice to pathologists in the district hospitals. We found much merit in this approach for its promise of making efficient use of *all* current resources and allowing a wider application of the skills of forensic pathology at a time when this speciality has been losing ground. One way to tackle the problem of providing and co-ordinating resources would be for the authority responsible for every large hospital to appoint a consultant pathologist trained in morbid anatomy who would be responsible for ensuring that all the necessary investigations were carried out, either by his own section or by other sections of the Division of Pathology. He might arrange, for example, that, where appropriate an autopsy should be performed by, or in the presence of, a paediatric, gynaecological or other specialist pathologist. He could see that the services of the toxicological, biochemical or other specialist sections were made available as necessary. Last, but by no means least, he might ensure that the advice of a *forensic specialist* was sought if it seemed likely that there were any suspicious features surrounding the death. (We give our views on the future of forensic pathology in the following chapter.)

The working link between the coroner and the pathology services

23.20 It seems to us that it would be for the convenience of the pathological services as well as of coroners if the appropriate National Health Service authority were to designate for each coroner a senior pathologist (or failing this a senior medical administrator) among whose responsibilities it would be to receive requests from each coroner for pathologist examinations, to select the pathologists to carry them out,[1] and to satisfy himself that facilities, e.g. mortuary and laboratory facilities were available for their purposes. We make a recommendation to this effect. We have no doubt that the coroner and his staff would do all they could to assist these " designated officers " in the selection of the appropriate pathologist, by providing any relevant clinical history already obtained from the deceased's own doctor and helpful information from other sources. We do not have in mind that the designated officer would take any personal responsibility for the reports of the investigations

[1] In effect the designated officer would assume the responsibility of the coroner (under Rule 3 (*a*) of the Coroners Rules 1953) "to have regard . . . the post-mortem examination should be made, whenever practicable, by a pathologist with suitable qualifications and experience and having access to laboratory facilities ".

unless he had himself played a part in them. As at present, responsibility for the findings of the examinations would be taken by those who made them.

23.21 In this context it would be necessary for the designated pathologist to take responsibility for applying, in his selection of the appropriate pathologist, any statutory restrictions of the kind mentioned in paragraphs (*b*), (*c*) and (*d*) of Rule 3 of the Coroners Rules 1953.[1] The selection of the pathologist where murder, manslaughter or infanticide is known or suspected is a separate and special case with which we deal in the next chapter. So far as hospital deaths are concerned we note that, notwithstanding the bias in Rule 3 (*c*) against using the pathological staff of the hospital in which a death in that hospital is to be investigated, Rule 8 (3) has a bias the other way.[2] We are satisfied that the principle of the restrictions in Rule 3 (*c*) should continue to be followed. As regards deaths which may have been caused by pneumoconiosis, the existing position is more fully described in Chapter 17 but may be summarised as follows. When a coroner has a suspected pneumoconiosis death referred to him, he will invariably arrange for a post-mortem examination to be made. In accordance with the Coroners Rules 1953, this should be performed by a " pathologist with suitable qualifications and experience and having access to laboratory facilities ". In accordance with these same Rules, a coroner is also required to inform the local pneumoconiosis medical panel when and where the post-mortem examination will be made and the Rules permit the panel to be represented at the post-mortem examination. The Rules prevent a coroner from requesting or directing a member of the pneumoconiosis medical panel to carry out the post-mortem examination. We have recommended that coroners should continue to arrange for post-mortem examinations to be made whenever a suspected pneumoconiosis death is referred to them and that relevant pathological material should continue to be made available to the pneumoconiosis panel by the pathologist acting on behalf of the coroner (paragraph 17.08). We have suggested that there should be closer liaison between the pathologist acting for the coroner and the pneumoconiosis medical panel (paragraph 17.09). We further recommend that the designated officer described in paragraph 23.20 should:—

(*a*) be prohibited from asking any member of the pneumoconiosis panel to carry out a post-mortem examination on behalf of the coroner in any case where pneumoconiosis is suspected to have caused the death; and

(*b*) do what he can in such a case to encourage the closest liaison between the pathologist acting on behalf of the coroner and the pneumoconiosis panel members.

[1] See paragraph 23.02 above.
[2] The rule reads as follows:

" Where a person dies in a hospital possessing such premises as aforesaid, any post-mortem examination of the body of that person shall, with the consent of the hospital authority, be made in those premises unless the coroner otherwise decides ".

CHAPTER 24

MEETING THE POLICE NEEDS IN FUTURE

24.01 One of the effects of the recommendations in the previous chapter should be to reduce the number of autopsies performed for coroners by pathologists whose background, training and experience label them as "forensic pathologists ". This should certainly be the case in London where, as our survey showed, forensic pathologists are responsible for well over half of all post-mortem examinations carried out by coroners—although only a few of these examinations have any forensic significance. To a lesser extent, the same thing should happen in those areas in which a Home Office pathologist has traditionally been much occupied with coroners' work. We do not think that these changes should make forensic pathology any less attractive than it is now to morbid anatomists thinking of specialising in this field. Indeed, we believe the converse is the more likely result. Under our proposals, the forensic pathologist should become more of a specialist in his own right. In any case, it is certainly not our intention that forensic pathologists should carry out for coroners only those autopsies which have a clearly discernible police interest; and we do not think that this is a likely consequence of our earlier recommendations. The services of a forensic pathologist should be available to the " designated pathologist " to whom we have suggested the coroner should turn in future for his pathological service. We are convinced that it would be futile to try to make a sharp distinction between " forensic " and " coroners " pathology: the latter will always include the former. Any death which requires investigation by the police is also a death in which a coroner will have an interest and the forensic pathologist may be required by both authorities. But in this chapter we are concerned primarily with the needs of the police. We shall consider the practical implications of the view we expressed in the previous chapter (paragraph 23.15) that the police require the assistance of a special kind of pathologist.

24.02 We start from the premise that the police need to have available to them a sufficient number of adequately qualified and experienced forensic pathologists throughout the country to help them in the investigation of crimes or other suspicious deaths. We are satisfied that the provision of a service in forensic pathology for the police should be put on a sounder footing. How is this to be achieved? One thing is certain: it would be unrealistic to propose that a service in forensic pathology should be based solely or even primarily, on the universities. The needs of the police (or even the police and coroners combined) for a forensic pathology service are not sufficiently strong in terms of actual or potential work-load to warrant an attempt to construct and maintain a national service based on the universities. Such a project would be unnecessarily wasteful of scarce resources.

24.03 This is not to say that we wish to see forensic pathology disappear from those universities in which it still has a home. On the contrary we consider that there is a place for forensic pathology in a university. Universities are the proper place for training and research into the subject; but it is

neither necessary nor desirable that there should be forensic pathology representation in every university medical school. Nor is it necessary or desirable that a forensic pathologist who does hold a university post should spend most of his time working for the coroner or the police.

24.04 We believe that it would be more sensible, and certainly more realistic, to base a *service* in forensic pathology for the police (like the pathology service for coroners) firmly in the National Health Service where it can make its maximum contribution to other aspects of pathology, where it will be in a common context with coroners' pathology, and where those who are principally engaged in forensic work can have the opportunity to develop their own skills within the wider setting provided by a hospital environment. We recommend accordingly. We believe that such a national service in forensic pathology can be obtained by basing it on the major hospitals. We make no distinction, for this purpose, between hospitals which are at present under Boards of Governors and Regional Hospital Boards. All major hospitals possess, or have ready access to, a comprehensive service in pathology both locally and nationally. Forensic pathology requires similar ready access to this service. This will be most easily achieved if forensic pathology becomes a sub-section of the main Division of Pathology rather than a separate specialty in university medical schools as well as in Regional Board Hospitals.

24.05 This service for the police does not need to involve large numbers of staff. We have no reason to think that the present number of forensic pathologists (about 40) is inadequate for this purpose—taking the country as a whole. The problem is to keep this number from falling much below its present figure and for this there must be satisfactory provision for training in forensic pathology and for an assured flow of trained recruits.

24.06 Training is all important. The basic training for a forensic pathologist should be one leading to a qualification in morbid anatomy. A pathologist wishing to specialise in forensic pathology should then add to that basic qualification by undertaking additional training in and acquiring additional experience of forensic work. We recommend that the general training framework should be based on National Health Service practice. A junior morbid anatomist at the registrar level, having passed Part I of the examination for membership of the Royal College of Pathologists, might then obtain a post as a senior registrar which would offer not only extensive experience in morbid anatomy but also substantial training in forensic pathology under the supervision of a recognised forensic pathologist. In due course the trainee should take Part II of the examination for the Membership of the Royal College of Pathologists (M.R.C.Path.) taking forensic pathology as his specialty. With this qualification and some four years training at senior registrar level, he should be in a position to compete for a post as a consultant pathologist in morbid anatomy with forensic pathology as a special qualification.

24.07 The principal training schools in forensic pathology should continue, as at present, to be located in universities. These will provide foci of research and experience in an academic background in close contact with medical science, science in general and law. Schools of forensic pathology should ideally be in a division of pathology which embraces a wide variety of relevant

disciplines. There should be facilities for work for higher degrees such as Ph.D. and M.D. It is probably not desirable that the trainee forensic pathologist should spend all his time in a university school; he might spend part of his time on attachment at another hospital where he can be supervised by another forensic pathologist. We suggest that only a relatively small number of medical schools should develop substantial schools of forensic pathology. It is not within our competence to suggest where and of what size these schools should be, but probably some four or five schools would suffice. We envisage that the senior staff in these schools would be responsible for teaching and research and that they would also provide some or all of the service in forensic pathology in their area. We consider it essential that these senior staff should all hold honorary contracts with the National Health Service: work in the National Health Service is essential as a complement to their teaching and research work and in this respect their position would be the same as that of the university teacher in such clinical subjects as medicine and surgery. The general supervision of post-graduate training in forensic pathology should be primarily the responsibility of the Royal College of Pathologists but we hope that it would also be of concern to the new Council for Postgraduate Medical Education in England and Wales, whose duty it is to co-ordinate and stimulate the growth of all postgraduate medical education.

24.08 We believe that the financial implications of these proposed arrangements could be settled along similar lines to those which at present obtain in university departments of pathology. The academic and research activities are financed by the university—supplemented, as a rule, by grants for research from research councils and private foundations. In the current circumstances of university finance we recognise that a university might well be reluctant to give the necessary priority to the adequate funding of a school of forensic pathology. But this difficulty can and must be overcome. One solution might be for the University Grants Committee to make a grant earmarked for this purpose alone. We understand that this is an expedient which has been used before in specific situations for the development of particular subjects. In its turn the University Grants Committee would, no doubt, require to get the monies for this purpose as an addition to its normal allocation. For the present at any rate we can see no alternative to a subvention from the Home Office. The recurrent costs which the university department incurred in providing a forensic pathological service would be met by some system of payment such as operates at present in respect of pathological services for the NHS.

24.09 Although we consider that the National Health Service should provide the framework in which a service in forensic pathology to the police should be based we do not think that the National Health Service should be asked to take sole responsibility for ensuring that the service is provided. The planning of cover for police purposes with its associated considerations of accessibility and scientific support would not be easily undertaken by hospital authorities alone. The requirements for a national service equivalent to the present " Home Office list" should be determined by consultation between the Home Office, police authorities and Regional Hospital Boards or similar authorities. From that starting point, we have come to the conclusion that it would be right for the Home Office to take responsibility for initiating such

discussions, for representing the police requirements, and for making a financial contribution in respect of the provision ultimately made. We envisage that the Home Office and the relevant National Health Service authorities would agree upon a minimum number of appointments of qualified forensic pathologists, whose contracts of service would include a specific liability to work for the police on request. The number and location of posts and the qualifications and facilities required would be planned so as to provide as adequate and accessible a service in forensic pathology as possible throughout the country. The Home Office and the relevant authorities would agree upon the proportionate financial contribution to be made by the Home Office for the " cover " thus provided in men and facilities, regardless of the amount of work actually done for the police by individual forensic pathologists. The contribution would no doubt be reviewed and adjusted in the light of experience and to take account of changes in the " cover " provided.

24.10 If systematic provision were made along these lines, we hope that in any given area the police could have access to one or more named forensic pathologists and the right at any time to obtain their assistance in any case of suspected homicide. Strictly speaking, the request for a pathologist should be made as it is now to the coroner who would then inform the designated senior pathologist (see para. 23.20 above) of the nature of the death requiring investigation. But in practice, it should be possible to adopt a flexible arrangement within any given area which would suit the convenience and the requirements of the persons primarily concerned—the coroner, the designated pathologist, the forensic pathologist and the police. It is desirable that an autopsy in which the police have a special interest should be subjected to exactly the kind of "service" investigation which we hope to see adopted in future in relation to other work done for coroners and it would be in line with this approach if the post-mortem examination in any case of suspected homicide were to be conducted jointly by a forensic pathologist and a suitable pathologist with a predominantly clinical background.

24.11 We also expect that cases would occasionally occur where evidence of a suspicious nature was found during a routine pathological investigation (by a pathologist selected by the designated officer) of what appeared to be an innocent death. In such circumstances the right course would be for the pathologist to inform the nearest forensic pathologist and give him opportunity to take part in the examination, at the same time making his action known to the designated pathologist.

PART VI

MEDICAL CERTIFICATES FOR THE DISPOSAL OF DEAD BODIES

CHAPTER 25

THE GENERAL LAW RELATING TO DISPOSAL OF DEAD BODIES

25.01 Although disposal of the body by burial or cremation is the ultimate consequence of virtually every death which occurs in England and Wales, there is no provision in the general law which specifically requires any individual to dispose of a body or which requires that disposal should be by burial or cremation.[1] Responsibility for arranging a funeral usually falls on an executor (if the deceased person made a will) or on a relative or close associate, but, so far as this is accepted as a duty, it arises from convention and not law. Such sanctions and obligations as the law does impose are contained in public health legislation. Thus, the Secretary of State for Social Services (formerly the Minister of Health) has power[2] to make regulations (in the interests of public health or public safety) imposing conditions and restrictions with respect to the embalming or preservation of bodies and to the period of time during which a body may be retained on any premises. No such regulations have been made. In theory, therefore, a body may be embalmed and kept above ground indefinitely, provided that such a procedure causes no offence under the Public Health Acts. But although there is no statutory duty to dispose of a dead body, respect for the dead, social interest and the availability of disposal services combine to produce a positive incentive towards disposal in nearly every case. The problem is not to ensure that the disposal procedure starts, but to see that it does not end before the proper safeguards have been observed.

Certificate for disposal

25.02 The law stipulates that certain requirements must be satisfied before disposal can be effected by any method. Thus, a body may not be buried, cremated or otherwise disposed of before a certificate authorising disposal has been issued either by a registrar of births and deaths or by a coroner.[3] The registrar's certificate for disposal[4] is normally[5] issued immediately after the

[1] A duty to dispose of a body may, however, fall on a local authority. Under section 50 of the National Assistance Act 1948 it is the duty of a local authority (as defined in the Act) to cause the body to be buried or cremated in any case in which it appears that no suitable arrangements for the disposal of the body have been made. Under section 162 of the Public Health Act 1936, a magistrate may, if he is satisfied that the retention of any body in a building is a danger to health, make an order requiring a local authority to bury or cremate a body within any time limit which he may stipulate.

[2] Public Health Act 1936, section 161.

[3] Births and Deaths Registration Act 1926, Section 1.

[4] See Figure 9 on page 286.

[5] A registrar may, however, issue a certificate for *disposal before* registering the death if he has received written notice of the death from a qualified informant and has received a medical certificate of the cause of death, *and* the death is not one which he is required to refer to the coroner (Chapter 3, paras. 2, 6, 8 and 11).

Figure 9

Unless this document is delivered intact to the person mentioned overleaf, the burial or cremation may be delayed.

DIS 10 925001

PART A

Name of deceased.....

.....

Certificate $\frac{\text{after*}}{\text{before}}$ Registration

Coroner's Order*/Certificate E* issued on.....

Duplicate issued on.....

Death registered on .....

In Register Book No.....

At Entry No.....

Notification of disposal received on.....

Means of disposal.....

Date of disposal.....

Place of disposal.....

.....

Enquiry due on.....

Enquiry made on.....

*Strike out whichever does not apply.

286

DIS 10 925001

PART B

Births and Deaths Registration Act 1953, S. 24 (1)

CERTIFICATE FOR BURIAL OR CREMATION (Issued *after* registration)

I, the undersigned registrar, do hereby certify that the death of

.....

aged.....who died on.....

at .....

.....has been duly registered by me at Entry No. .....

Witness my hand this.....day of.....19.....

.....(Registrar of Births and Deaths)

Registration District.....Sub-district.....

CERTIFICATE FOR BURIAL (Issued *before* registration)

(This Certificate is not available for purposes of Cremation)

I, the undersigned registrar, do hereby certify that the death of

.....

aged.....who died on.....

at .....

.....has been duly notified to me.

Witness my hand this.....day of.....19.....

.....(Registrar of Births and Deaths)

Registration District.....Sub-district.....

IMPORTANT.—If it is intended to remove the body out of England and Wales for burial, etc., notice must be given to the Coroner in advance of the intended removal. A form for giving notice may be obtained from the Registrar giving this certificate. If the Death has not already been registered it must be registered within 14 days of the date on which it took place by a relative of the deceased or one of the persons required by law to give information for the purpose.

DIS 10 925001

PART C

NOTIFICATION OF DISPOSAL (see *back*).

Births and Deaths Registration Act 1926, S.3(1) (*Form prescribed by the Registration of Births, Deaths and Marriages Regulations 1968*)

This is to notify that the body of

.....

deceased, who died on.....

at .....

.....

was buried/cremated* on.....

at .....

(Signature) .....

on behalf of.....

.....

Date.....

* Strike out whichever does not apply.

death has been registered, i.e. formally entered in the statutory register. Unless he has received a coroner's certificate after inquest (in which case the personal attendance of an informant is not necessary), a registrar cannot *register* a death unless he has received information about it from a qualified informant (who must attend in person to give this information) and has also received from a doctor or coroner a certificate giving the cause of death.

25.03 A certificate for disposal issued after registration is valid for burial or cremation[1] provided that the other requirements of the Cremation Regulations have been fulfilled. These requirements are discussed in detail in Chapter 26 below.

25.04 Once a death has been reported to a coroner, the body cannot be disposed of until the coroner has decided whether or not to hold an inquest. In such a case, the registrar must await the decision of the coroner before registering the death and refrain from issuing a certificate for disposal until he has satisfied himself that the coroner has released the body for disposal but has not issued an order for burial.[2]

25.05 After the disposal has been carried out, a notification of the date, place and means of disposal must be delivered to the registrar within 96 hours by the person effecting the disposal.[3] In practice, this notification is delivered by the funeral director who is acting for the relatives or executor of the deceased. A form of notification is provided as a detachable part of the certificate for disposal issued by the registrar and of the order for burial and certificate for cremation issued by a coroner. The registrar has a duty to make enquiries in any case where he receives no notification of disposal and, if he discovers that no disposal has taken place, he must report the facts to the Medical Officer of Health.[4]

Place of disposal

25.06 There is, at present, no limitation in the general law on the place in which a body may be buried, though there are certain local restrictions. In London, for example, it is not lawful for a body to be buried otherwise than in a recognised burial ground and, in certain other areas, a similar prohibition is created by Orders in Council.[5]

25.07 The Cremation Regulations 1930 prohibit the *burning* of human remains in any place other than in " a crematorium in respect of which a notice of completion has been sent to the Secretary of State ".

25.08 The law allows the removal to other parts of the United Kingdom or foreign countries or for burial at sea[6] of bodies of persons who died in England

[1] A certificate for disposal issued *before* registration may be used only for burial.
[2] If a death has been referred to a coroner and cremation is the intended method of disposal, the coroner and not the registrar issues the disposal certificates.
[3] Births and Deaths Registration Act 1926, s. 3 (1).
[4] Regulation 62 (2), Births, Deaths and Marriages Regulations 1968. The duty of the Medical Officer of Health upon receipt of such a report is explained in footnote 1 on page 285 of this chapter.
[5] Made under section 1, Burial Act 1853.
[6] For practical reasons, a disposal of this kind must take place outside the 3 mile territorial limit and the " out of England " procedure must therefore be followed.

and Wales. Broadly speaking, the effect of Regulations[1] made in 1954 by the then Minister of Health is to require any person who desires to take a body out of England (or Wales) to give notice of his intention to do so to the coroner within whose jurisdiction the body is lying. The coroner must give his permission before the body may be lawfully removed and, before giving this permission, he must satisfy himself that there is no reason for the body to be retained for any purpose in this country. When a body is removed out of England, for whatever reason, any certificate of disposal (whether issued by a coroner or by a registrar) must be surrendered to the coroner, who gives permission for the removal and himself retains the detachable portion of the disposal certificate. This contains space for the provision of information about the date, place and means of disposal.

Disposal of still-births

25.09 The law relating to the disposal of still-births is similar to but not the same as the law relating to the disposal of dead bodies. The similarity lies in the fact that it is necessary to obtain a certificate of disposal from a registrar or a coroner if the intention is to dispose of the still-birth in a burial ground or a crematorium.[2] As is the case with the disposal of dead bodies, a still-birth may not lawfully be disposed of in a way which contravenes the Public Health Acts or the law relating to public nuisance.

25.10 The procedure for disposal of still-births differs from that for disposal of dead bodies in regard to the period allowed for registration and the obligation on the person who makes the disposal arrangements. Whereas a death must be registered within 5 days of its occurrence, a period of 42 days (the same as for a live birth) is allowed for the registration of a still-birth. There is, at present, no obligation on a person effecting the disposal of a still-birth to send a notification to the registrar giving the details of disposal, even in those cases in which the registrar has issued a disposal certificate. In a system which relies to any extent on the registrar to bring suspicious cases to the attention of the coroner, a delay of up to 42 days in registering a still-birth could seriously impair the value of subsequent investigation; and we have recommended (in Chapter 8) that the period allowed for registering a still-birth should be same as for registering a death. We see no justification for the absence of the requirement to notify the registrar of the means of disposal of the still-birth and recommend that the procedure for the disposal of dead bodies and still-births should, in future, be the same.

Does the law need amendment?

25.11 The existing law governing the disposal of dead bodies is complementary to the existing law governing the certification of the medical cause of death and the reporting of deaths to the coroner. In Parts I and III of the Report

[1] The Removal of Bodies Regulations 1954 (S.I. 1954/448).

[2] Under Regulation 3 of the Cremation Regulations 1930, it is unlawful to burn " human remains " except in a crematorium of the opening of which notice has been given to the Secretary of State (see paragraph 25.07 above). The term " human remains " is generally understood to include a still-birth. Although the point has not, to our knowledge, been determined by the courts, it seems likely that it would be an offence to burn a still-birth anywhere else, e.g. in a hospital incinerator.

we have made recommendations which we believe will substantially improve these two procedures. If they are put into effect, the registrar who receives a medical certificate of the fact and cause of death should, in future, have increased assurance that the cause of death has been accurately established, that no suspicion attaches to the death, and that disposal may be authorised without risk that grounds may subsequently emerge justifying further enquiry into the cause of death for which retrieval of the body might be of value. This new situation will have important implications for the procedure governing the disposal of dead bodies—in particular for the cremation certification procedure which we look at in the next chapter.

CHAPTER 26

CREMATION CERTIFICATION— THE EARLY HISTORY AND THE EXISTING LAW

The early history

26.01 The modern practice of cremation in this country began in March 1879, when the body of a horse was successfully reduced to ashes in an Italian-designed furnace operating in premises at Woking owned by the Cremation Society. The Society was founded in 1874 by Sir Henry Thompson, Bt., surgeon to Queen Victoria. In the six years between March 1879 and March 1885, when the same apparatus was used for the first time to cremate human remains, the bodies of three persons were cremated on apparatus constructed on a private estate in Dorset and a Welsh doctor was unsuccessfully prosecuted for attempting to cremate the body of a 5-months-old child. This unsuccessful prosecution was of very great importance to the development of cremation in Britain, since it led to a declaration by Mr. Justice Stephen that cremation was not unlawful provided that the act of cremation was not carried out in such a way as to cause a public nuisance.[1]

26.02 Following these proceedings, the Cremation Society declared itself willing to cremate human remains at Woking, provided that those persons applying for cremation followed a procedure laid down by the Society. This procedure was especially designed to ensure that cremation should not be used to destroy the remains of any person into whose death further enquiries might be desirable. An applicant for cremation was required to complete a detailed form of application and to obtain two medical certificates from different doctors. All three documents had to be scrutinised by another doctor, who was known as the " medical referee ". The first medical referee at Woking was Sir Henry Thompson.

26.03 In 1885, the Cremation Society carried out three cremations—all at Woking. By 1901, there were crematoria at Manchester, Liverpool, Darlington and Hull (the last-named was the first municipal crematorium) which between them carried out 427 cremations. Cremations in each of these new crematoria were controlled by a procedure broadly in line with the one adopted by the Cremation Society for use at Woking.[2]

26.04 The practice of cremation received statutory recognition in 1902, with the passing of the Cremation Act of that year, which gave burial authorities power to provide and maintain crematoria. The Act did not, itself, lay down any precise rules; instead, it placed a duty upon the Home Secretary to make

[1] *R.* v. *Price* (1884) 12 QBD 247.
[2] For details of these procedures see Appendix III of the Report of the Departmental Committee on Cremation, 1903 (Cd. 1452).

detailed regulations to control the practice of cremation.[1] Later that year, the Home Secretary appointed a Departmental Committee (consisting of two officials from the Home Office and a Senior Assistant Medical Officer from the Local Government Board) whose terms of reference required it to prepare a draft of the regulations to be made under the Act. Representatives of the Cremation Society were among those who gave evidence to the Committee and the regulations which finally emerged from the Committee's deliberations closely followed the procedure already being operated voluntarily by the Society.[2] The avowed objective of the regulations was to detect crime. They were designed to " reduce to a minimum the risk of cremation being used to destroy the evidence of murder by violence or poison ".[3]

26.05 The risk that cremation would be used to conceal a crime was very much stronger at the beginning of this century than it is now. In 1902, it was still not necessary to obtain a certificate for disposal from either a registrar or a coroner before proceeding to dispose of a body by burial or removal out of England and Wales and it was possible to carry out the disposal without first registering the death. Moreover, although the fact that a death has been registered certainly made disposal easier to arrange, it was possible to register a death without first providing the registrar with a medical certificate of the cause of death given by a registered medical practitioner. Since there was in 1902 no strict regulation of earth burial, which, in theory at least, left open the possibility of a further examination of the body after exhumation, it is hardly surprising that strict controls were thought necessary to regulate the practice of cremation. In 1971, the situation is very different. As we have seen in Chapter 25 it is impossible lawfully to dispose of a body by any method without first obtaining a disposal certificate either from a coroner or from a registrar and neither document will be issued if there is any suspicion in the mind of the registrar or coroner that there may be a need for the body to be retained for any purpose.

The existing cremation law

26.06 The existing law is contained in regulations made in 1930, as amended by regulations made in 1952 and 1965.[4] An application for cremation must be made on a prescribed form (Form A) by an executor or other person whose duty it is to dispose of a body. Unless the death is one which has been reported to the coroner (in which case a different procedure applies) the applicant must obtain two medical certificates in duly prescribed form, one

[1] Section 7 of the Cremation Act 1902 requires the Secretary of State " to make regulations as to the maintenance and inspection of crematoria and prescribing in what cases and under what conditions the burning of any human remains may take place ... and prescribing the forms of the notices, certificates, and declarations to be given or made before any such burning is permitted to take place ".

[2] The first Cremation Regulations came into force on 3 June 1903 and, although new principal regulations have been made twice since that date, the 1903 provisions have been in force, in their essentials, ever since that time. Since 1903, the practice of cremation has grown steadily—slowly at first, but with increased momentum in the last 25 years. In 1945, less than 8 per cent of all persons who died in England and Wales were cremated; in 1968 (for the first time) more dead persons were cremated than were buried. Table T on pages 292 and 293 shows that the proportion of cremations as a percentage of all deaths has risen consistently by about 2 per cent in every year since the end of the last war.

[3] Report of the Departmental Committee on Cremation, 1903 (Cd. 1452), page 6.

[4] See Appendix 8 for the text of the Regulations as amended.

TABLE T

Number of Cremations Carried Out in England and Wales 1885–1970

(1) Year	(2) No. of Crematoria	(3) No. of Registered Deaths	(4) No. of Cremations Carried Out	(5) % of Col. 4 to Col. 3
1885	1	522,750	3	—
1886	1	537,276	10	—
1887	1	530,758	13	—
1888	1	510,971	28	—
1889	1	518,353	46	—
1890	1	562,248	54	—
1891	1	587,925	99	—
1892	2	559,684	107	—
1893	2	569,958	131	—
1894	2	498,827	172	—
1895	2	568,997	208	—
1896	3	526,727	191	—
1897	3	541,487	234	—
1898	3	552,141	329	—
1899	3	581,799	351	—
1900	3	587,830	424	—
1901	5	551,585	427	—
1902	7	535,538	431	—
1903	8	514,628	453	—
1904	8	549,784	550	0·1
1905	12	520,031	569	0·1
1906	12	531,281	698	0·1
1907	12	524,221	677	0·1
1908	12	520,456	767	0·1
1909	12	518,003	824	0·2
1910	12	483,247	812	0·2
1911	12	527,810	984	0·2
1912	12	486,939	1,090	0·2
1913	12	504,975	1,139	0·2
1914	12	516,742	1,222	0·2
1915	13	562,253	1,348	0·2
1916	13	508,217	1,295	0·3
1917	13	498,922	1,444	0·3
1918	13	611,861	1,721	0·3
1919	13	504,203	1,947	0·4
1920	13	466,130	1,716	0·4
1921	13	458,629	1,835	0·4
1922	14	486,780	1,934	0·4
1923	14	444,785	1,898	0·4
1924	15	473,235	2,308	0·5
1925	15	472,841	2,585	0·5
1926	15	453,809	2,779	0·6
1927	15	484,609	3,136	0·6
1928	17	460,389	3,295	0·7
1929	17	532,492	4,149	0·8
1930	18	455,427	4,281	0·9
1931	19	491,630	4,864	1·0
1932	21	484,129	5,875	1·2
1933	28	496,465	6,890	1·4
1934	32	476,810	7,593	1·6
1935	33	477,401	8,746	1·8
1936	34	495,764	10,188	2·1
1937	38	509,574	12,641	2·5
1938	44	478,996	14,523	3·0
1939	47	499,902	17,643	3·5
1940	49	581,537	22,312	3·8
1941	50	535,180	22,833	4·3
1942	50	480,137	24,778	5·2

TABLE T—Continued

Number of Cremations Carried Out in England and Wales 1885–1970

(1) Year	(2) No. of Crematoria	(3) No. of Registered Deaths	(4) No. of Cremations Carried Out	(5) % of Col. 4 to Col. 3
1943	51	501,412	29,956	6·1
1944	51	492,176	34,459	7·0
1945	51	488,108	38,269	7·8
1946	51	492,090	44,844	9·1
1947	51	517,612	55,195	10·7
1948	51	469,898	57,907	12·3
1949	51	510,736	72,517	14·2
1950	51	510,301	81,576	16·3
1951	52	549,380	98,028	17·8
1952	56	497,484	98,523	19·8
1953	61	503,529	107,505	23·0
1954	67	501,896	115,201	23·0
1955	76	518,864	129,957	25·0
1956	91	521,331	141,214	27·3
1957	99	514,870	150,400	29·2
1958	111	526,843	166,154	31·5
1959	121	527,651	175,740	33·3
1960	137	526,268	188,172	35·8
1961	146	551,752	206,872	37·5
1962	154	557,836	222,027	39·8
1963	159	572,868	240,495	41·9
1964	164	534,737	235,287	44·0
1965	166	549,379	249,378	45·4
1966	174	563,624	270,856	48·1
1967	178	542,516	270,959	49·9
1968	182	576,754	302,130	52·4
1969	182	579,378	311,624	53·8
1970	184	574,256	325,552	56·7

of which (Form B) must be completed by the ordinary medical attendant of the deceased person and the other (Form C) by a doctor not connected with the first doctor. All these documents are then sent to the medical referee of the crematorium, who, if he decides to authorise cremation, issues another certificate (Form F), which is sent to the crematorium superintendent. Alternatively, if the death has been reported to a coroner, the regulations provide for him to issue a certificate (Form E) which the medical referee is empowered to accept in lieu of the medical certificates issued by the two doctors. A medical referee may also allow cremation on the production of a certificate in Form D (certificate after post-mortem examination) issued either by himself or by a pathologist appointed by the cremation authority or, in case of emergency, appointed by the medical referee. In certain circumstances, a referee may allow cremation on the production of other documents to which we shall refer later.

26.07 In every case, the medical referee must satisfy himself that the requirements of the Cremation Acts and Regulations have been complied with, that the cause of death has been definitely ascertained and that there is no reason for any further enquiry or examination of the body.[1]

[1] See Form F (the authority to cremate) printed in Appendix 8.

The application for cremation (Form A)

26.08 Form A requires an applicant to give his name and address and occupation, and the same particulars plus age and sex in respect of the deceased person. He must then answer a series of questions designed to establish such particulars as his relationship with the deceased, the attitudes of the near relatives[1] of the deceased to the proposed cremation, the particulars of the death (i.e. date, time and place), the names and addresses of the ordinary medical attendant of the deceased and any other doctor who may have attended during the last illness. The applicant is asked to state on the form whether he has any reason to suspect that the death was due directly or indirectly to violence, poison, privation or neglect or for supposing that there is any reason why an examination of the remains is necessary. The form has to be countersigned by " a householder to whom the applicant is known " who can certify that he has " no reason to doubt the truth of any of the information furnished by the applicant ".[2]

The first medical certificate (Form B)

26.09 Under the regulations, Form B must be given by the registered medical practitioner who attended the deceased person during his last illness and who has given the ordinary medical certificate of the cause of death which is required for registration purposes. According to the regulations, the doctor who gives Form B must be able to certify definitely the cause of death and the form of the certificate requires him to have seen and identified the body after death. The form contains 18 questions. Like the person applying for cremation, the doctor is required to give particulars of the hour, date and place of death and the name and address of the deceased. He must disclose his relationship, if any, to the dead person and state whether he has any pecuniary interest in the death. He must also say whether he was the ordinary medical attendent of the deceased and whether he attended the deceased person during his last illness. In both cases, he must state the length of his attendance. As to the death itself he must indicate how soon after death he saw the body, describe his examination of it, state the cause of death, and the mode of death[3] and its duration in days, hours and minutes. He is asked to state whether his answers concerning the mode of death are based either on his own observation or on those of some other person who was present at the moment of death. If they are partly based on the statement of others, he must indicate by whom these statements were made. Particulars are required also of any operation undergone by the deceased person during the final illness or within a year of death and the doctor is asked to name the persons nursing the deceased person during the last illness and the persons (if any) present at the moment of death. Finally, the certifying doctor must say whether, in view of his knowledge of the deceased person's habits and constitution, he feels any doubt whatever as to the character of the disease or cause of death, whether he has any reason to suspect that the death was due directly or indirectly to violence, poison,

[1] The term " near relative " is defined in a note appended to the certificate as including a widow or widower, parents, children above the age of sixteen, and any other relative usually residing with the deceased.

[2] See Form A as printed in Appendix 8.

[3] The examples of "mode of death" given on the certificate are "syncope, coma, convulsions, etc. "—the same examples that were on the certificate in 1903.

privation or neglect, or to suppose that a further examination of the body is desirable. If he has not also given the certificate required for registration purposes, he must say who has. The doctor must certify all his answers as being true and accurate to the best of his knowledge and belief and he must further certify that he knows of no reasonable cause to suspect that the deceased person died either a violent or an unnatural death or sudden death of which the cause is unknown or died in such place or circumstances as would require an inquest to be held.

The confirmatory medical certificate (Form C)

26.10 The second medical certificate must be issued by a registered medical practitioner of more than 5 years' standing who is neither a relative of the deceased nor a relative or partner of the doctor who has given Certificate B.[1] The Form requires him to state that he has examined Form B and that he has based his answers to the eight questions of Form C upon personal enquiry. Neither the Regulations, nor the prescribed Form itself, contain a specific requirement that the second doctor must have seen the body, but he must say whether he has done so and whether he has carefully examined it externally. He must also indicate whether he has made a post-mortem examination. The form of the certificate requires the doctor to name those persons whom he has seen and questioned concerning the death. He is obliged to indicate whether he has seen and questioned the doctor who issued Form B, any other doctor who attended the deceased, those who nursed the deceased during the last illness or were present at the death, or any relative of the deceased or any other person. He must give the names and addresses of all these persons except those of the doctor who signed Form B. He must also say whether he saw those persons alone. The confirming doctor must state that he is satisfied that the cause of death is as stated and certify, in exactly the same terms as the Form B doctor, that he has no reason to suspect that an inquest is necessary.

26.11 According to a " Note " printed at the bottom of Form C as prescribed in the regulations, it is the duty of one of the two certifying doctors to hand both certificates to the medical referee or send them to him in a closed envelope.

The cost of cremation certificates

26.12 It is the practice for a charge to be made by the medical practitioners responsible for the issue of Certificates B and C. The amount of the fee charged is, in law, a matter for private agreement between the relatives of the deceased and the certifying doctor. The Cremation Act 1952, which was introduced by a Private Member, gives the Home Secretary power to prescribe fees for the medical certificates required by the regulations, but this power has never yet been exercised. When the Bill was before Parliament, the Home Office spokesman indicated that, while the Home Secretary accepted such a power, he was anxious not to use it and that he preferred to rely on the fees being controlled by voluntary arrangements in the medical profession. In 1953, a fee of 2 guineas (£2.10p) for each certificate was recommended by the

[1] It is lawful for the medical referee if he has personally investigated the cause of death to give a certificate in Form C (Regulation 11, Cremation Regulations 1930).

British Medical Association and, in the absence of evidence that this recommendation was being widely ignored, successive Home Secretaries declined to exercise their power to prescribe the amounts that might be charged. In July 1969, the Association recommended that the fee for each certificate should be increased to 3 guineas (£3.15) and in April 1971 a further increase to £4 was recommended. We learned from witnesses that there has always been controversy about the proper amount for these fees. Not all doctors follow the BMA recommendation and some charge more than the recommended fee. The arguments about the amounts of these fees ranged from the contention that the certificates should be free under the National Health Service to one that doctors should be free to charge " what the market will pay ". The Home Office informed us that there was no proposal for the Home Secretary to exercise his power to prescribe fees before receiving this Report.

Form D—certificate after post-mortem examination

26.13 The effect of Regulations 8 and 12 of the principal Regulations is such that a medical referee may also authorise a cremation on receipt of a certificate in Form D. This is a certificate giving the result of a post-mortem examination and may be completed either by the medical referee himself, if he has performed the autopsy, or by any medical practitioner who has carried out such an examination on his instructions. The doctor completing this certificate certifies that he has made a post-mortem examination on the body of the deceased person whose name, address and occupation he must insert on the certificate. He must declare that he is satisfied that the cause of death is as stated on the certificate and that there is no reason for making a toxicological analysis or for holding an inquest. The reference to a toxicological analysis has to be deleted if one has been made and the result is stated on the certificate or on another attached to it.

26.14 The Regulations are not very clear about the circumstances in which a certificate in Form D should be completed. But, in practice, it is issued either because the medical referee is for some reason not satisfied with the certificates submitted to him and decides to exercise his right to order a post-mortem examination (see paragraph 26.26 below) or because for some reason it is not possible for Forms B and C to be completed and a post-mortem examination arranged by the medical referee provides the only way of securing a cremation without reporting a death to a coroner. The Regulations do not give the medical referee any power to pay for a post-mortem examination. In practice, the cost of a certificate in Form D is borne sometimes by the relatives or other persons arranging the cremation and sometimes by the cremation authority.

The coroner's certificate (Form E)

26.15 A coroner's certificate in Form E (which is issued without charge to the relatives) is the only certificate available to the medical referee in cases where a coroner has accepted jurisdiction over the death. A coroner is usually called upon to issue a cremation certificate because the death has been reported to him as a result of the operation of the normal processes of certification and registration of deaths and because the relatives want the body to

be cremated. (It can, and on very rare occasions does, happen that a coroner issues this certificate after the death has been referred to him as a result of the operation of the cremation certification procedure.)

26.16 A coroner may issue Form E as soon as he has either certified the medical cause of death after a post-mortem examination or opened an inquest on the dead person. The possibility of issuing a cremation certificate before the conclusion of an inquest has existed only since 1965, when the principal regulations were amended. Before 1965, with certain exemptions for industrial, railway, flying or road accidents, a coroner could not issue a certificate in any case in which he was holding an inquest until the completion of the inquest proceedings. The exceptions were intended to apply to a situation in which the coroner was satisfied as to the medical cause of death on the basis of a post-mortem examination but was adjourning his own proceedings until the result of some other form of enquiry into the accident was known. In the event, however, the proviso proved unsatisfactory in respect of deaths caused by road accidents. In these cases, delay arose because of the requirement that an inquest should be adjourned if, as a result of the accident, anyone was charged with the offence of manslaughter or causing death by dangerous driving. The view was taken that when an inquest was adjourned pending the result of criminal proceedings, this was not an adjournment " with a view to the investigation of the causes of the accident " (the phrase mentioned in the proviso to the 1930 Regulations). It followed that, on the numerous occasions on which inquests were adjourned for this reason, cremation might be delayed for many months until the trial at assizes had been completed. It was observed that this situation caused considerable distress to relatives who were unable to go ahead with the funeral arrangements until the coroner had concluded his enquiries. The change in the law brought about by the 1965 amending Regulations has virtually done away with this hardship. But, as a direct result of this change, Form E no longer provides for a statement of the cause of death since the Form is now sometimes issued before the end of the inquest when it is not possible, in a legal sense, to state the cause of death.[1] It follows that the medical referee in such a case is, theoretically at least, in difficulty if he wishes both to issue Form F authorising cremation and to carry out, before doing so, his statutory duty to satisfy himself that the cause of death has been definitely ascertained. In addition to this apparent anomaly, there are a few other circumstances to be noted here in which a medical referee is empowered to allow a cremation in the absence of a definite ascertainment of the cause of death or, alternatively, in the absence of the prescribed certificates.

Orders made by the Home Secretary

26.17 The 1930 regulations make provision specifically for the cremation of the remains of persons who have died outside this country and whose bodies have been brought back for cremation. Under Regulation 12, the Home Secretary has power, in any case in which a death took place out of England and Wales and he is satisfied that the case is one in which cremation may properly take place, to authorise a medical referee to allow cremation

[1] When a death is the subject of a coroner's inquest, the cause of death recorded for registration purposes must agree exactly with the findings of the coroner's inquest.

without the production of Forms B and C. We were informed that, in every such case, the Home Office asks to see all the documents which have accompanied the body to this country as well as the form of application for cremation. It is usually practicable to establish that a death was " natural " from examination of documents issued in the country where the death occurred. But it is not practicable to make detailed enquiries about every such death which occurs abroad, so that, for the most part, the Home Office has to be satisfied with whatever information is available.

26.18 Under this same Regulation, the Home Secretary may authorise a medical referee to allow cremation in the absence of a coroner's certificate in Form E if he is satisfied that " by reason of any special circumstances it is undesirable or impracticable to hold an inquest ". Although the Regulation does not specifically limit the exercise of this power to deaths occurring abroad, the Home Office told us that, in practice, the power is only used when a death has occurred overseas in circumstances which would, if they had occurred in this country, have made an inquest mandatory. It has been recognised by coroners and the Department that it would be virtually impossible for an English coroner to summon to the United Kingdom the witnesses necessary to hold an inquest on such a death. Nevertheless, it has been the invariable practice of the Home Office to secure the agreement of the coroner in whose area the body is lying before proceeding to make an order. In any case in which the Home Office has had doubts about the adequacy of the enquiry made abroad into the cause of death it has sought the help of the Foreign and Commonwealth Office in obtaining information from the country where the death occurred. However plentiful or scarce the information supplied, it has been almost unknown for the Home Office to refuse to issue an Order. In 1970 the Home Office issued 247 Orders in respect of bodies brought in from abroad—at least half of which represented deaths which, if they had occurred in this country, would have been reported to coroners.

Deaths in Scotland

26.19 Where a person dies in Scotland and his relatives wish him to be cremated in England or Wales, it is not necessary to seek an order from the Home Secretary. The Cremation Regulations 1952 empower a medical referee to accept an application accompanied by certificates given in accordance with the regulations operating in Scotland. These are, broadly, comparable to the English regulations.

Cremation of remains buried for more than one year

26.20 Under Regulation 13 of the 1930 Regulations a medical referee may allow the cremation of human remains which have been buried for one year without production of any of the certificates usually required, but subject to such conditions as the Home Secretary may have imposed either in his licence authorising the removal of the interred remains or otherwise. This provision is used, for example, when, for various reasons, old burial grounds are being developed for other purposes and it is necessary to remove the remains in the course of development.

Dispensing with certificates in the interests of public health

26.21 Under Regulation 14 of the 1930 Regulations, the medical referee may, if he is satisfied as to the cause of death, authorise the cremation of persons who have died of " plague, cholera or yellow-fever " even though the ordinary requirements of the cremation regulations have not been met. There is also provision in this regulation for certain other regulations to be " temporarily suspended or modified in any district during an epidemic or for other sufficient reason by an order of the Secretary of State on the application of a Local Authority ". We are not aware that any such order has been issued in recent years.

The disposal of anatomical remains—Form H

26.22 Another change introduced by the 1965 regulations concerned the disposal of human remains which have been used for instructional purposes in hospitals or medical schools. A medical referee may now authorise cremation in the absence of any of the usual certificates when the body has undergone an anatomical examination under the provisions of the Anatomy Act 1832 and a certificate in Form H has been given by a person licensed to practise anatomy under that Act. A person giving Form H is required to state the full name, age and sex of the deceased person together with the date and place of death.

The powers and duties of the medical referee

26.23 The Regulations provide that every crematorium must possess a medical referee and a deputy medical referee and that no cremation may take place except upon the authority of a certificate given by a referee. Medical referees and their deputies are appointed by the Home Secretary on the nomination of the cremation authority. They are required by the Regulations to be registered medical practitioners of not less than 5 years' standing and they must possess such experience and qualifications as will fit them for the discharge of their duties.

26.24 We made enquiry of the Home Office to discover how far these provisions had been found useful in the selection of referees of recognisable standing. We learned that, in practice, the Home Office has found itself unable to do more than check that the candidate nominated by the cremation authority has the necessary medical qualifications. In other words, appointments are, in effect, made by the cremation authority and the approval of the Home Secretary amounts to little more than a " rubber stamp ". Most crematoria are run by local authorities, either individually or jointly, and, where this is the case, it is the usual practice for medical officers of health to be appointed to the post of medical referee.[2] The 19 privately owned crematoria all employ general practitioners as medical referees.

[1] A cremation authority is defined in the Regulations as " a burial authority or any company or person by whom a crematorium has been established ".

[2] There is a difference of opinion between the British Medical Association on the one hand and the professional organisations of the medical officers of health and medical referees on the other about the suitability of medical officers of health for the post of medical referee. The BMA claim that the post requires wide clinical experience which few medical officers of health can be expected to possess. The contrary argument lays emphasis on the independence of the medical officer of health from the medical practitioners whose certificates he will be called upon to scrutinise and points to the administrative advantages that can flow from the combination of the two offices.

Remuneration of medical referees

26.25 There is no prescribed fee for the issue of Form F (the authority to cremate) and both the amount of the fee charged by medical referees and the payment made to them by cremation authorities varies throughout the country. The fee paid for this certificate may be as little as 25p or as much as £1.05. In some places, payment for the certificate is included in a single cremation fee charged by the cremation authority. Medical referees sometimes retain the whole of the fee, sometimes a part of it, but often pass the whole amount to the cremation authority. Those who are also medical officers of health usually retain no part of the fee, but receive in addition to their salary as medical officers an allowance proportionate to the number of cremations which they are asked to authorise. This allowance is computed in accordance with a scale agreed during Whitley Council negotiations. It is difficult to convert this allowance into a figure for each cremation, but, roughly, it represents a scale running from a maximum of about 25p, which will be exceeded if there are very few cremations, to a minimum of about 5p. Medical referees who are also medical practitioners are more likely to retain the whole of the fee paid by the applicant for cremation and this fee is usually £1.05—the amount recommended by the BMA.

26.26 On paper, the duties of a medical referee look onerous—although, as we have seen, the payment which he receives does not always suggest that the work is very demanding. His duties are set out in detail in Regulation 12 (as amended) of the principal Regulations. The medical referee is required to examine the application and the certificates presented to him and to satisfy himself that they are in order and that they have been completed after adequate enquiry. He has an unfettered power to make whatever further enquiry he thinks necessary and he may decline to authorise cremation without giving any reason. If he is, for any reason, not satisfied with the documents presented to him, it is open to him to require a post-mortem examination, to refer the death to a coroner or simply to refuse cremation. He is, however, obliged to require a post-mortem examination " if the cause of death assigned in the medical certificates is such as, regard being had to all the circumstances, might be due to poison, to violence, to any illegal operation, or to privation or neglect ". The results of this examination will be reported to him on a certificate in Form D. If this examination fails to reveal the cause of death, he must decline to allow the cremation unless an inquest is opened. He may, of course, refer the death to the coroner without calling for a post-mortem examination, for which, in any event, he cannot himself pay. We shall consider the use to which the medical referee puts these various powers as we consider the way in which the Cremation Regulations work out in practice.

CHAPTER 27

CREMATION CERTIFICATION— THE EXISTING PRACTICE AND OUR RECOMMENDATIONS FOR THE FUTURE

27.01 A quarter of a million cremations annually are authorised by medical referees on the basis of information provided by an applicant for cremation on Form A and certificates in Forms B and C given by two doctors. Once cremation has been decided upon, the responsibility for providing the medical referee with these Forms usually falls on the funeral director or upon whoever is making arrangements for the funeral. The application form and the certificates are provided by cremation authorities—almost all of whom print their own. Form B and Form C are printed together on the same document. Once Form A has been completed, the funeral director will hand Forms B and C to a doctor who has attended the deceased in his last illness and who, provided he has seen the body after death, will be able to complete Form B. From this point, the doctors giving the cremation certificates work to a time-table which is determined by whatever funeral arrangements the relatives, the cremation authority and the funeral director himself regard as most convenient. Table U on page 302 indicates that the interval between death and disposal does not vary significantly according to whether disposal is to be by burial or cremation. Most funerals take place between three and six days after death. In many cases, the decision that the disposal should be by cremation is taken before death, either by the deceased person himself or by his relatives, so that the process of cremation certification can begin soon after death. We understand that, where cremation is intended, doctors complete the medical certificate of the cause of death required for registration purposes and Form B soon after they have seen the body following death. The doctor who has completed Form B is responsible for handing this certificate to a second doctor to complete Form C and both forms are then sent to the medical referee.

27.02 Having regard to the other demands and pressures on the time of the doctors responsible for completing Forms B and C and on the medical referee (all of whom are involved in the cremation certification process on a "part-time" basis), we had expected to be told that this process of intercommunication between the doctors and also between doctors and the relatives or friends of the deceased sometimes caused difficulty or inconvenience. In fact, however, our witnesses made no mention of any problems of this nature and the Home Office told us that it was almost unknown for a complaint to be received from a member of the public discomfited by questions put to him by the doctor responsible for completing Form C or by a medical referee. We have concluded that, if they are to be judged only by the test of convenience *to the public*, the present arrangements for cremation certification can be said to be generally satisfactory.

27.03 The evidence which we received from our witnesses about the working of the certification procedure set out in the Cremation Regulations was

TABLE U

Interval Between Death and Disposal of Body

Source: A sample of 2,202 deaths occurring in the latter half of 1969, taken from one registration subdistrict in each of the ten registration regions, and supplied by the Registrar General for England and Wales

Days	*Burial* Disposal document issued by		*Cremation* Disposal document issued by	
	Registrar	Coroner	Registrar	Coroner
0	1	1	2	2
1	1	—	—	—
2	52	1	43	3
3	221	12	216	24
4	287	12	214	54
5	195	18	158	59
6	129	10	103	50
7	68	5	38	40
8	32	4	14	17
9	23	5	14	14
10	11	1	3	2
10+	25	6	7	5
Totals ...	1,045	75	812	270
Grand Totals	1,120		1,082	

coloured by the view which they each took of cremation itself. The representatives of the cremation movement, for example, started from the premise that cremation is, in itself, " a good thing " and that it, therefore, deserved official encouragement (or, at the very least, not discouragement). They saw the existing procedures as being unnecessarily complicated, out of date, expensive and restrictive; and they made no secret of their desire to see a simplified procedure. The British Medical Association, on the other hand, while recognising the " considerable sanitary and economical advantages " of cremation chose to place their own emphasis on the fact that cremation is the most efficient way of completely destroying the dead body. From that position, they concentrated their evidence and their arguments on the need for the strictest precautions to be taken before a body was disposed of in this way. Other witnesses tended towards one or the other of these extreme views and the burden of their evidence was shaped accordingly. All of our witnesses concerned themselves chiefly with the merits of the medical certificates required for cremation purposes and with the care (or lack of it) in the completion of these documents taken by the three doctors concerned in the certification process. The following were the main lines of argument put to us.

27.04 The representatives of the cremation movement and of the National Association of Funeral Directors accepted the need for a certificate broadly along the lines of Form B (they were ready to suggest modifications to the present certificate) because they recognised that, for the purposes of cremation, it was necessary to have a " stronger " certificate than the existing medical certificate of the cause of death required for registration purposes. They saw

the need for a certificate which would require the doctor completing it to have made some kind of examination of the body before doing so. They also suggested that, whether by means of this certificate or otherwise, the certifying doctor should be encouraged to consider carefully whether any factors relating to the death made a further examination of the body desirable. As to Form C, they accepted that, where genuine doubts existed about the cause of death, this certificate might be more valuable if it were completed by an experienced hospital pathologist after a post-mortem examination.[1] In their view, only an examination of this kind could provide conclusive evidence of the cause of death and confirm whether there was reason to suppose that any suspicion attached to the death. But, subject to this proviso, they saw little value or purpose in requiring a confirmatory certificate. They told us that, in their experience, Form C was frequently produced in a hasty or perfunctory manner, often even without a sight of the body. If an examination of the body was made, it was, they thought, usually too superficial to be able to detect foul play or negligence of a sort which might have escaped the attention of the doctor giving Form B, or for which that doctor might have had some responsibility. Funeral directors told us that, in their experience, doctors often completed a certificate in Form C in respect of a body which was already in its coffin and after an examination consisting merely of a glance at the deceased person's face.

27.05 The British Medical Association took the view that the involvement of three doctors in the certification process and the existence of a requirement that the medical referee should be satisfied that the cause of death had been " definitely ascertained " were both essential safeguards against the destruction of evidence of crime or neglect. Like the representatives of the cremation movement and the National Association of Funeral Directors, they had their own suggestions to offer for improving the content and general layout of Form B; but they had no serious criticisms to offer about the way in which the Form B doctor approached his responsibilities in connection with the completion of this certificate. Form C they regarded as the " lynch-pin " of the cremation certification process. They strongly urged that the requirement for a confirmatory certificate should be retained (calling it a " vital safeguard "). They accepted that the wording of the questions in Form C could be improved, but they did not accept that the fact that the form was badly worded and the answers to the questions often very brief meant that the forms were inadequately completed or that the doctor's examination of the body had been cursory or that he had asked no questions before completing the certificate.

27.06 The Association of Crematorium Medical Referees expressed themselves, on the whole, content with the present cremation regulations. In their view, the regulations encouraged improvements in the standards of certification of the cause of death, for registration as well as for cremation purposes, and, at the same time, they provided a protection for the public interest. They argued also that the requirement that Form C should be

[1] We were told that, even when a post-mortem examination had not been carried out in a hospital by an experienced pathologist, it was not unusual for a certificate in Form C to be given by another member of the hospital staff.

completed by a medical practitioner not connected with the doctor who completed Form B was conducive to a more careful assessment of the causes of death by both doctors; and they asserted that interviews with those who had nursed the deceased or who had been present at the death could bring to light " sources of dissatisfaction and anxiety " which it was proper for doctors to take into account before completing these certificates.

27.07 Other witnesses, notably the Police Federation, the Coroners' Society and individual pathologists, all stressed the need for safeguards against crime in any cremation certification procedure. But, at the same time, they were strongly of the opinion that the existing arrangements were far from perfect. There was support from these sources for the view that Form C, in particular, was an over-rated document which should either be dispensed with altogether or replaced by something better. The Police Federation and the Coroners' Society both suggested that the functions of a medical referee in scrutinising cremation certificates might be better carried out by whole-time coroners.

27.08 This bare summary of the main arguments put to us does no justice to the vigour, or sense of conviction, with which the various interests pressed their respective views. We were impressed by our witnesses on this subject, but we confess that we found none of them wholly convincing. It seemed to us that, in preparing their evidence, none of them had taken sufficiently into account either the changes in the law and practice of medical certification of the cause of death which have taken place over the last 70 years or the experience of other forms of disposal in the same period. None of them advanced their arguments from the context of a fully comprehensive and improved procedure for certifying the medical cause of death, such as the one which we have recommended in Part I of our Report. To our minds, two developments in this century are of particular significance. First, the existing law relating to the medical certification of the cause of death (despite the defects which we have noted in Part I) provides a much greater measure of assurance that an untoward death will come to notice than was the case in 1903.[1] Secondly, experience of exhumations since 1903 has shown that, notwithstanding the great advances in forensic science since then, the practical distinction between earth burial and cremation, from the point of view of the destruction of evidence of unsuspected homicide, is much smaller than was believed to be the case in 1903.[2] With these developments in mind and in the knowledge that cremation will become more and more the predominant method of disposal, we concluded that the principal questions which we should ask ourselves with regard to the cremation certification procedure were:

(1) What lessons are there to be learned from the experience of 70 years' operation of the cremation regulations? or, put another way, what advantages, if any, does a procedure involving the issue of certificates by three doctors hold over the improved procedure for certification of the medical cause of death which we have recommended in Part I of this Report?

[1] Chapter 26, paragraph 4.
[2] Chapter 4, paragraph 27.

(2) Assuming that our recommendations in Part I are adopted, what supplementary safeguards, if any, will be needed after a registrar or appropriate authority has authorised disposal but before the body is cremated?

(3) What changes should be made in the cremation law?

(i) *What lessons are there to be learned from the experience of 70 years of the cremation regulations?*

Form B

27.09 As we have seen in Chapter 26, Form B is a long, and at first sight, rather a complicated document. It was criticised by nearly all our witnesses on the grounds that it is repetitive and, in places, less than clear. At the same time, they were all agreed that, given the deficiencies in the existing law relating to the certification of the cause of death for registration purposes, a certificate along these lines was an essential element in the cremation certification procedure.

27.10 We agree with these criticisms and we accept, too, that the virtue of this certificate lies in the fact that it is a better medical certificate of the cause of death than the one which a doctor who has attended a deceased person in his last illness is required to send to the registrar of deaths. It is better because it is so constructed as to concentrate a doctor's mind on two important matters, viz:

(1) the need to describe the medical cause of death accurately, and

(2) the need to consider whether there is any factor or circumstance which would make it desirable that a further examination of the body should be carried out.

The certifying doctor should be prompted to consider both these points by the questions on the certificate (in particular, questions 15, 16 and 17), the content of which we have already described in paragraph 26.09 above. The certifying doctor should also be encouraged to consider the knowledge and judgment of others close to the deceased by the question asking whether, in furnishing certain information, he is relying on his own knowledge or on what other people have told him.

27.11 But, despite these obvious merits, the certificate is far from perfect. In the first place, it contains a number of features which we have considered and rejected for inclusion on a new medical certificate of the fact and cause of death (see Chapter 7), e.g. the references to the mode of death and to the date and place of death. Secondly, although the form may succeed in directing the mind of a certifying doctor to such questions as " violence, poison, privation or neglect ", neither the Regulations, nor the Form itself, require a doctor to take any specific action if he does have suspicions that these factors may be involved in the death. Thirdly, we think that it would be fair to say that the form is designed not so much to ensure that the certifying doctor makes his own careful examination into the causes and circumstances of the death as to ensure that another doctor (the medical referee or the Form C doctor) has

the opportunity of doing so. A large number of the questions on Form B simply require the doctor to name the persons who might be able to help with such an investigation.

27.12 A particularly unsatisfactory feature of the certificate in Form B is the question which requires the certifying doctor to state whether he has any pecuniary interest in the death. We discussed the whole question of whether or not a known pecuniary interest in a death should disqualify a doctor from giving a certificate of the fact and cause of death in Chapter 6 above. It is sufficient to say here that we see no point in a question which admits of the answer " yes ", but leaves in doubt the question of whether an affirmative answer has any significance.

27.13 As to the manner in which Form B is completed, our witnesses had no serious complaints to make, although we were informed by funeral directors that, in their experience, the examination of the body referred to in the certificate (but not required, in terms, by the Regulations) was sometimes very brief, particularly if it took place at the funeral director's premises.

Form C

27.14 The second medical certificate (Form C) is a much shorter and simpler document than Form B. It is also the feature of the cremation certification procedure which, perhaps more than any other, distinguished it in the minds of our witnesses from the procedure applying to burials. Realising the importance of this certificate in any assessment of the value of the cremation certification procedure, we tried to discover how doctors were accustomed to answer the questions which it contains. We made this attempt not only by closely questioning all those of our witnesses who had had an opportunity to observe the way in which the certificate was completed but also by seeking factual information on the subject. At our request, the Association of Crematorium Medical Referees were kind enough to let us have some data extracted from the answers to the questions on Form C given by doctors to medical referees at four crematoria in different parts of the country. This information is analysed in Table V below. The sample was a small one, but it remains possible to discern from the table certain significant features. The table indicates, for example, that there is a striking reliance by doctors completing Form C on seeing the body and making direct contact with the Form B doctor rather than on making a post-mortem examination, or conducting extensive enquiries involving persons other than the doctor who has given the first certificate. The table also shows that the practice of questioning other doctors who had attended, or other persons who had nursed, the deceased was much the same whether the death had occurred inside or outside hospital. But, as might have been expected, more inquiry was made in hospital of other doctors than of those involved in nursing attendance. When the death took place in hospital, little enquiry was made of relatives. For deaths outside hospital the pattern of answers to this question was erratic, ranging from an affirmative answer rate of 86 per cent at one crematorium (where a whole year's cremations were included in the sample) to nil in another (where the period reviewed was only six weeks). The overall rate of enquiry of relatives when the death occurred outside hospital was about one in every six cases.

TABLE V

Analysis of Replies by Doctors to Questions in Form C

Source: Figures supplied by four cremation authorities and sent to us by the Association of Crematorium Medical Referees

Questions	Deaths in Hospital								Deaths out of Hospital							
	Answer — Yes Cremation Authority				Answer — No Cremation Authority				Answer — Yes Cremation Authority				Answer — No Cremation Authority			
	A	B	C	D	A	B	C	D	A	B	C	D	A	B	C	D
	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
1. Have you seen the body of the deceased?... ...	100	100	100	100	—	—	—	—	100	100	100	100	—	—	—	—
2. Have you carefully examined the body externally	100	100	100	100	—	—	—	—	100	100	100	100	—	—	—	—
3. Have you made a post-mortem examination? ...	7·7	10·9	23·7	16·4	92·3	89·1	76·3	83·6	2	0·2	7	—	98	99·8	93	100
4. Have you seen and questioned the medical practitioner who gave the certificate in Form B?... ...	100	100	100	100	—	—	—	—	100	100	100	100	—	—	—	—
5. Have you seen and questioned the other medical practitioner who attended the deceased?	4·8	17·5	7	6·4	95·2	82·5	93	93·6	1	1·3	1	2	99	98·7	99	98
6. Have you seen and questioned any person who nursed the deceased during his last illness or who was present at his death?	37·5	83·6	42·1	72·4	62·5	16·4	57·9	27·6	61·9	89·6	60·5	52·6	38·1	10·4	39·5	47·4
7. Have you seen and questioned any of the relatives of the deceased?... ...	—	4·5	1	1	100	95·5	99	99	13·4	86·1	—	28·2	86·6	13·9	100	71·8
8. Have you seen and questioned any other person?	6·7	2·1	—	1·4	93·3	97·9	100	98·6	1	7·1	3·5	2·2	99	92·9	96·5	97·8

Replies from Cremation Authority A represent 201 certificates given in the month of January, 1968.
" " " " B " 1,024 " " " " year 1967.
" " " " C " 228 " " " " six weeks ending 31st December, 1967.
" " " " D " 1,161 " " " " six months ending 31st December, 1967.

27.15 What does this evidence amount to? Superficially, the pattern simply reflects the circumstances which we might have expected to find inside and outside hospital and poses no serious questions. But before any deductions are drawn from this data, or, indeed, any judgment is made about the value of Form C, we suggest that two extraneous factors deserve to be considered most carefully. First, Form C is easy enough to complete without real enquiry: none of the eight questions which it contains *must* be answered in the affirmative if it is to have validity. Second, Form C is, in practice, completed by a doctor who is ignorant of the basic facts relating to the patient's death.[1] Such a doctor has two choices. He can complete Form C merely by reproducing the information provided for him by the Form B doctor, or he can make extensive enquiries of his own. The information provided by the Association of Crematorium Medical Referees incorporated in Table V suggests that most doctors choose the first alternative.

27.16 Reliance on information provided by the first doctor would be less a matter for concern if we were convinced that, as indicated in Table V doctors completing Form C do in practice invariably make a careful examination of the body externally. The fact is, however, that a number of our witnesses cast doubt on this. Funeral directors and representatives of the cremation movement told us that, frequently, such an examination was not carried out. Mortuary attendants in hospitals told us that it was rare for doctors invited to complete Form C to ask to have a body laid out on a mortuary table for examination. Individual pathologists who gave evidence to us stated that doctors in their hospitals did not always carry out an examination of the body before giving this certificate and added that, even if the body was examined, the examination might amount to no more than a look at the face. In Chapter 5, where we considered a proposal that a thorough external examination should be a universal requirement before a doctor gives the medical certificate required for registration purposes, we pointed to the difficulties of making such examinations. We do not believe that much effort is being made by doctors at the present time to try to overcome these difficulties—even in hospitals, where, because bodies are in mortuaries and physical assistance is available from mortuary attendants, examination is easier than in a private house. If the doctor completing Form C has *not* examined the body, the fact that he does not trouble to question knowledgeable doctors (other than the Form B doctor) or nurses or relatives clearly has much greater significance. We know from the information provided in Table V that many doctors do not ask these questions.

[1] This is the effect of the requirement in Regulation 9 that the certificate in Form C, if not given by the medical referee " must be given by a registered medical practitioner of not less than five years standing who shall not be a relative of the deceased or a relative or partner of the doctor who has given the certificate in Form B ". The Home Office has frequently advised that the " spirit " of the Regulations requires that the certificate shall be completed by a doctor who has been completely unconnected with the deceased person's treatment. The requirement that the second doctor should be completely independent of the first may once have been justified on the ground that it reduced the risk of the second doctor being subjected to pressures of one sort or another, but, in relation to hospital deaths, one of its effects is to prevent an experienced senior doctor who has some knowledge of the patient's history before death but, for technical reasons, cannot complete Form B, from giving a confirmatory certificate which might have shed new light on the medical cause of death.

27.17 We have not been able to establish whether the Form C procedure ever served a useful purpose. We were informed by medical references that, unless Form C has been completed after an autopsy, the cause of death given on the certificate is invariably the same as that given on Form B. The situation, as we see it, is that the Form C doctor is generally content to rely on the competence of his colleague who has given Form B; that he does not make extensive independent enquiries of his own shows how generally reluctant he is to challenge his colleague's judgment. At its best, therefore, a certificate in Form C not given by a pathologist after an autopsy is, in our view, no more than a statement of confidence in the judgment of the Form B doctor. In its present form, it is impossible to see any case for the continuance of Form C.

The medical referee (Forms D and F)

27.18 If the Cremation Regulations are to be effectively administered a great deal must depend on the actions and attitude of medical referees—about which, as might have been expected, our witnesses offered very different opinions. We were assured by the organisations representing the medical profession and referees that, by and large, referees carried out their duties conscientiously and that they provided a genuine safeguard against crime. A different view was presented to us by the representatives of the cremation organisations and the funeral directors: according to their experience, it was not unusual for the main scrutiny of the certificates to be carried out by clerical staff with no medical qualifications, and some medical referees issued an authority to cremate as a matter of course once the prescribed certificates had been presented to them.

27.19 Partly in the hope that it might help us to resolve their conflict in our evidence but, partly also to improve our general knowledge of the way in which medical referees exercised their responsibilities, we asked each cremation authority to let us have factural information about the cremations that took place in the two years 1965 and 1966 indicating the number authorised in accordance with the various alternative procedures. We are most grateful to all those (nearly 100 per cent) who went to considerable trouble to provide the figures in Tables W and X below. Table W on page 212 summarises the information provided on a national basis and Table X illustrates the practice at individual crematoria. In these tables, there are two references to the Form D procedure, by which a medical referee allows cremation on the production of a certificate after post-mortem examination issued either by himself or by a pathologist appointed by him. The figures in columns 5 and 6 represent the *total* number of cremations authorised on the basis of Form D in each of the two years. The figures in columns 13 and 14 represent those cases where the medical referee decided to resort to Form D after the initial submission of certificates in Forms B and C.[1] The figures for the two years show a remarkable consistency in the practice of individual referees within the annual aggregates. Whereas some medical referees referred at least one or two cases in

[1] The net differences between the figures in columns 5 and 13, 6 and 14 comprise those cases in which the medical referee arranged for a post-mortem examination and for a certificate to be given in Form D because, for some reason, e.g. the absence on holiday of the family doctor, it was not possible for an applicant to provide Forms B and C although the death was not within the jurisdiction of a coroner.

each year to the coroner, others referred none at all. Only 39 medical referees (from a total of 178 crematoria) reported a death to a coroner in either of the two years and only 25 of these in both years. In each year, the medical referee at Liverpool provided nearly 60 per cent of all such reports.

27.20 The figures in columns 5 and 6, 15 and 16 of Table X suggest that, generally, medical referees use a report to the coroner as an alternative to their power to require a post-mortem examination to be held. The medical referee at Liverpool, who reported more deaths to the coroner than any other, did not use the Form D procedure on any occasion. On the other hand, the medical referee at Newcastle-upon-Tyne required a post-mortem examination to be held on 35 occasions (taking both years together), but reported a death to a coroner only once.

27.21 The information in the tables indicates that the vast majority of cremation applications apparently presented medical referees with little trouble. The sum total of the occasions on which a medical referee either required a post-mortem examination (and obtained a certificate in Form D) because he was not satisfied with Forms B and C, or referred a death to a coroner, or refused a cremation amounted to less than 0·2 per cent of the total number of cremations in both years. But, after reading the commentaries sent with some of the statistics and hearing evidence from the Association of Crematorium Medical Referees, we accept that it would be unreasonable to regard the information in the tables as a completely adequate indication of the activities of medical referees. We were told that in some cases, and especially where the cause of death or some feature of the circumstances aroused the referee's interest, medical referees discussed certificates with the doctors who had signed them. According to the Association, some referees, if satisfied that the death is natural though they do not know its precise cause, go to great lengths not to report it to the coroner in order to spare the relatives any embarrassment which such a report might bring. Sometimes, so we were told, a medical referee, not satisfied as a result of these discussions, would arrange for a post-mortem examination to be carried out *informally*, i.e. in such a way that its result was not notified to him in Form D. It is difficult to know why referees should choose this course, since we are not aware that any " stigma " attaches to a certificate in Form D and the relatives could scarcely be spared embarrassment by such a procedure, since their consent is required by the Human Tissue Act if any post-mortem examination is to be performed otherwise than on the authority of the coroner, whatever the method of disposal. In any case, we are satisfied that the number of " informal " post-mortem examinations arranged at the request of a medical referee must be fairly small. Nearly all post-mortem examinations not authorised by a coroner (about 50,000 a year in the last few years) take place in hospital and are performed on the bodies of persons who have died in hospital (occasionally they are performed on persons who have been patients in the hospital but have died outside). We are satisfied, after making enquiries of some of the hospitals in which these post-mortem examinations were carried out, that much the larger proportion are undertaken for what may be conveniently termed " hospital purposes " and without any reference to the method of disposal. As regards informal post-mortem examinations carried out for cremation purposes on the bodies of persons who died outside hospital, we

came across only one instance of an area in which a hospital performed a significant number of post-mortem examinations. This was at Southend and we are prepared to believe that the abnormally high number of " voluntary " post-mortem examinations performed there on non-hospital patients owed something to the activities of the medical referee.

27.22 Again, the figures in the tables do not provide any guide to the *indirect* effect that the activities of medical referees might have had on the practice of certifying doctors in their area. Where, for example, the medical referee was known to make a strict scrutiny of the certificates presented to him, the doctors invited to complete Forms B and C might have been more ready to make a report to the coroner in cases where there was an element of doubt about the cause of death. The variation in the percentages of Form E cases (columns 9 and 10 in Table X) in different parts of the country could be interpreted as sustaining this possibility, although there are so many factors governing the proportion of all deaths in a given area which are reported to a coroner that any inference drawn simply from the figures in Table X could be no more than speculative.

27.23 Another imponderable in the figures in Table X (especially in columns 13 and 14) is the difference of interpretation placed by individual referees on the duty laid upon them by Regulation 12 (5) to be satisfied that the cause of death has been " definitely ascertained ". At first sight, it might be thought that there should be little difficulty about understanding the meaning of what seems to be an essential safeguard against premature destruction of a particular body. But, in practice, we understand the requirement has proved difficult to interpret. On the one hand, the accuracy of ascertainment of the cause of death is broadly related to the scale of investigation; and what is " definite " has to be arbitrarily decided. On the other hand, there are certain deaths in which a comparatively brief investigation is sufficient to rule out any suspicion of the untoward, even though ascertainment of the cause in any real sense has not been achieved. On one view, the cause of death can be said to have been definitely ascertained only if it has been certified after an autopsy.[1] But this is not the view on which Regulation 12(5) has been administered and, in the large majority of cases, the medical referee has to be satisfied that the cause of death has been " definitely ascertained " on the basis of and within the terms of certificates given in Forms B and C. Evidence submitted in addition to the figures in Tables W and X indicated that most referees are ready to be satisfied on this basis. The Regulation does not require the referee to acquaint himself personally with the cause of death (much less decide it for himself), nor does it limit his discretion as to how he satisfies himself that there has been a " definite ascertainment ".

27.24 These uncertainties surrounding the referee's function and duties, taken together with the deficiences which we have already noted in the Form C

[1] In a report entitled " Medical Aspects of Cremation " which was approved by the Annual Representative Meeting in 1959, the British Medical Association argued that " the only certain method of determining definitely the cause of death is to carry out a necropsy in every case " but concluded that this " would not be practicable, nor would it be acceptable to public opinion " (Appendix VI, Supplement to the British Medical Journal, 11th April, 1959, page 173).

procedure, are sufficient to cast serious doubt on the efficacy of the defence against the concealment of crime for which, historically, the cremation procedure was devised. Does the cremation certification procedure ensure the detection or deterrence of crime? We have looked at this question most carefully, but we have found no evidence to suggest that the procedure has ever led directly to the exposure of a previously unsuspected crime. The only element of deterrence which we can see in the existing law lies in the requirement that the body of the deceased person should be seen by two different doctors before it is cremated. We doubt the effectiveness of this. The first doctor normally sees the body before he gives a medical certificate of the cause of death or completes Form B. As we have already noted, the second doctor only infrequently makes a full external examination of the body. But nobody other than a " family murderer " is likely to be able to exploit any inadvertence on the part of either doctor. And few people seem to realise that there is any significant difference in the procedure to be followed when the body is cremated rather than buried. All we can safely say is that the contribution of the regulations to the avoidance of crime is " not proven ".

27.25 In face of the statistical and other evidence, it is hard to believe that, for most of the time and in most places, the issue of a certificate in Form F by a medical referee is much more than a formality once he has received either the two medical certificates in Forms B and C or a coroner's certificate in Form E. The realities speak for themselves. Most medical referees have neither the time nor the facilities to do more than satsify themselves that doctors giving Form B were in a position (having regard to the number of occasions on which they had seen the deceased and the length of time before death when these visits occurred) to diagnose the cause of death. The test they apply in that context is much the same as that which they apply in the case of a certificate in Form E submitted to them by a coroner. We think that the system would indeed long since have broken down in a welter of complaints from the public if medical referees had taken the strict view of their responsibilities and assumed that they were the first and last line of defence against undetected homicide. In fact, this has never been the case and it would certainly by unrealistic to regard the restrictions contained in the Cremation Regulations as now providing the sole or even the main safeguard against premature destruction of a body. It provides no more than a " long-stop " against this contingency.

27.26 There is no question here of any lack of professional integrity on the part of medical referees. It is simply that, in the circumstances of today, the Regulations (which, by general consent, contain a number of unsatisfactory features and are, to say the least, ill-drafted) ask a medical referee to perform an impossible task. He is asked to satisfy himself that the cause of death has been definitely ascertained, but is compelled to accept assertions of this rather than proof. He may require a post-mortem examination before authorising cremation, but has no power to pay for it. He has absolute discretion to decline to authorise a cremation, but no duty to take any positive action to prevent the body being disposed of in some other way, e.g. by reporting the death to a coroner for further enquiry. He receives a substantial amount of information which is relavant to death certification in a general

sense, but he has no duty to communicate any of this to the Registrar General's Office for the purposes of analysis or research.[1] It is hard to see that, in his present isolated role of " long-stop " against a threat which we believe to be virtually non-existent, the medical referee has a place within the integrated system of death certification and disposal which we have set ourselves to achieve.

Conclusion

27.27 None of our witnesses claimed that the certification procedure for cremation was so good that it should be applied to all deaths. As we have observed, the present system gives an illusory impression of preventing the concealment of crime. We are not persuaded that it would be any more efficacious as a method of generally improving the certification of the medical cause of death. The second and third certificates required for cremation purposes only rarely serve to remedy any deficiencies which may be contained in the certificates given by the first doctor. Moreover, we believe that it is possible that they actually work adversely against the general objective, by tempting the doctor who gives the first certificate to put aside a doubt which he may have about the cause of death in the knowledge that the law requires a colleague to sign a confirmatory certificate and another doctor to issue an authority to cremate. In other words, a system of certification involving three doctors may, in practice, succeed only in ensuring that the real responsibility for establishing the medical cause of death lies nowhere.

27.28 The main lesson to be learned from experience since 1903 seems to us to be that any system is to be avoided which puts the emphasis on scrutiny of documents rather than on personal investigation. There is certainly room for improvement in the design and content of the forms which are at present scrutinised by a medical referee, but we do not think that it would be possible to devise a form which could be *guaranteed* to bring to light those features in the cause or circumstances of a death which might merit closer attention. Even the most experienced and highly qualified scrutinising doctor will be able to pick out only the most obvious discrepancies in the information on a certificate, however well thought out is its design. In the last resort, any procedure broadly along the lines of that laid down in the Cremation Regulations must depend almost entirely on the medical skill and the integrity of the doctor who gives the first certificate. We are satisfied that the new procedure for certifying the medical cause of death which we have proposed in Part I represents *inter alia* a very considerable advance towards securing the objective for which the Cremation Regulations were originally formulated.

[1] The operation of the cremation certification procedure ensures that a good deal more information about the deceased person and the manner of his death is collected when disposal is to be by cremation rather than earth burial; but this information is an incidental by-product of the system and is not put to any practical use. The cause of death that is recorded for statistical purposes is that entered on the ordinary medical certificate of the cause of death, even if a pathologist completing Form C or Form D has arrived at a different and more accurate diagnosis. It is not the function of the Cremation Regulations to assist in the process of accurately determining the cause of death for any purpose other than cremation. Nor is any use made of the other information on the cremation certificates, which are simply stored by the registrar of the crematorium for a period of 15 years before they are destroyed.

(ii) *What supplementary safeguards, if any, are needed if disposal is to be by cremation?*

27.29 Disposal by removal from the country is, in practice, almost as final and complete a method of disposal as cremation; and much the same can be said of burial, because the evidence obtained by exhumation in the very rare cases where this is now arranged is often inconclusive as a means of establishing a cause of death. This fact is illustrated by the evidence which we reviewed in Chapter 4 above. There is a strong case, therefore, for arguing that if additional safeguards as regards disposal should be introduced in support of the procedure for establishing the fact and cause of death for registration purposes, these should be applied to all forms of disposal. We received no representations in favour of such a development.

27.30 If certification of the medical cause of death is in future carried out in accordance with the recommendations which we have made in Part I, there will be a situation in which, before a death is registered, there will be a high degree of certainty (and, as we believe, a significantly higher certainty than now exists) that the medical cause of death will have been accurately established. The effect of our recommendations should be positively to encourage a doctor not to give a medical certificate of the fact and cause of death if he is in any doubt about the cause of death or whether it is one that ought to be investigated by an appropriate authority. A certificate for disposal given by a registrar of deaths, or by the coroner if an inquest has been held, should be issued only when it is clear that the body will no longer be required as an aid to the discovery of the cause of death.

27.31 Against that background we have carefully considered the possible arguments in favour of a " second chance " to make sure that a body is not prematurely destroyed. Briefly, this argument can be summarised as follows: to leave certifying doctors with sole responsibility increases the risk that criminal neglect and homicide may go undetected, that certification may become less and not more accurate with consequent damage to the statistics relating to death, and that, in the worst case, homicide by the doctor may be easily concealed. It is important that the last-mentioned argument should be seen in its proper perspective. As we have shown earlier,[1] the general risk of homicide going undetected is extremely small; and there is no reason—to put it at its lowest—to think that the risk of homicide by doctors is higher than for any other profession. Apart from this the arguments call in question the quality and to some extent the morality of professional conduct. They also depend for much of their force on the assumption that relatives, friends and others with knowledge of or interest in the death are likely to remain silent if they are dissatisfied with the conduct of a certifying doctor.

27.32 It is important to remember that certification of the fact and cause of death by a qualified doctor will not, under our proposals, necessarily be the end of the story in a case where there is reason for disquiet. The registrar will still have a duty to report a death to the appropriate authority if information given to him by a qualified informant or some other source suggests to him that further enquiry is called for. What is essentially at issue in these

[1] See Chapter 4.

arguments is whether the registrar represents a sufficient safeguard since, unlike the medical referee, he has no medical training. Experience of the operation of the cremation regulations shows, in our view conclusively, that any elaborate procedure which relies mainly on medical scrutiny of documents is of little or no practical value. The only other possible safeguard which might be suggested in place of or in support of the registrar and which would offer potentially greater value than a scrutiny of documents would be a system providing for the collection of new information, e.g. by mandatory post-mortem examinations in every case. We are satisfied that this line of approach is impracticable and unnecessary. The facilities are not available; in many cases the cause of death is not in doubt. But such an approach is also undesirable because it would seriously diminish the status of the qualified doctor and his certificate of the fact and cause of death; and because it would obscure the importance of the new responsibility we have proposed should be given to him, to certify the fact and cause of death only when he is confident that he can do so with accuracy and precision and the death is not one which he is obliged to report to an appropriate authority on other grounds.

27.33 We recognise that in some minds apprehension may be raised about the ease with which family doctors will be able to adjust to their new responsibilities. When the new arrangements are working we hope that there will be wide public understanding of the significance of the certifying doctor's role and of the contribution which those who have relevant information to give about each individual death can make by communicating this to the doctor and other interested parties and questioning conclusions which are inconsistent with their own observations. Given this kind of partnership we have no doubt that the proposals we have made in Part I of our Report will produce more efficient safeguards against premature disposal than are available today.

(iii) *What changes should be made in the cremation law?*

27.34 We have already stated our conclusion that, provided our recommendations for changes in the law relating to the certification of the medical cause of death are implemented, there should be no need for any additional safeguards to deal solely with disposal by cremation. In other words, we are satisfied that a certificate for disposal issued either by a registrar of deaths or by the coroner to whom the death has been reported should be sufficient authority for disposal by any method. It follows from this that we see no need for the retention of any of the existing cremation forms and certificates or for the office of medical referee and we recommend that they be abolished. All the provisions in the law relating to the medical referee and his powers and duties and to the completion of Form A (the application for cremation), Forms B and C (the two medical certificates), Form D (the certificate after post-mortem examination), Form F (the medical referee's authority for cremation) and Form H (which is used for the cremation of anatomical remains) will need to be revoked. Form G (the Register of Cremations), which is kept by each cremation authority, is the only statutory form which we recommend should be retained. It corresponds with the register of burials kept by every burial authority. These changes may involve an amendment to the Cremation Act 1902 as well as new amending regulations; but, in our

view, they can all be made without the sacrifice of anything except cumbersome administration.

27.35 As to the timing of these changes, we recommend that they should be made at the same time as the changes which we have recommended in Part I. We strongly urge that the changes should be made all at once and as soon as possible. But if, for any reason, there is a likelihood that the changes may be deferred for a considerable period, we recommend that Form C (the confirmatory certificate) should be abolished without delay. We have already indicated that the reasons why we consider that this certificate may be abolished with complete safety and we believe that the existing regulations (minus the reference to this certificate) can adequately protect the public interest until the introduction of the changes which we have recommended in Part I.

TABLE W

Table of Cremations in 1965 and 1966
Showing Number Authorised by the Different Procedures and the Number Involving Formal Challenge of Some Kind

Number of Cremations Authorised by each Procedure												No. of cremations where original certificates were unsatisfactory a post-mortem was made and cremation authorised on basis of Form D		No. of cases where death was reported to Coroner by Medical Referee		No. of cases where Medical Referee declined to allow cremation	
Total number of cremations		Forms B and C		Form D		Form E		Form E as % of Total Cremations		Form H							
1965	1966	1965	1966	1965	1966	1965	1966	1965	1966	1965	1966	1965	1966	1965	1966	1965	1966
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
247,719	260,685	201,276	211,409	208	404	45,855	48,418	18·5 %	18·6 %	56	134	144	136	178	171	2	13

Table of Cremations
Showing Number Authorised by the Different Procedures

Date of Opening	Name of Cremation Authority	Number of Cremations Authorised by: Total number of cremations		Forms B and C		Form D	
		1965	1966	1965	1966	1965	1966
		1	2	3	4	5	Local 6
1956	Accrington B.C.	654	718	—	—	—	—
1959	Airedale and Wharfedale J.C.C. ...	1,111	1,243	698	882	—	—
1960	Aldershot B.C.	1,111	1,252	874	1,016	—	—
1959	Altrincham, Bowden and Hale D.C.B.	932	1,062	785	938	—	1
1922	Barnet B.C.	469	615	328	417	—	—
1962	Barnsley B.C....	988	1,196	732	887	5	9
1962	Barrow-in-Furness C.B.C.	606	631	553	555	—	1
1961	Bath B.C.	1,505	1,694	1,230	1,403	1	—
1955	Bedford B.C.	865	938	719	758	—	—
1934	Birkenhead Corporation	2,581	2,160	2,151	1,772	2	—
1937	Birmingham Corporation (Lodge Hill Crematorium) ...	3,087	3,150	2,534	2,631	4	4
1952	Birmingham Corporation (Yardley Crematorium)	2,056	2,225	1,692	1,820	4	5
1957	Birtley B.C.	1,249	961	1,036	812	3	2
1956	Blackburn C.B.C.	944	1,059	724	890	1	1
1935	Blackpool Corporation	1,898	1,898	1,625	1,643	—	—
1956	Blyth and Bedlingtonshire J.C.C. ...	710	797	673	693	8	9
1954	Bolton C.B.C.	3,008	3,288	2,380	2,615	—	1
1966	Boston B.C.	—	305	N.I.U.	259	N.I.U.	—
1938	Bournemouth Corporation	3,199	3,480	2,615	2,951	7	15
1905	Bradford Corporation	1,951	2,016	1,607	1,649	—	—
1957	Breakspear J.C.C.	3,439	3,399	2,496	2,485	—	—
1930	Brighton Corporation	1,682	2,086	1,389	1,731	1	6
1956	Bristol City C.	1,889	1,823	1,553	1,474	2	2
1958	Burnley C.B.C.	1,370	1,468	1,071	1,195	—	—
1939	Cambridge City C.	1,494	1,494	1,207	1,207	—	—
1953	Cardiff C.B.C.	1,987	2,357	1,581	1,888	—	—
1956	Carlisle City C.	1,016	1,145	877	992	7	10
1960	Central Durham J.C.C.	1,273	1,386	1,053	1,139	2	—
1961	Chelmsford B.C.	868	988	674	798	—	—
1965	Chester City C.	131	1,029	106	848	—	—
1959	Chesterfield and District J.C.C. ...	1,142	1,369	897	1,081	1	4
1938	Cheltenham B.C.	1,462	1,512	1,230	1,270	1	—
1966	Chilterns J.C.C.	—	720	N.I.U.	562	N.I.U.	1
1905	City of London Corporation ...	3,512	3,678	2,763	2,868	—	—
1957	Colchester B.C.	1,419	1,746	1,203	1,529	—	—
1957	Colwyn Bay B.C.	1,259	1,498	1,065	1,292	11	14
1956	Cornwall J.C.C.	1,166	1,413	1,024	1,193	—	3
1943	Coventry Corporation	2,625	2,658	2,137	2,132	—	—
1957	Croydon London B.C.	2,525	2,650	1,981	2,053	—	—
1958	Crewe B.C.	600	706	543	625	—	—
1963	Crosby, Litherland and Waterloo J.C.B.	625	619	535	534	—	—
1901	Darlington C.B.C.	1,214	1,416	1,018	1,212	—	—
1956	Derby C.B.C....	2,865	3,037	2,302	2,415	—	—

in 1965 and 1966
and the Number Involving Formal Challenge of Some Kind

each Procedure						Number of Cremations where original certificates were unsatisfactory, a post-mortem was made and cremation authorised on basis of Form D		Number of cases where death was reported to to Coroner by Medical Referee		Number of cases where Medical Referee declined to allow cremation	
Form E		Form E as per cent of Total Cremations		Form H							
1965	1966	1965	1966	1965	1966	1965	1966	1965	1966	1965	1966
Authority Crematoria											
7	8	9	10	11	12	13	14	15	16	17	18
—	—	—	—	—	—	—	—	—	—	—	—
176	213	15·9	17·1	—	—	—	—	—	—	—	—
237	227	21·4	18·2	—	—	—	—	—	—	—	—
146	122	15·7	11·5	—	—	—	—	—	—	—	—
141	198	30·0	31·9	—	—	—	—	—	—	—	—
245	289	24·7	24·1	2	2	4	9	—	—	—	—
53	75	8·7	11·9	—	—	—	—	—	—	—	—
273	291	18·1	17·2	—	—	1	—	—	—	—	—
146	180	16·7	19·1	—	—	—	—	—	—	—	—
428	387	16·6	17·9	—	1	—	—	—	—	—	—
546	509	17·7	16·2	3	6	4	2	1	1	—	—
360	400	17·5	17·9	—	—	4	2	3	2	—	—
208	145	16·7	15·2	—	—	2	2	—	—	—	—
218	168	23·2	15·8	—	—	1	—	—	—	—	—
273	255	14·4	13·4	—	—	—	—	—	—	—	—
29	95	4·1	11·8	—	—	8	—	—	—	—	—
622	658	20·7	20·0	—	—	—	1	6	13	—	—
N.I.U.	46	—	14·8	N.I.U.	—	N.I.U.	—	N.I.U.	—	—	—
566	544	17·7	15·6	4	—	7	4	—	2	—	—
344	366	17·6	18·1	—	—	—	—	—	1	—	—
939	909	27·0	26·7	4	5	—	—	—	—	—	—
291	348	17·3	16·7	—	—	1	1	—	—	—	—
332	344	17·6	18·9	—	—	2	2	—	1	—	—
299	273	21·8	18·6	—	—	—	—	—	—	—	—
275	275	18·5	18·5	11	11	—	—	1	1	—	—
405	465	20·4	19·7	1	4	—	—	—	—	—	—
129	138	12·6	12·0	—	—	3	5	—	—	—	—
216	247	17·0	17·8	—	—	2	—	—	—	—	—
194	190	22·6	19·2	—	—	—	—	—	—	—	—
25	181	19·2	17·6	—	—	—	—	—	—	—	—
239	278	20·9	20·3	—	—	1	4	4	2	—	—
231	242	15·8	16·0	—	—	—	—	—	—	—	—
N.I.U.	156	—	21·7	N.I.U.	1	—	—	—	—	—	—
749	810	22·3	22·0	—	—	—	—	—	—	—	—
216	217	15·2	14·5	—	—	—	—	—	—	—	—
178	183	14·1	12·2	—	—	5	9	—	—	—	—
140	211	11·1	14·9	—	—	—	3	2	3	—	—
487	526	18·5	19·8	—	—	—	—	—	—	—	—
544	597	21·5	22·5	—	—	—	—	—	—	—	—
67	81	11·2	11·4	—	—	—	—	—	—	—	—
88	85	13·9	13·7	—	—	—	—	2	—	—	—
196	202	16·2	14·2	—	—	—	—	—	2	—	—
563	586	19·6	19·3	—	—	—	—	—	—	—	—

TABLE X

Table of Cremations
Showing Number Authorised by the Different Procedures

Date of Opening	Name of Cremation Authority	Number of Cremations Authorised by: Total number of cremations		Forms B and C		Form D	
		1965	1966	1965	1966	1965	1966
		1	2	3	4	5	Local 6
1960	Dewsbury Moor Cremation Board...	1,093	1,196	891	957	—	—
1960	Doncaster C.B.C.	1,539	1,745	1,220	1,394	—	1
1953	Dukinfield J.C. and C.C.	1,539	1,672	1,258	1,361	—	—
1960	Eastbourne C.B.C.	1,540	1,625	1,318	1,350	2	4
1955	Eccles B.C.	844	996	680	838	—	—
1956	Eltham Crematorium J.C.	2,914	3,079	2,145	2,269	—	—
1956	Folkestone B.C.	519	570	430	483	—	—
1966	Gateshead C.B.C.	—	334	N.I.U.	285	N.I.U.	2
1953	Gloucester C.B.C.	1,016	1,095	814	914	—	1
1966	Grantham Burial J.C.	—	210	N.I.U.	163	N.I.U.	—
1954	Grimsby C.B.C.	1,554	1,508	1,301	1,300	—	—
1966	Guildford B.C.	—	—	—	—	—	—
1956	Halifax C.B.C.	1,610	1,780	1,336	1,484	—	1
1955	Hastings B.C.	1,317	1,422	1,129	1,184	2	1
1938	Haringey London B.C.	4,684	4,778	3,622	3,741	—	—
1961	Harlow U.D.C.	326	453	267	355	2	—
1936	Harrowgate B.C.	718	944	605	840	—	—
1956	Hereford City C.	501	573	423	492	2	5
1958	Huddersfield C.B.C.	1,631	1,831	1,324	1,475	—	—
1961	Isle of Wight J.C.C.	794	734	606	628	—	—
1928	Ipswich C.B.C.	1,381	1,572	1,165	1,286	—	—
1937	Islington London B.C.	755	936	591	716	—	—
1960	Keighley B.C.	364	433	313	374	—	—
1940	Kettering B.C.	1,452	1,495	1,208	1,235	8	12
1901	Kingston Upon Hull Corporation ...	2,230	2,408	1,794	1,941	—	1
1952	Kingston Upon Thames London B.C.	1,272	1,352	962	1,206	—	—
1958	Lambeth London B.C. (Lambeth Crematorium)	497	—	368	—	—	—
1915	Lambeth London B.C. (West Norwood Crematorium) ...	389	424	284	310	—	—
1938	Leeds Corporation (Cottingley Hall Crematorium) ...	1,282	1,425	1,015	1,048	—	—
1905	Leeds Corporation (Lawnswood Crematorium) ...	3,090	3,127	2,456	2,452	1	—
1902	Leicester City C.	2,691	2,784	2,286	2,279	6	4
1956	Lewisham London B.C.	1,278	1,278	918	897	—	—
1896	Liverpool Corporation	3,410	3,344	2,751	2,768	—	—
1960	Loughborough B.C.	757	828	658	725	3	5
1960	Luton B.C.	1,492	1,671	1,294	1,428	—	—
1958	Lytham St. Annes B.C.	775	934	671	814	—	—
1960	Macclesfield B.C.	608	745	495	622	3	1
1962	Maidstone and District Crematorium J.C.	835	927	693	779	—	—

continued

in 1965 and 1966
and the Number Involving Formal Challenge of Some Kind

each Procedure						Number of Cremations where original certificates were unsatisfactory, a post-mortem was made and cremation authorised on basis of Form D		Number of cases where death was reported to Coroner by Medical Referee		Number of cases where Medical Referee declined to allow cremation	
Form E		Form E as per cent of Total Cremations		Form H							
1965	1966	1965	1966	1965	1966	1965	1966	1965	1966	1965	1966
Authority Crematoria											
7	8	9	10	11	12	13	14	15	16	17	18
202	239	18·5	19·1	—	—	—	—	—	—	—	—
317	348	20·6	19·9	—	—	—	1	1	—	1	1
281	311	18·2	18·6	—	—	—	—	—	—	—	—
220	269	14·3	16·5	—	—	—	2	—	—	—	1
164	158	19·5	15·9	—	—	—	—	—	—	—	—
768	801	26·4	26·3	1	—	—	—	—	—	—	—
89	87	17·1	15·3	—	—	—	—	—	—	—	—
N.I.U.	45	—	13·6	N.I.U.	—	N.I.U.	2	N.I.U.	—	N.I.U.	—
200	180	19·6	16·5	—	—	1	—	1	—	—	—
N.I.U.	47	—	22·4	N.I.U.	—	N.I.U.	—	N.I.U.	—	N.I.U.	—
253	208	16·3	13·8	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—
274	295	17·0	16·6	—	—	—	1	—	—	—	—
186	231	14·1	16·2	—	—	1	—	—	—	—	—
1,062	1,037	20·6	21·7	—	—	—	—	—	—	—	—
56	97	16·9	21·6	—	—	2	—	—	—	—	—
113	104	15·7	11·1	—	—	—	—	—	—	—	—
66	74	13·2	13·0	—	—	10	12	—	—	—	—
307	356	18·8	19·5	—	—	—	—	—	—	—	—
118	106	14·9	15·9	—	—	—	—	—	—	—	—
213	285	15·4	18·1	—	—	—	—	—	—	—	—
164	218	21·9	23·2	—	—	—	—	—	—	—	—
51	59	14·2	13·7	—	—	—	—	—	—	—	—
236	236	16·3	15·7	—	—	8	12	—	—	—	—
436	465	19·6	19·3	—	—	—	1	2	—	—	—
310	326	24·4	24·1	—	—	—	—	—	—	—	—
129	—	25·8	—	—	—	—	—	—	—	—	—
105	114	26·9	27·1	—	—	—	—	—	—	—	—
266	371	20·8	25·9	1	6	—	—	—	—	—	—
630	673	20·4	21·5	3	2	—	—	—	—	—	—
399	496	14·8	17·8	—	—	6	4	—	—	—	—
360	381	28·1	29·8	—	—	—	—	—	—	—	—
551	459	16·2	13·7	3	—	—	—	105	103	—	—
96	98	12·6	11·8	—	—	3	5	—	—	—	—
198	248	13·3	14·6	—	—	—	—	—	—	—	—
104	120	13·3	12·9	—	—	—	—	—	—	—	—
110	122	18·0	16·3	—	—	2	—	1	—	—	—
142	148	16·9	15·9	—	—	—	—	4	—	—	—

TABLE X

Table of Cremations
Showing Number Authorised by the Different Procedures

Date of Opening	Name of Cremation Authority	Number of Cremations Authorised by: Total number of cremations 1965	Total number of cremations 1966	Forms B and C 1965	Forms B and C 1966	Form D 1965	Form D 1966
		1	2	3	4	5	Local 6
1959	Manchester City Council	836	860	710	708	—	—
1960	Mansfield and District Crematorium J.C.	—	—	—	—	—	—
1959	Medway Crematorium Comm. ...	1,621	1,636	1,338	1,350	3	—
1961	Merton London B.C.	960	1,163	758	949	—	—
1952	Middleton B.C.	339	424	267	352	—	—
1961	Middlesborough C.B.C.	1,630	1,943	1,346	1,572	—	—
1966	Monmouth and Newport J.C.C. (Gwent Crematorium)	1,424	1,652	1,190	1,402	—	—
1963	Morecombe and Heysham B.C. ...	1,026	1,241	868	1,070	—	—
1939	Mortlake Crematorium Board ...	2,923	2,965	2,199	2,191	—	—
1934	Newcastle Upon Tyne City C. ...	3,600	3,464	3,190	3,008	26	16
1965	Newcastle under Lyme B.C. ...	385	437	261	300	—	—
1966	North Devon Crematorium Comm.	—	—	—	—	—	—
1958	North East Surrey Crematorium Board	1,246	1,292	919	955	—	—
1966	North West Durham J.C.C. (Mountsett Crematorium) ...	—	198	N.I.U.	154	N.I.U.	—
1964	Norwich City C.C.	415	409	337	340	—	3
1931	Nottingham City Council	4,205	4,352	3,316	2,405	—	1
1957	Nuneaton B.C.	686	729	541	589	—	—
1953	Oldham C.B.C.	1,349	1,502	1,067	1,167	—	1
1959	Osgoldcross J.C.B.	1,004	1,078	786	859	—	—
1958	Peterborough C.C.	1,313	1,319	1,124	1,110	—	—
1934	Plymouth C.C.	1,767	1,883	1,457	1,589	5	4
1924	Pontypridd B.B. and C.A.	1,989	2,157	1,511	1,622	—	—
1966	Pentrelychan (Wrexham) J.C.C. ...	—	90	N.I.U.	69	N.I.U.	—
1958	Porchester Crematorium J.C. ...	3,076	3,160	2,525	2,560	12	8
1962	Preston C.B.C.	801	920	642	757	—	—
1932	Reading Corporation	1,731	1,857	1,448	1,569	3	4
1938	Rochdale Corporation	1,434	1,534	1,134	1,257	—	—
1962	Rotherham C.B.C.	784	913	633	732	—	—
1962	Rowley Regis B.C.	—	—	—	—	—	—
1957	Salford B.C.	930	980	749	822	—	—
1960	Salisbury City	714	894	631	762	—	1
1961	Scarborough B.C.	908	993	812	879	—	—
1964	Scunthorpe B.C.	622	1,476	505	617	—	—
1960	Sedgley, Dudley and Brierly Hill J.C.	752	911	610	735	—	1
1905	Sheffield Corporation	4,482	4,160	3,885	3,444	3	2
1955	Shipley U.D.C.	977	1,067	839	913	—	—
1958	Shrewsbury B.C.	1,125	1,146	987	980	—	—
1952	Skipton U.D.C.	795	887	680	792	1	—
1963	Slough B.C.	1,183	1,183	955	946	—	1

continued

in 1965 and 1966
and the Number Involving Formal Challenge of Some Kind

each Procedure						Number of Cremations where original certificates were unsatisfactory, a post-mortem was made and cremation authorised on basis of Form D		Number of cases where death was reported to Coroner by Medical Referee		Number of cases where Medical Referee declined to allow cremation	
Form E		Form E as per cent of Total Cremations		Form H							
1965	1966	1965	1966	1965	1966	1965	1966	1965	1966	1965	1966
Authority Crematoria											
7	8	9	10	11	12	13	14	15	16	17	18
125	152	14·9	17·7	1	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—
279	286	17·2	17·4	1	—	1	—	—	—	—	—
202	214	21·0	18·4	—	—	—	—	—	—	—	—
72	72	21·1	17·1	—	—	—	—	—	—	—	—
284	371	17·4	19·4	—	—	—	—	—	—	—	—
234	250	16·5	15·2	—	—	—	—	1	—	—	—
158	171	11·1	13·7	—	—	—	—	—	—	—	—
723	769	24·8	25·9	1	—	—	—	4	—	—	—
379	438	10·5	12·7	5	2	26	9	1	—	1	—
124	137	31·8	31·1	—	—	—	—	1	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—
326	333	26·1	25·8	—	—	—	—	—	—	—	—
N.I.U.	44	—	22·0	N.I.U.	—	—	—	—	—	—	—
78	66	18·6	16·1	—	—	—	3	—	—	—	—
889	945	21·1	21·0	—	1	—	1	—	4	—	—
145	140	21·0	19·2	—	—	—	—	—	—	—	—
282	334	20·9	22·3	—	—	—	1	—	—	—	—
218	219	21·8	20·3	—	—	—	—	—	—	—	—
189	208	14·4	15·6	—	—	—	—	—	—	—	—
305	290	17·2	15·4	—	—	5	1	—	—	—	1
478	535	24·0	24·8	—	—	—	—	—	—	—	—
N.I.U.	21	—	23·3	N.I.U.	—	N.I.U.	—	—	—	—	—
537	590	17·4	18·7	—	—	1	1	—	—	—	1
156	161	19·5	17·5	—	—	—	—	3	2	3	—
280	284	16·2	15·3	—	—	3	4	1	—	—	—
297	272	20·8	17·8	—	—	—	—	—	—	—	—
151	181	19·4	19·9	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—
181	158	19·5	16·1	—	—	—	1	—	1	—	—
83	131	11·7	14·7	—	—	—	—	—	—	—	—
96	113	10·5	11·4	—	—	—	—	—	—	—	—
117	121	18·9	13·3	—	—	—	—	—	—	—	—
141	175	18·8	19·2	1	—	—	1	4	2	—	—
593	711	13·2	17·1	1	3	3	2	1	—	—	—
138	154	14·8	14·4	—	—	—	—	—	—	—	—
138	166	12·3	14·4	—	—	—	—	—	—	—	—
113	95	14·3	10·7	—	—	—	—	—	—	—	—
228	236	19·3	20·0	—	—	—	—	—	—	—	—

Table of Cremations
Showing Number Authorised by the Different Procedures

Date of Opening	Name of Cremation Authority	Number of Cremations Authorised by					
		Total number of cremations		Forms B and C		Form D	
		1965	1966	1965	1966	1965	1966
		1	2	3	4	5	Local 6
1958	Solihull B.C.	1,152	1,224	941	995	—	—
1961	South Shields C.B.C.	864	836	758	745	—	—
1932	Southampton Corporation ...	2,098	2,370	1,696	1,906	1	—
1953	Southend-on-Sea C.B.C.	2,043	2,335	1,572	1,875	4	3
1957	South Essex Crematorium J.C. ...	1,910	2,085	1,554	1,657	—	—
1959	Southport C.B.C.	954	998	795	831	—	—
1939	Southwark, London B.C.	2,402	—	1,609	—	—	—
1962	St. Helens C.B.C.	503	586	425	498	—	—
1964	Stafford B.C.	331	399	275	348	—	—
1940	Stoke-on-Trent Corporation ...	1,811	1,875	1,196	1,232	7	10
1960	Stourbridge B.C.	855	964	699	803	—	—
1951	Sunderland C.B.C.	1,776	1,979	1,542	1,673	—	—
1964	Sutton Coldfield B.C.	594	800	502	639	—	1
1954	S.W. Middlesex Crematorium Board	2,345	2,499	1,681	1,718	—	—
1956	Swansea C.B.C.	2,173	2,455	1,779	2,036	—	—
1966	Swindon B.C.	—	361	N.I.U.	293	—	—
1966	Thanet Crematorium J.C.	—	527	N.I.U.	441	—	—
1963	Taunton J.B.C.	1,019	1,195	855	1,038	6	8
1958	Tunbridge Wells B.C.	1,341	1,427	1,113	1,190	2	2
1959	Tynemouth C.B.C.	629	657	557	591	5	3
1961	Wakefield City Crematorium ...	555	683	405	531	—	—
1955	Wakall C.B.C.	867	990	666	771	—	—
1938	Wandsworth, London B.C. ...	1,679	1,756	1,315	1,373	—	—
1962	Warley C.B.C.	299	314	234	258	—	—
1964	Warrington and Runcorn Rural J.C.C.	634	903	549	680	—	—
1961	West Bromwich C.B.C.	782	976	632	810	—	1
1954	West Hartlepool C.B.C.	574	656	472	556	—	—
1958	West Hertfordshire Crematorium J.C.	2,596	2,666	2,210	2,186	2	—
1937	Westminster, London B.C.	1,656	1,674	1,251	1,233	—	—
1966	Weston-super-Mare B.C.	—	381	N.I.U.	289	—	—
1939	Weymouth and Melcome Regis B.C.	862	1,033	769	894	—	—
1960	Whitley Bay B.C.	542	567	467	503	4	3
1959	Widnes B.C.	400	399	348	338	—	—
1955	Wigan C.B.C.	903	944	780	804	—	—
1954	Wolverhampton B.C.	1,771	2,033	1,493	1,703	—	1
1962	York City Corporation	1,120	1,340	929	1,114	—	—
1960	Worcester City	845	966	725	833	—	—
	SUB-TOTAL	201,678	216,408	163,966	175,715	173	367
1903	Birmingham Crematorium Co. Ltd.	2,555	2,375	2,117	2,032	3	4

continued

in 1965 and 1966
and the Number Involving Formal Challenge of Some Kind

each Procedure						Number of Cremations where original certificates were unsatisfactory, a post-mortem was made and cremation authorised on basis of Form D		Number of cases where death was reported to Coroner by Medical Referee		Number of cases where Medical Referee declined to allow cremation	
Form E		Form E as per cent of Total Cremations		Form H							
1965	1966	1965	1966	1965	1966	1965	1966	1965	1966	1965	1966
Authority Crematoria											
7	8	9	10	11	12	13	14	15	16	17	18
211	229	18·3	18·8	—	—	—	—	—	—	—	—
106	91	12·3	10·8	—	—	—	—	—	—	—	—
401	464	19·1	19·6	—	—	1	—	2	—	—	—
467	457	22·9	19·5	—	—	4	3	—	—	—	—
356	427	18·6	20·4	—	1	—	—	—	—	—	—
159	166	16·7	16·8	—	1	—	—	—	—	—	1
791	—	33·0	—	2	—	—	—	—	—	—	—
78	88	15·6	15·8	—	—	—	—	—	—	—	—
56	51	17·0	12·8	—	—	—	—	—	—	—	—
608	643	33·5	34·2	—	—	2	4	—	—	—	—
156	161	18·1	16·8	—	—	—	—	4	3	—	—
234	306	13·1	15·5	—	—	—	—	—	—	—	1
92	160	15·4	20·0	—	—	—	—	—	—	—	—
660	779	28·1	31·2	4	—	—	—	5	2	—	—
394	419	18·2	17·0	—	—	—	—	—	—	—	—
—	68	—	18·9	—	—	—	—	—	—	—	—
—	86	—	16·4	—	—	—	—	—	—	—	—
158	149	15·5	12·4	—	—	6	8	—	—	—	—
226	235	16·8	16·4	—	—	—	—	—	—	—	—
67	64	10·6	9·7	—	—	5	3	—	—	—	—
150	152	26·8	22·4	—	—	—	—	—	—	—	—
201	216	23·1	21·8	—	—	—	—	—	—	—	—
364	383	21·7	21·8	—	—	—	—	—	—	—	—
65	56	21·7	18·1	—	—	—	—	—	—	—	—
85	123	13·5	13·7	—	—	—	—	—	—	—	—
150	165	19·2	16·8	—	—	—	1	—	—	—	—
102	98	17·9	14·8	—	—	—	—	—	—	—	2
384	480	14·8	18·0	—	—	2	—	—	—	—	—
404	441	24·3	26·4	1	—	—	—	—	—	—	—
—	91	—	23·9	—	—	—	2	—	2	—	—
93	139	10·8	13·5	—	—	—	—	—	—	—	—
71	61	13·1	10·7	—	—	—	—	—	—	—	—
52	61	13·0	15·3	—	—	—	—	—	—	—	—
123	140	13·7	14·9	—	—	—	—	—	—	—	1
278	328	15·7	16·2	—	—	—	2	—	—	—	—
191	225	17·1	16·8	—	—	—	—	—	1	—	—
120	133	14·1	13·7	—	—	—	—	10	7	—	10
37,180	39,970	18·5	18·4	51	59	137	127	169	160	2	10
		Private Crematoria									
435	339	17·0	14·3	—	—	3	4	1	—	—	—

TABLE X

Table of Cremations
Showing Number Authorised by the Different Procedures

Date of Opening	Name of Cremation Authority	Number of Cremations Authorised by					
		Total number of cremations		Forms B and C		Form D	
		1965	1966	1965	1966	1965	1966
		1	2	3	4	5	Local 6
1941	Brighton and Preston Cemetery Co. Ltd.	4,541	4,368	3,663	3,622	28	26
1928	Bristol General Cemetery Co. ...	2,547	2,589	2,078	2,108	1	3
1956	Crystal Palace District Cemetery Co. Ltd. (Beckenham Crematorium)...	1,595	1,625	1,195	1,230	—	—
1939	Counties Crematorium Ltd. (Northampton Crematorium) ...	1,290	1,352	1,096	1,170	—	1
1954	East London Cemetery Co. Ltd. ...	316	337	216	235	—	—
1963	Exeter and Devon Crematorium Ltd.	1,837	2,077	1,618	1,810	—	—
1957	Great Northern Crematorium Co....	608	546	462	403	—	—
1939	General Cemetery Co. (West London Crematorium) ...	1,159	—	822	999	—	—
1956	Kent County Crematorium Ltd. (Barham)	2,422	2,228	2,049	1,809	—	—
1936	Kent County Crematorium Ltd. (Charing)	1,351	1,387	1,131	1,153	—	—
1902	London Crematorium Co. Ltd. (Golders Green)	4,867	4,719	3,599	3,545	—	—
1885	London Crematorium Co. Ltd. (Woking St. Johns)	2,890	3,011	2,326	—	—	—
1892	Manchester Crematorium Ltd. ...	3,392	3,540	2,870	2,954	—	1
1955	Manor Park Cemetery Co. Ltd. ...	707	805	550	633	—	—
1937	Norwich Crematorium Ltd. ...	2,236	2,257	1,905	1,890	1	—
1938	Oxford Crematorium Ltd.	2,283	2,239	1,894	1,875	—	—
1936	South London Crematorium Co. Ltd.	4,175	4,398	3,028	3,194	—	—
1934	Stockport Borough Cemetery Co. Ltd.	2,168	2,212	1,798	1,843	2	1
1956	Torquay Cemetery Co.	1,671	1,792	1,440	1,561	—	—
1956	The Crematorium Co. Ltd. (Surrey and Sussex)	1,788	1,968	1,453	1,628	—	1
	SUB-TOTAL	46,041	44,214	37,310	35,694	35	37
	GRAND TOTAL	247,719	260,685	201,276	211,409	208	404

continued

in 1965 and 1966
and the Number Involving Formal Challenge of Some Kind

each Procedure						Number of Cremations where original certificates were unsatisfactory, a post-mortem was made and cremation authorised on basis of Form D		Number of cases where death was reported to Coroner by Medical Referee		Number of cases where Medical Referee declined to allow cremation	
Form E		Form E as % of Total Cremations		Form H							
1965	1966	1965	1966	1965	1966	1965	1966	1965	1966	1965	1966
Authority Crematoria											
7	8	9	10	11	12	13	14	15	16	17	18
850	720	18·7	16·5	—	—	—	—	—	—	—	—
468	472	18·4	18·2	—	6	1	3	2	1	—	—
400	395	25·0	24·2	—	—	—	—	—	—	—	—
194	181	15·0	13·4	—	—	—	—	—	—	—	2
100	102	31·4	30·0	—	—	—	—	—	—	—	—
219	267	11·9	12·8	—	—	—	—	—	—	—	—
146	146	23·9	25·1	—	—	—	—	—	1	—	—
337	368	29·1	—	—	2	—	—	—	—	—	—
373	419	15·4	18·8	—	—	—	—	—	—	—	—
220	234	16·3	15·3	—	—	—	—	—	—	—	—
564	1,242	26·0	26·3	—	4	—	—	1	—	—	—
1,268	—	19·5	—	—	—	—	—	—	1	—	—
522	557	15·4	15·7	—	27	—	1	5	8	—	—
157	172	22·1	21·2	—	—	—	—	—	—	—	—
330	367	14·7	16·2	—	—	1	—	—	—	—	1
389	364	17·1	16·3	—	—	—	—	—	—	—	—
1,142	1,169	27·3	26·6	5	35	—	—	—	—	—	—
368	368	16·9	16·6	—	—	2	1	—	—	—	—
231	231	13·8	12·9	—	—	—	—	—	—	—	—
335	338	18·7	17·2	—	1	—	—	—	—	—	—
8,675	8,448	18·8	19·1	5	75	7	9	9	11	—	3
45,855	48,418	18·5	18·6	56	134	144	136	178	171	2	13

CHAPTER 28

DISPOSAL—MISCELLANEOUS MATTERS

A. Interference with a body after death and before disposal

28.01 Ideally, for authoritative determination of the fact and cause of death, a doctor should have an opportunity to look at the body as soon as possible after it is alleged that life is extinct and there should be, at most minimal, and preferably no interference with the body between the moment of death and his viewing of the corpse. However, as we have noted in Chapter 1, deaths occur in various places and circumstances and it is not possible to lay down hard and fast rules about what should happen to bodies after death. In a road accident, for example, the first persons to arrive at the scene may remove a body from an obviously dangerous site before a doctor arrives or ambulance men may remove an obvious corpse direct to a mortuary. Again it may be necessary to remove quickly away from the scene of death the body of someone who is obviously dead, e.g. if the death has occurred in a public place, a hotel, an old peoples' home or anywhere in which living conditions are crowded.

28.02 The persons most often called upon to move dead bodies are funeral directors and their staff. Representatives of the National Association of Funeral Directors told us that it was the practice of their members always to ask the relative or other person " in charge " of a body whether a certificate had been given by a doctor before removing a body to their own premises. It is not possible for a funeral director to see the actual certificate since this must, by law, be sent forthwith to the registrar of deaths,[1] but, at the same time as he issues this certificate, the doctor is obliged to issue also a notification that he has given a medical certificate. We were told that it was rare for a funeral director to remove a body before it had been inspected and death had been confirmed by a doctor—though this might be found necessary in exceptional circumstances, for example, if the weather was hot, the corpse was clearly a corpse and the doctor had some distance to travel or was not immediately available.

28.03 One form of " interference " with a dead body which commonly takes place soon after death is the practice of " laying-out ". Where death occurs at home, it has long been the custom in some areas for a relative or friend to wash the body, dress it in fresh clothing, comb the hair, lower the lids over the open eyes and, in the case of a man, shave the face. These ministrations are often carried out before a doctor has examined the body or issued a certificate of the medical cause of death. They are part of the tradition of the English way of death and they are performed for practical as well as aesthetic reasons. It is natural for a family whose relative has died at home, perhaps after a long illness, to want to clean and tidy the body as well as the room in which the death has occurred without waiting for the doctor to come

[1] Births and Deaths Registration Act 1953, section 22.

and examine the body. If the death occurs in the middle of the night, it may be mid-day before a doctor can get round to visit the house. It would be extremely difficult to impose any general prohibition on " laying-out " and, since we received no evidence to suggest that it has in the past interfered with a doctor's ability to determine the cause of death, we see no reason to make a recommendation to this effect.

28.04 The form of interference with a body which most concerned our witnesses was embalming or the injection of preserving fluid. The purpose of embalming is to prevent the immediate decomposition of the body, to obviate unpleasant or obnoxious odours and generally to avoid unnecessary distress to relatives and other persons who may see the body before disposal takes place. Witnesses representing the funeral service told us that, taking the country as a whole, some kind of preserving treatment is carried out in well over half of all deaths. In London, the precentage of bodies embalmed is as high as 80 or 90 per cent.

28.05 Embalming may take various forms and different preservatives may be used. In Britain, the embalming fluid usually contains a solution of formaldehyde and the amount and the method used depends upon whether a temporary or a " permanent " preservation is desired—and upon the state of the body. A body in which the circulatory system has been destroyed (e.g. by autopsy) requires more treatment than a " freshly dead " body.

28.06 The effect of embalming is to " fix " and thus preserve the body tissues. It also has other effects. In the words of the British Medical Association[1]:—

> " . . . 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 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. . . . "

28.07 Other witnesses (including pathologists) pointed out that poisoning was a rare occurrence and made reference to some of the advantages of embalming for subsequent pathological examination. Formalin prevents decomposition and, by fixing the body tissue, preserves histological evidence which would otherwise be lost. We were assured that a great deal of evidence about the cause of death can be revealed by an autopsy on a body which has been embalmed.

28.08 The National Association of Funeral Directors told us that, for many years, the general advice contained in the Manual issued to all their

[1] " Deaths in the Community " (1964) BMA, Tavistock House.

members has been to the effect that preservative treatment should never be started before a death has been registered or before a disposal certificate has been issued by a registrar or coroner. The National Association of Funeral Directors mention cremation specifically in their manual, but their advice does not go so far as to indicate that embalming should not be permitted before the medical referee has issued his authority to cremate (Form F.). The manual says simply that, if cremation is the intended method of disposal, embalming should not be started before both doctors giving cremation certificates have viewed the body. Our impression is that, in general, funeral directors keep to the letter of this advice, but that it nevertheless happens quite frequently that embalming is carried out before the separate process of cremation certification is complete. Both the Home Office and the British Medical Association informed us that they had from time to time received complaints, from doctors called upon to give Form C for the purpose of cremation or to perform an autopsy for cremation purposes, that the body had already been embalmed.

28.09 We accept the view of the doctors who made these complaints that such a circumstance can completely frustrate the object of the cremation certification procedure; but we are inclined to believe also that one reason why bodies are embalmed before the cremation certificate procedure is complete is because funeral directors have learned from experience that the procedure is a matter of routine. The chance that anyone will want to make a further examination of the body once it is no longer required by the two certifying doctors is too remote to be contemplated. Representatives of the funeral service organisations informed us that there were also practical reasons for beginning embalming before cremation had been authorised by a medical referee. The certification process prescribed by the Cremation Regulations took time to complete and, for their own convenience as well as that of relatives who might wish to see the body in the period before cremation, funeral directors felt that they could no longer delay the start of the preservative treatment once the two certifying doctors had seen the body. The particular problems sometimes posed by the cremation certification process should disappear as a consequence of the implementation of the recommendations in Chapter 27 above that the existing procedure be abolished. The single medical certificate, which should in future suffice as the only certificate required before authority is given for disposal by any method, should be issued (or it should be clear that it is not going to be issued) well in advance of the time which the second doctor would have looked at the body for the purposes of the existing cremation law. In the new situation, it should be easier (though it will still be difficult) to introduce a realistic check on preservative treatment.

28.10 If our recommendations for a new procedure for certifying the medical cause of death are to work effectively it is essential that there should be no unnecessary interference with a body while there is still a possibility that it may be required for further examination. We recommend, therefore, that preservative treatment should in future never be started before either (*a*) the fact and cause of death has been certified by a doctor qualified in the terms set out in Chapter 5 or, (*b*) if the death has been reported to the coroner, the consent of the coroner has been obtained.

B. Disposal certificates

28.11 Under the present law, certificates authorising the disposal of a body are issued both by registrars of deaths and by coroners.[1] A registrar is *obliged* to issue a disposal certificate once he has registered a death, provided that a coroner has not already done so. A coroner has the *authority* (but not an obligation) to issue either an order for burial or a certificate for cremation; the circumstances in which he may do either are specified by the law. He is also responsible for the issue of another kind of disposal certificate: an authority to remove a body out of England or Wales (see paragraphs 28.19 and 28.20).

28.12 A registrar issues a disposal certificate only when he is satisfied that the cause of death has been duly certified as required by law and that no further enquiry into the death is necessary. In the usual way[2] he will issue this certificate at the same time as he registers a death. Except in inquest cases, when the coroner supplies all the information required for registration on his certificate after inquest (see Chapter 18) the registrar obtains his information in one of two ways. Non-medical information is supplied to him by an " informant " who must attend personally at the office of the registrar to give this information. The medical information comes either from a doctor (on a medical certificate of the cause of death) or from a coroner (who sends to the registrar a notification known as a Pink Form B[3] in which is stated the cause of death as revealed by a post-mortem examination).

28.13 A coroner may issue an order for burial at any time after he has decided to open an inquest into a death; in practice, this means after he has seen the report of an autopsy and is satisfied that he knows the medical cause of death and that the body will not be required for further investigation. He may issue his certificate for cremation either as soon as he has *opened* an inquest or after he has seen the results of an autopsy and decided that an inquest is unnecessary. Thus, it is only when cremation is the intended method of disposal that a coroner can issue a disposal certificate without having opened, or decided to open, an inquest. Once a coroner has accepted jurisdiction over a body which it is intended to dispose of by means of cremation, he always issues the disposal certificate, since a coroner's certificate in Form E is the only prescribed certificate available to the crematorium medical referee who has the task of deciding whether or not cremation can be authorised (see Chapter 26 above).

28.14 It is, we think, a legitimate criticism of the existing law that it puts no clear obligation on a coroner to issue a disposal certificate in any circumstances. In theory, therefore, by declining to issue a disposal certificate in circumstances in which he has the authority to issue such a certificate, a coroner may cause considerable inconvenience to relatives who are anxious to

[1] The sequence of events leading up to the authorisation of disposal by both the registrar and the coroner are illustrated in Diagrams A and B on pages 337 and 338.

[2] A registrar may issue a disposal certificate before registration (valid only for burial) only when he has received notice of the death from a qualified informant (see Chapter 3) and has also received a medical certificate of the cause of death and has no reason to believe that the death is one which either has been or ought to be reported to a coroner.

[3] See Chapter 14.

complete funeral arrangements as soon as possible. We emphasise, however, that this is a criticism of the law rather than of individual coroners, who, almost invariably, go out of their way to release a body at the earliest possible moment. Nevertheless, we think it would be for the convenience of the public if the respective duties of registrar and coroner could be set out more clearly in future.

28.15 We considered first whether the coroner should be under an obligation to issue a disposal document in respect of every death that is reported to him. But we have concluded that such a change would be most difficult to bring about and that it would not, in any case, bring any real benefit to the bereaved relatives. Coroners already investigate most deaths reported to them without proceeding to an inquest—and they are likely to proceed in this way even more often as a result of our proposals. In these " non-inquest " cases, a coroner may have no direct contact with the deceased person's relatives and may, therefore, find it difficult to identify the person responsible for making the funeral arrangements. It is, in most cases, more convenient for the informant or person making the arrangements for the funeral to get in touch with the registrar of deaths rather than with a coroner, for the simple reason that the registrar is likely to be the more accessible official. There are four times as many registrars as coroners. Moreover, a visit to the registrar has to be made in any case, both to provide the information necessary for registration and to collect a copy of the entry in the death register—the document popularly known as the " death certificate " which serves as proof of death for many legal purposes. There would seem to be an obvious advantage in making one journey serve the three purposes—of giving information for registration purposes, collecting the " death certificate " and collecting a certificate for disposal.

28.16 There is no evidence that registration is unduly delayed now when a death is reported to a coroner and no inquest held. It is common for most deaths, whether certified by doctors or by coroners in non-inquest cases, to be registered within four days of death (see Table Y). Our own proposals for changes in the procedure for reporting deaths to a coroner and in the coroner's procedure once a death has been reported to him are designed to speed this process still further. We have no reason to suppose, therefore, that there will be any undue delay in the sending of a coroner's notification of the cause of death to a registrar. In these circumstances, and because we are recommending that, in future, there should be no difference between the procedure to be followed in burial and cremation cases, we recommend also that the registrar should be responsible for issuing the certificate for disposal in all cases except where an inquest is held.

28.17 In inquest cases, it seems reasonable to leave the issue of a disposal certificate to the coroner and for his present discretion to issue a disposal certificate in these cases to be replaced by an obligation to do so. We recommend, therefore, that in every case in which a coroner holds an inquest he should be obliged to issue a disposal certificate to a person who appears to him (i.e. the coroner) to be responsible for arranging the disposal of the body. It is only in inquest cases that there is any delay now in the issue of disposal

certificates and the fact that, in every inquest case, the certificate will be issued by the coroner direct to the person responsible for the disposal may help to cut down such delays as do now occur. It should also be more convenient for the relatives, since, in inquest cases, it will not be necessary for them to attend at the registrar's office to give information about the death.[1] The certificate issued by the coroner should be in the same form whatever the proposed method of disposal. A possible " layout " for the new form is appended to this chapter (Figure 10).

28.18 When there is a delay in the issue of a disposal certificate in the case of a death which has been reported to the coroner, this is nearly always because cremation is desired and the death in question is one which the police are still investigating or which is likely to become the subject of criminal proceedings. In these circumstances, coroners are usually reluctant to issue a certificate which will allow cremation to take place until they are satisfied that the " defence " in any criminal proceedings does not wish to arrange for a further examination of the body. Accepting that the interests of justice should always be paramount, we can see no easy solution to this difficulty, which may sometimes bear hardly on the relatives of a deceased person. Nevertheless, on the basis of the one or two cases which have been brought to our attention, we are inclined to think that coroners may sometimes have been a little too cautious in withholding their disposal certificates in circumstances in which the need for a further examination of the body for " defence " purposes was so remote as to be almost non-existent. It is, we think, impossible to regulate this matter by legislation: the timing of the issue of a disposal certificate must remain at the discretion of the coroner.

Removal of a body out of England

28.19 Removal of a body out of England[2] is another method of disposal and, at present, it can only be authorised by a coroner. As we have seen (in Chapter 25), the law requires that every person intending to remove the body of a deceased person out of England must give notice of his intention to do so to the coroner within whose jurisdiction the body is lying. The body may not be removed out of England until the expiry of four clear days after the day on which the coroner receives notice of intention to remove unless the coroner states in his acknowledgment (also on a prescribed form) that no further enquiries are necessary. In the latter case it is lawful to remove a body on receipt of the coroner's acknowledgment. When a body is removed out of England, any certificate of disposal (whether issued by a coroner or a registrar) must be surrendered to the coroner who gives permission for the removal, except when it is intended to dispose of the body by cremation in another part of the British Isles.

28.20 The intention of the procedure is to give a coroner the opportunity to make enquiries into the circumstances of a death and to consider whether an inquest or a post-mortem examination is necessary before the body is removed from the jurisdiction of English law. In general, these provisions work

[1] The new procedures for disposal which we propose should apply both to burials and cremations are illustrated in Diagram C on page 339.
[2] This procedure also applies to Wales.

well and we have received no specific recommendations in favour of any amendment of them. We are, however, aware that delays by coroners in giving their authority have occasionally caused hardship to relatives anxious to proceed with funeral arrangements in another country. The few cases that have been brought to our attention were all ones in which there was either a certainty or a strong probability of criminal proceedings being taken in connection with the death and in which a coroner was reluctant to allow the removal of a body for the same reason as he would have been reluctant to allow its destruction by cremation (see paragraph 28.18 above). The comments which we have made in relation to delays of this kind in cremation cases apply equally to a situation in which it is desired to remove a body from England or Wales. No hard and fast rules can be laid down: the timing of the issue of a coroner's authority for the removal of a body from this country must be left to his discretion.

Disposal of a body brought into England

28.21 When the body of someone who has died outside England and Wales is brought back into this country for burial or cremation, there is no requirement that the death should be registered. But before disposal may be carried out, it is necessary to obtain from the registrar of deaths in the district in which it is intended to bury or cremate, a " certificate of non-liability to register ". If burial is the intended method of disposal, this is the only certificate required, but if it is intended to cremate the body it is necessary also to obtain the authority of the medical referee (see paragraph 26.23 above). We have explained in paragraphs 28.17 and 18 above the procedure whereby the Home Secretary may issue an Order authorising the referee to allow the cremation to proceed without the production of the statutory cremation certificates. In the light of our decision to recommend the abolition of any distinction in the certification procedure for burial and cremation, which would *inter alia* involve the disappearance of the office of medical referee, it is necessary to consider who should, in future, be responsible for authorising disposal by either method.

28.22 We are satisfied that a procedure which would involve the Home Secretary in every case—along the lines of that which now operates in relation only to cremation—would be both cumbersome and pointless. It would cause unnecessary delay and inconvenience to relatives; and if it was thought necessary that detailed enquiries should be made into the death, the Home Secretary would seldom be well placed to see that they were carried out speedily. It follows that either the registrar or the coroner must take on this responsibility. We think it would be sensible to adopt an arrangement in respect of deaths which occur abroad similar to that which will operate in future in respect of deaths which occur in this country. We recommend that in these circumstances the registrar should issue a disposal certificate valid for either burial or cremation in respect of any death in which a coroner does not decide to hold an inquest. This arrangement is likely to be convenient to relatives, or others responsible for funeral arrangements, since in the majority of cases they will only have to approach one office. They will need to visit the registrar in any case in order to obtain a certificate of non-liability

to register. The registrar will be under an obligation to report to the coroner a death which occurred abroad if it appears to fall into one of the categories of " reportable deaths " (see Chapter 6 above). This is, in fact, the procedure already adopted by registrars when they are approached for a certificate of non-liability to register. But a registrar may not be the only source of a report to the coroner of a death which occurred abroad. Such a death may also be reported directly by a relative or other person concerned about the circumstances in which the death occurred or doubtful about the medical cause assigned to the death in the foreign country. The coroner has now, and will continue to have, power to enquire into such a death. If he decides to hold an inquest he should be responsible for authorising the disposal; in all other cases, the registrar should exercise this responsibility.

TABLE Y

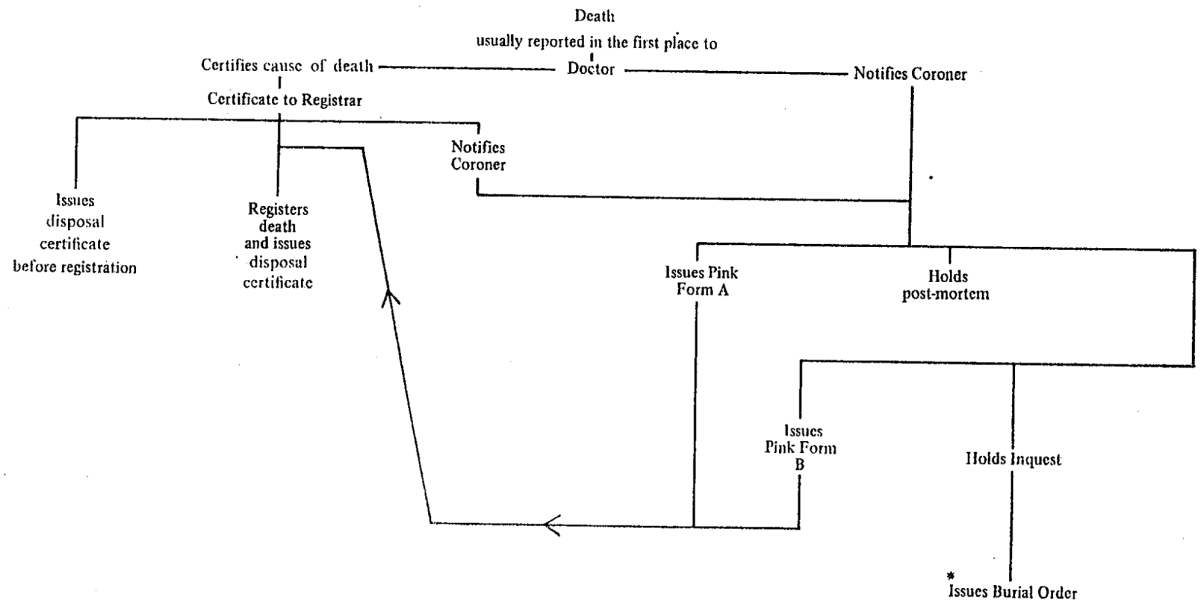
Time Taken to Register a Death, According to the Method of Certification

Source: The Registrar General for England and Wales (taken from a 1 per cent sample of all deaths registered in England and Wales in 1968).

All cases 1968 Certifications	Interval in days between death and registration									Total
	0	1	2	3	4	5	6	7	8+	
Coroners' cases										
Inquest and P.M.	—	4 (2%)	4 (2%)	10 (5%)	18 (9%)	11 (5·5%)	19 (9·5%)	13 (6·5%)	119 (60%)	198
Inquest, no P.M.	—	1 (2%)	2 (4%)	6 (12%)	4 (8%)	5 (10%)	3 (6%)	5 (10%)	24 (48%)	50
P.M., no inquest	7 (0·7%)	70 (8·3%)	156 (18·8%)	187 (22·4%)	182 (21·8%)	109 (13%)	38 (4·5%)	22 (2·5%)	61 (7·3%)	832
Doctors' cases										
P.M.	88 (19%)	165 (36%)	94 (20·5%)	68 (14·8%)	14 (3·9%)	10 (2·9%)	6 (1·3%)	4 (0·8%)	9 (1·9%)	458
No P.M.	909 (22%)	21,053 (50%)	803 (19·5%)	305 (7·4%)	58 (1·4%)	29 (0·7%)	11 (0·26%)	9 (0·2%)	27 (0·6%)	4,101
Uncertified	—	1 (20%)	2 (40%)	1 (20%)	—	—	1 (20%)	—	—	5
Total numbers	1,001	2,294	1,061	577	276	164	78	53	240	5,744
per cent	17	40	18	10	5	3	1	1	4	

Disposal – Burial
Sequence of events leading to the disposal of a body by burial

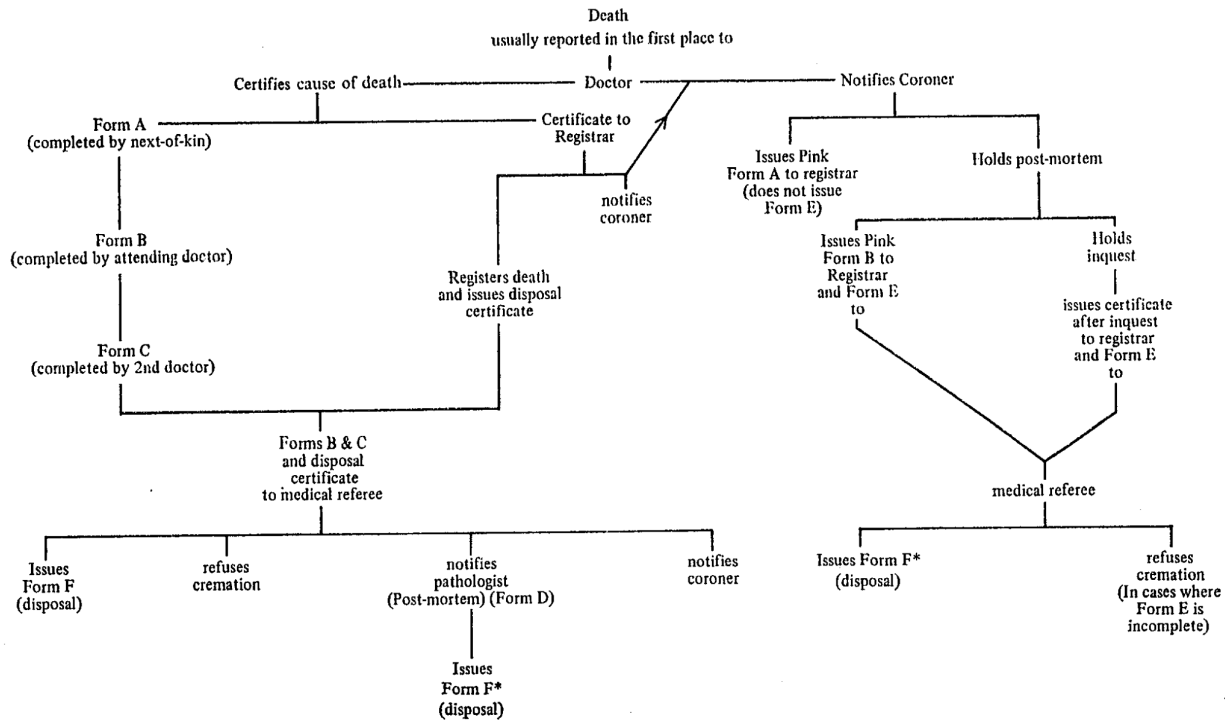
Diagram A



*The coroner may issue an order for burial at any time after he has decided to open an inquest.

Diagram B

Disposal - Cremation
Sequence of events leading to disposal of a body by cremation



* Crematorium registrar notifies Registrar of Births and Deaths of disposal

Diagram C

Burials and Cremations
Proposed Procedure for Disposal

Person responsible for effecting disposal to notify Registrar of Births and Deaths after completion

Figure 10

PART A

Name of deceased .....

Certificate issued on ..... to (name) .....

(address) .....

.....

PART B

CORONER'S CERTIFICATE FOR DISPOSAL

Form prescribed by the Coroners Rules 1972

I am satisfied that there are no circumstances likely to call for a further examination of the body of the deceased and hereby authorise disposal.

PARTICULARS OF DECEASED PERSON

Full names ..... Aged .....

Sex .....

late of .....

who died at ..... on .....

Registration district and sub-district
in which the death is to be registered .....

Dated this ..... day of ..... 19 .....

.....

Coroner for .....

Any intention to remove the body out of England and Wales must be notified to the coroner in advance of removal. A form for giving notice may be obtained from the coroner or the registrar.

This certificate will authorise the disposal of the remains of a still-born child.

The coroner is requested to fill in spaces 1 and 2 of part C of this form (see notes on cover). FORM 101

Unless this document is delivered intact to the person mentioned overleaf the disposal may be delayed.

PART C

NOTIFICATION OF DISPOSAL (See overleaf)

1. Certificate issued by the coroner for .....

2. The disposal must be notified on this form to the Registrar of births and deaths at

.....

This is to notify that the body of .....

deceased, who died on ..... at .....

.....

was buried/cremated* on ..... at .....

Signature..... on behalf of .....

Date .....

*Delete whichever is inapplicable FORM 101

CONCLUSION

Objectives

1. Our terms of reference required us to undertake a wide-ranging review and we are glad that this was so. It has enabled us to trace the thread which runs through and binds together the disparate elements of the legal and administrative procedures which we have reviewed. They have a common purpose: the accurate determination of the cause (including, sometimes, the circumstantial cause) of every death. The desire to improve the accuracy of certification is the rationale of our proposals in Part I for increasing the responsibility of the certifying doctor and for our proposals in Part V for placing a pathology service for coroners on a new basis. In Parts II and III, we recognised that accurate certification of the cause of death had become the most important function of the coroner and we made recommendations accordingly. Achievement of increased accuracy in certification provides the necessary basis for the proposals in Part VI for improving the procedures for authorising the disposal of dead bodies. Most of our more important recommendations have accurate certification of the cause of death as their starting or finishing point.

2. Several of our recommendations are based on the premise that, to a very large extent, coroners and doctors are mutually dependent agents in the same process—the certification of the cause of death—and that their objective is the same: to certify the cause of death as accurately as possible. The emergence of the coroner as a principal agent in the procedure for certifying the medical cause of death was foreshadowed by the changes made in the legislation of 1926 (see Chapters 2 and 10 above). But the significance of the fact that the coroner now has this role has been recognised only slowly and the contribution which the coroner can make to the certification process has not yet been fully understood, let alone achieved. Our proposals for extending the coroner's role as an agent of medical certification are intended as a logical development of existing trends and they are evolutionary rather than revolutionary. We have seen our task as being partly to identify those changes which have already occurred, and to draw conclusions from them, as well as to make specific recommendations to improve the efficiency with which both medical certification of the cause of death and enquiry by the coroner serve the interests of the community.

Evolution and Development

3. The tempo of change is accelerating, particularly in matters influencing the activities and organisation of the services which we have examined. Post-mortem examinations are being performed in increasing numbers every year. The number of bodies which are cremated rather than buried continues to rise steadily. So do the numbers of accidents on the roads and in the home. Advances in technology, science and medicine all proceed apace. It is impossible to forecast the precise effect of these developments, and we have not attempted to do so, but they all will have continuing implications for the subject matter of this Report.

4. Among the factors which may well have an influence on the future organisation of the coroner service is the close working relationship which

already exists between coroners and registrars of deaths and which will probably develop still further in the future. It is possible that this working relationship could become the basis of a closer organisational relationship culminating perhaps in some form of integration of the two services. It is possible, for example, that the same officer might ultimately become responsible for the scrutiny of all medical certificates of the fact and cause of death, the detailed investigation (including the investigation of the circumstances) of some deaths, the provision of a legal record of all deaths and the provision of material for vital statistics. There would, of course, be problems to overcome before any such integration of functions could be achieved—even if it were decided in principle that it should be attempted. A great deal would depend on how the registration service, as well as the coroner service, develops in the future. There is, at present, a wide disparity of function and status between the registrar and the coroner. As regards death certification the coroner seeks out and takes responsibility for certifying causes while a registrar normally records the information supplied to him. The former already has a great deal of discretion and, under our proposals, will in some respects enjoy still further freedom of action while the latter works much more closely in accordance with rules and regulations. Moreover, registrars are concerned with matters other than deaths and there may be compelling reasons (including benefit to the general public) for continuing the administrative connection between the registration of births, marriages and deaths. Care would need to be taken to ensure that the coroner's independence in judicial matters was not compromised in any integrated service.

5. Wide though our terms of reference have been, they have not allowed us to review the registration service. We cannot therefore foresee just how closely together the coroner and the registrar might work in future. In the belief, however, that possibilities for a closer organisational relationship between the registrar and the coroner may well be opened up as a result of changes which are already taking place and that such a development could offer greater administrative efficiency as well as increased benefit to the community, we recommend that, when a review of the registration service is next arranged, special study should be given to the question of whether a closer degree of integration could or should be sought between the two services.

6. Our review has convinced us that the evolution of the processes of death certification and investigation is likely to be a continuing process. We have therefore tried to preserve a sufficient flexibility in the new arrangements which we have recommended to allow changes in procedure or in the structure of the coroner service to be made as soon as they are found necessary, without the need for constant changes in the statute law. It will be remembered that we recommended that there should be an element of flexibility in any new statutory provisions to determine the boundaries of coroners' jurisdictions to take account of possible future requirements (see paragraph 20.24 above). The coroner's qualification is another case in point. Thus, while our evidence satisfied us that, in terms of current practice, a coroner should be legally rather than medically qualified, we are conscious that this may not always be a sensible requirement. With the passage of time, and as our recommendations on coroners' procedure take effect, inquests will become less frequent and

the causes of deaths will be increasingly determined by coroners on the advice of pathologists or other medical experts. In that situation, our recommendations for a legal qualification may require review and for this reason we proposed that the appropriate qualification for coroners should be prescribed by regulations made by the Home Secretary rather than written into the statute law.

7. Another consequence of the dynamic state of the matters which we have reviewed is that the continuing validity of some of our own conclusions may be limited by changes in medical or scientific techniques, or by changes in social attitudes. We hope that the new framework of law and practice which we have suggested earlier in this Report will allow account to be taken of such developments more easily than has been the case in the past. The ultimate responsibility for making necessary changes must rest with Government, but we believe that Ministers might be better placed to perceive and secure such changes if there were some permanent form of expert body charged with the task of monitoring developments and evaluating their significance for the matters which we have reviewed in the Report. Accordingly, we recommend that consideration should be given to the appointment of an Advisory Committee representative of coroners, doctors and other relevant interests.

8. We have not considered in detail the form which such a body might take but we would expect its membership to reflect the interests most closely concerned with the field of work which we have studied—those concerned with the investigation and recording of the medical and circumstantial causes of death and with the administrative procedures concerned with the disposal of dead bodies. It would consist, therefore, of representatives of coroners, the medical profession (preferably nominated by the Royal Colleges), local authorities, the police and various Government Departments (which would certainly include the Home Office, the Lord Chancellor's Department and the Department of Health and Social Security). We would think it appropriate for the Home Secretary to take responsibility for appointing the Chairman and members of such a committee and receiving its reports, although we would hope that other Ministers would look to it for advice as appropriate. The committee should be financed and serviced by the Home Office.

9. If such a committee were to be established we suggest that it might have the following functions:

(i) to advise Ministers generally on the operation of the procedures and the organisation of the system which we have reviewed and specifically on matters referred to it;

(ii) to provide, through the appropriate Minister, guidance to coroners, doctors and other individuals about standards of good practice;

(iii) to keep under regular review the categories of death required by law to be reported to coroners and to make recommendations to Ministers for any changes which it may consider necessary.

10. It is not in our minds that such a committee should enquire into specific complaints or exercise any disciplinary powers, although it might be a suitable body to give consideration to general problems of organisation and procedure which may be seen by Departments to lie behind specific complaints. It should have nothing to do with the terms and conditions of service of coroners which should be negotiated directly between coroners' representatives and the central government.

11. We hope that the Committee would publish an annual report. This would have the advantage of giving the public a better idea than it now has of the purpose of the various procedures concerned with the investigation and certification of causes of death, and it would, at the same time, allow the Committee to draw attention to such parts of its advice which had not been accepted by the Government. The right to secure a public audience would re-inforce the prestige of the Committee and enhance its authority.

Implementation

12. Not all our recommendations will require an Act of Parliament before they can be implemented. For example, changes in the coroner's procedure at and before inquests and the phasing-out of the use of police officers as coroners' officers can be introduced by subordinate legislation under existing powers, or even by administrative action. We hope that a start will be made in dealing with these matters as soon as possible. But we recognise that nearly all the important changes which we have recommended can only be implemented by new statute law; they need not wait on each other for their introduction. The changes which we have recommended in the doctor's "qualification" to give a certificate of the fact and cause of death acceptable for registration purposes and his obligation to report a death to the coroner unless certain criteria are met can be introduced in legislation completely separate from that which will be necessary to implement the other changes to which we attach importance. We hope, therefore, that a start will be made by dealing with the matters with which we have been concerned in Part I. Improvements in the law relating to the certification of the cause of death are a basic pre-requisite to some of the other changes which we have recommended, particularly those concerned with rationalising the procedures for authorising burial and cremation. We have already expressed the hope (in Chapter 27 above) that these changes can be introduced at the same time as steps are taken to implement the recommendations in Part I. Some of the major changes which we have recommended in the law relating to coroners—in particular our proposals for re-organising the structure of the service on the basis of a new partnership between central and local government—will require further discussion between the Government and the various interests involved. The same is true for our proposals for improving the pathological resources available to coroners. But we feel confident that other very necessary changes in coroners' law can be made more quickly. We are particularly anxious that legislation to abolish the existing duty of a coroners' jury to name an individual as guilty of homicide, to re-define the coroner's powers and responsibilities and to give him much greater discretion to choose the form of his enquiry should not be long delayed.

13. The effect on coroners of re-organising the service in accordance with our recommendations will vary, but for many it will be profound. Some appointments will disappear under the re-organisation that will in any case be necessary as a result of the Government's proposed changes in local government and others will follow when our own longer term proposals are implemented. Coroners who lose their appointments should be adequately compensated. Those who remain will be asked to adopt a new and more flexible approach to their work, to accept the use of some less formal procedures and to recognise much more explicitly their accountability for their actions and decisions. On one view it might be argued that coroners are being asked to sacrifice some of the major interest in their work and to surrender a measure of responsibility and independence. Any such impression would be mistaken and completely at variance with the intention behind our proposals. It follows from our basic wish to improve the accuracy of death certification that individual coroners—just as much as individual doctors—will have more rather than less responsibility in the particular cases with which they deal. To help them exercise this responsibility, we have proposed that coroners should enjoy greater discretion to choose the most appropriate method of procedure and benefit from improved supporting services in terms of both staff and accommodation. We are looking to a situation in which coroners will be more closely involved than they are now with others whose interests and concerns are relevant to their own. We have already mentioned the registrar of deaths. Coroners are also moving towards a closer relationship with the Health Services as the number of deaths which are reported to them for purely medical reasons continues to rise. Our own proposals will strengthen this trend. As a result, coroners will have frequent contact with individual doctors in order to elucidate diagnoses of the medical cause of death and they will need to call increasingly on the pathological resources of the National Health Service. We foresee, too, that coroners will find themselves collaborating ever more closely with medical officers of health (or their successors as specialists in community medicine) and with such community institutions as the Social Service Departments of local authorities and occupational health services. We are convinced that, through these contacts, coroners can make an important and positive contribution to the welfare of the community.

14. Throughout this Report we have emphasised the inter-relationship of the procedures for certifying the medical cause of death, the registration of deaths, the disposal of dead bodies and the system of investigation of deaths by coroners. These matters are not only inter-connected, they are interdependent. But we have become aware during our enquiries that many of the individuals involved in these procedures—doctors who give medical certificates of the fact and cause of death, coroners and pathologists who carry out post-mortems on their behalf—play their part in remarkable isolation and do not always see the essential unity of purpose which underlies their separate activities. Goodwill and co-operation between the individuals and the interests involved are essential if the improvements which we have identified as necessary are to be achieved. This co-operation cannot be created by Act of Parliament or even by changes in administrative procedures. We are sure that a constructive lead will be given by the many representative organisations who gave evidence to us. We hope that our Report will help all concerned to build a common understanding.

SUMMARY OF RECOMMENDATIONS

The following is a definitive summary of our principal recommendations but reference to the text must be made for a full explanation of our proposals.

Medical Certification of the Cause of Death

The " qualification " to give a medical certificate of the fact and cause of death

1. Before a doctor is allowed to certify the fact and cause of death for registration purposes he must:

(i) be a fully registered medical practitioner (paragraph 5.05); and

(ii) have attended the deceased person at least once during the seven days preceding death (paragraph 5.12).

The doctor's obligations

2. If a doctor who is called upon to certify the fact and cause of death is qualified under the terms of paragraph 1 above to give a certificate, he should be obliged to:

(i) inspect the body of the deceased person (paragraph 5.22); and

(ii) EITHER send a certificate of the fact and cause of death to the registrar of deaths, OR report the death to the coroner (paragraph 5.25).

3. The Secretary of State for the Social Services should have power to make regulations, which may be national or local in their application, prescribing certain categories of death as " reportable deaths " and a doctor should be obliged to report to the coroner any death which he has reasonable cause to believe falls within one of these categories (paragraph 6.20).

Circumstances in which a " qualified " doctor should issue a certificate

4. A qualified doctor should issue a certificate of the fact and cause of death only if:

(i) he is confident on reasonable grounds that he can certify the medical cause of death with accuracy and precision;

(ii) there are no grounds for supposing that the death was due to or contributed to by any employment followed at any time by the deceased, any drug, medicine or poison or any violent or unnatural cause;

(iii) he has no reason to believe that the death occurred during an operation or under or prior to complete recovery from an anaesthetic or arising out of any incident during an anaesthetic;

(iv) the cause or circumstances do not make the death one which the law requires should be reported to the coroner;

(iv) he knows of no reason why in the public interest any further enquiry should be made into the death (paragraph 6.33).

The " unqualified " doctor

5. Any doctor who is not qualified to give a certificate of the fact and cause of death and who, in the course of his professional duties, is informed of the death of a person whom he has previously attended, or who attends someone

whom he finds to be dead, should be obliged to report the fact of the death to the coroner together with any information which may assist the coroner's enquiries. He should not report a death to the coroner without first seeing the body and establishing the fact of death (paragraph 6.40).

Procedure for reporting deaths

6. A doctor should be obliged to report a death to the coroner as soon as possible after he has decided that a report is necessary (paragraph 6.42). An oral report should be followed up as soon as possible by the issue of a certificate. The certificate which the doctor sends to the coroner should be a new certificate of the fact and cause of death. In future this should be sent either to the registrar of deaths or to the coroner as appropriate.

The Registrar of Deaths

7. In relation to the certification of the medical cause of death, the registrar of deaths should retain his present functions and in drawing up his instructions to registrars the Registrar General should have regard to the specific categories of " reportable deaths " (paragraph 6.44).

The new certificate of the fact and cause of death

8. The new certificate should specify the circumstances in which the doctor should report to the registrar and to the coroner (paragraph 7.06).

9. The new certificate should have space for:

(i) the National Health Service number (paragraph 7.08);

(ii) the recording of major morbid conditions which have not caused or contributed to death (paragraph 7.25);

(iii) the provision of information about surgical operations performed within three months of death (paragraph 7.25);

(iv) the inclusion of details of serious accidents occurring within twelve months of death (paragraphs 7.24 and 7.25).

Registration of still-births

10. The time allowed for registering a still-birth should, in future, be the same as the time allowed for registering a death (paragraph 8.14).

A new certificate of perinatal death

11. A single certificate of perinatal death should be introduced for use in the case of still-births and the deaths of children within seven days of birth (paragraph 8.25).

12. The qualification of a doctor to give a certificate of perinatal death should be the same as of a doctor giving a certificate of the fact and cause of death (paragraph 8.25).

Still-births: Circumstances in which a doctor (or midwife) should issue a certificate of perinatal death or report the death to the coroner

13. A doctor (or midwife in the case of a still-birth) who has attended at the birth should be obliged to give a certificate of perinatal death or to report the still-birth to the coroner, but a certificate should only be given if:

(i) the certifier is confident on reasonable grounds that he (or she) can certify the fact and the medical cause of still-birth with accuracy and precision;

(ii) there are no grounds for supposing that the still-birth was due to or contributed to by any employment followed at any time by the mother, any drug, medicine or poison, any surgical operation, any administration of an anaesthetic, or any other violent or unnatural cause;

(iii) the certifier knows of no reason why, in the public interest any further enquiry should be made into the still-birth (paragraph 8.17).

14. In every case where neither a doctor nor a midwife is present at the birth, an alleged still-birth should be reported to the coroner. An obligation to make this report should be placed first on any doctor or midwife who is called to see the body and then on any person present at the moment of still-birth (paragraph 8.18).

The registrar's obligation to report a still-birth

15. The registrar of births and deaths should be obliged to report a still-birth, or alleged still-birth to the coroner in three sets of circumstances, viz:

(i) when he is unable to obtain a certificate from a doctor or midwife in respect of a still-birth which has been reported to him;

(ii) when he has reason to believe that the still-birth should have been reported to the coroner by the certifying doctor or midwife; and

(iii) when it is suggested to him by any person that a product of conception certified as a still-birth may have been born alive (paragraph 8.19).

THE CORONER'S PRESENT AND FUTURE RESPONSIBILITIES

Reporting of deaths to a coroner

16. Persons in charge of prison service establishments, similar institutions maintained by the armed forces, approved schools and remand homes should continue to be required to report the deaths of inmates to the coroner (paragraph 12.06).

17. There should be a statutory obligation upon the officer in charge of a police station to report a death to a coroner when a person dies in police custody (paragraph 12.07).

18. It should be a requirement of the law that the death of a compulsorily detained psychiatric patient should be reported to a coroner and the obligation to make such a report should be placed on the person in administrative charge of the hospital in which the patient was detained (paragraph 12.09).

19. Intentional failure by any person to comply with an obligation to report a death to a coroner should be an offence punishable by a fine (paragraph 12.32).

Territorial jurisdiction of a coroner

20. If the coroner in the area where the death occurred has grounds for believing that an inquiry should be made into the circumstances of the death and that it could more appropriately be made in the area where the incident leading to death occurred, he should be able to refer the death to that other coroner and the latter should then have a duty to accept jurisdiction over the death. It should not be necessary to move the body for this purpose (paragraph 13.02(i)).

21. When a competent court orders an inquest, or a fresh inquest, to be held, it should have power to direct any coroner (regardless of the area of his territorial jurisdiction) to hold the inquest (paragraph 13.02(ii)).

Duties of the coroner

22. When a death is reported to a coroner who has a territorial jurisdiction over the death he should have a duty

(i) to determine the identity of the deceased and the fact and cause of death;

(ii) to make such enquiries as will allow him to decide whether a post-mortem examination or an inquest or a reference to some other authority (or any combination of these) is required in order that he may determine the matters referred in (i) above; and

(iii) to send a certificate incorporating the results of his enquiries to the registrar of deaths for the district in which the death occurred (paragraph 13.06).

Powers of investigation

23. The coroner should have a statutory power to require a post-mortem to be carried out, to open an inquest or to make the reference referred to in paragraph 22(ii) above (paragraph 13.06).

24. The coroner, or any person acting with his authority, should have an express power

(i) to take possession of a body and to enter and inspect the place or area where the body was found, and any place from which the body was moved, or any place from which there is reasonable grounds to believe that the body was moved, before it was found; and

(ii) to enter and inspect the places or areas in which the deceased person was, or the places or areas in which there is reason to believe that the deceased person was, prior to his death, if in the opinion of the coroner, the entry and inspection of such places or areas is necessary for the purposes of his investigation.

Further, if a coroner has reasonable grounds for believing that it is essential for the purposes of his investigation that he should proceed in this way, he or any person acting with his authority should have the express power

(iii) to enter into any place to inspect and receive information from any records or writings relating to the deceased and to reproduce and retain copies therefrom; and

(iv) to take possession of anything that he has reasonable grounds for believing is material to the purposes of his investigation and to preserve it until the conclusion of his investigation. When his investigation is complete, the coroner should have a duty to restore that thing to the person from whom it was taken unless he is authorised or required by law to dispose of it in some other way (paragraph 13.07).

Inquests in the absence of a body

25. The Secretary of State should continue to have the power to direct that an inquest be held in the absence of a body (paragraph 13.08).

26. If, for a particular reason (see paragraph 13.09), a second inquest into a death is held, the finding of the second inquest should automatically replace the finding of the first, but where the second inquest is conducted in the knowledge that an earlier inquest has already been held, the coroner conducting the second inquest should have power to take into account the evidence given at the first inquest (paragraph 13.09).

27. The Home Office should keep a register of the cases in which the Secretary of State has directed inquests to be held in the absence of a body and coroners should consult the Home Office in cases where a body is found in circumstances which suggest that it may reasonably be thought to have been lost (paragraph 13.10).

Deaths outside England and Wales

28. For the avoidance of doubt it should be provided that a coroner has discretion whether or not to act in any case where he is informed that there is within his area a body of a person who has died overseas in circumstances which had they occurred in this country would have given him jurisdiction to act (paragraph 13.12).

29. There should be legislation to provide that the death on an off-shore installation of any person ordinarily resident within the United Kingdom whose body is, for any reason, not brought into the jurisdiction of a coroner should be reported to a coroner so that the latter may be in a position, if he thinks it desirable and practicable, to make enquiries to ascertain the fact and cause of death and, if he wishes to hold an inquest, to seek the Secretary of State's authority for this (paragraph 13.17).

Exhumations

30. The coroner should have a statutory power to make an order for exhumation (paragraph 13.19).

Treasure Trove

31. Coroners should continue to exercise the duty of enquiring into finds of treasure until comprehensive legislation is introduced to deal with the whole question of the protection of antiquities (paragraph 13.27).

Fire inquests in the City of London

32. The City of London Fire Inquests Act 1888 should be repealed (paragraph 13.29).

The coroner's procedure when a death is reported to him

33. Coroners should be recipients, not seekers, of reports of deaths which call for their investigation and their enquiries should extend so far as, but no further than, is necessary to enable them to complete the task of establishing the cause and, where necessary the circumstances of death (paragraph 14.10).

34. The coroner should retain the right to accept the cause of death given to him by a doctor but having done so he should take responsibility for certifying the cause of death. He should send a certificate to the registrar on the basis of the information which the doctor has provided (paragraph 14.17).

35. The coroner should be obliged to open an inquest when he is informed of:

(i) a death from suspected homicide;

(ii) deaths of any person in legal custody (including persons who are compulsorily detained in hospitals); and

(iii) deaths of persons whose bodies are unidentified (paragraph 14.10).

36. Except in those cases mentioned in recommendation 35 above, the coroner should have a complete discretion as to the form which his enquiries may take after a death has been reported to him (paragraph 14.10).

37. The restriction which precludes the coroner from returning any verdict which may appear to determine any question of civil liability should be retained (paragraph 14.24).

View of the body

38. It should no longer be obligatory for a coroner to view the body prior to an inquest (paragraph 15.08).

Arrangements for holding inquests

39. A coroner should have authority to summon witnesses from anywhere in England and Wales (paragraph 15.12).

40. When witnesses are told about the arrangements for an inquest, they should be told also that, as properly interested persons, they are entitled to legal representation (paragraph 15.13).

41. If a properly interested party asks to be kept informed of the inquest arrangements and has supplied a telephone number or address at which he can be contacted, then the coroner should be obliged to inform him of the arrangements which he makes (paragraph 15.15).

42. A coroner should be required to exhibit a list of the inquests which he proposes to hold (together with a list of the witnesses to be called to each) on a notice board outside his office and outside the place or places most commonly used as a coroner's court (paragraph 15.16).

43. Coroners should not change the declared time of an inquest without giving adequate notice to the persons concerned (paragraph 15.17).

Notification of inquest findings

44. If for any reason the nearest surviving adult relative whose existence is known to the coroner is not present at the inquest, the coroner should be obliged to notify him of the findings of the inquest, and to inform him that a certificate can be obtained from the registrar of births and deaths to whom the coroner's own certificate has been sent (paragraph 15.14).

Recording of evidence

45. A transcript of the evidence should be taken at every inquest (paragraph 15.22).

Interim death certificate

46. Coroners should be required to complete and deliver to the next of kin an interim certificate of the fact of death in cases where the conclusion of an enquiry is likely to be delayed. This certificate should be acceptable to third parties, e.g. insurance companies, as evidence of the fact of death (paragraph 15.38).

Abolition of the duty to assess guilt and the obligation to commit for trial

47. The duty of a coroner's jury to name the person responsible for causing a death and the coroner's obligation to commit a named person for trial should be abolished (paragraph 16.18).

48. There should be express provision for the coroner to refer his papers to the Director of Public Prosecutions, should he consider it necessary to do so, at whatever stage in the inquest seems to him to be most appropriate (paragraph 16.20).

49. A coroner should avoid making any statement directly implying that a dead person thought by the police to be a murderer was, in fact, responsible for a death (paragraph 16.24).

50. In a case where a coroner sends his inquest papers to the Director of Public Prosecutions, the Director should be obliged to notify the coroner of his decision where no further court action ensues, no matter for what reason, and the coroner should publish a statement to the effect that the Director of Public Prosecutions is satisfied upon the evidence presently available that there is no case for any criminal proceedings (paragraph 16.28).

51. The coroner should be responsible for notifying the registrar of deaths of the results of any criminal proceedings or the results of further enquiries

made by the Director of Public Prosecutions or by the police on behalf of the Director (paragraph 16.30).

Other offences

52. If, during the course of an inquest, evidence is adduced for the first time which suggests that an offence which has a bearing on the cause of death may have been committed, the coroner should make a report to a responsible public authority and announce in neutral terms that he is doing so (paragraph 16.33).

Result of an enquiry

53. Coroners should continue to record in inquest cases the medical cause of death and sufficient information about the circumstances of the death to enable the Registrar General to ascribe the death to a statistical category (paragraph 16.42).

Verdicts

54. The term " verdict " should be abandoned and replaced by " findings " (paragraph 16.43).

The jury

55. The mandatory requirement to summon a jury for inquests on certain categories of death should be abolished, but a coroner should retain the power to summon a jury where he considers that there are special reasons for doing so (paragraph 16.49).

56. When a coroner decides to sit with a jury, it should be summoned in accordance with the same rules as are used by the High Sheriff in summoning juries for other courts (paragraph 16.50).

Riders and recommendations

57. The right to attach a rider to the findings of a coroner's court should be abolished; the coroner should confine his enquiry to ascertaining and recording the facts both medical and circumstantial which caused or led up to a death; and, where he thinks that action should be considered to prevent recurrence of the fatality, he should have a right to refer the matter to the appropriate expert body or public authority, and he should announce that he is doing so (paragraph 16.53).

58. The coroner should not be prevented from commending the conduct of an individual or an institution, provided this can be done without prejudice to others (paragraph 16.55).

Participation in inquest proceedings

59. The following categories of properly interested persons should be given an absolute right to be present at an inquest and to ask relevant questions either by themselves or through their legal representatives:

(*a*) the next-of-kin of the deceased;

(*b*) the parents, children and personal representatives of the deceased;

(*c*) any beneficiary of a policy for insurance on the life of the deceased and any insurer having issued such a policy;

(*d*) any person whose act or omission on the part of himself, his servants or agents, irrespective of whether it may give rise to civil liability, may be thought to have caused or contributed to the death of the deceased;

(*e*) a chief officer of police; and

(*f*) any person appointed by a Government Department to attend the inquest.

In addition the coroner should retain a discretionary right to allow any other person to appear (paragraph 16.57).

60. In cases of industrial injury or disease, the existing right of a Trade Union representative to examine a witness at an inquest should be preserved (paragraph 16.57).

61. A coroner should have a discretionary power to waive the requirement that the police may only appear at an inquest by legal representative (paragraph 16.58).

Legal aid

62. Legal aid should be made available to enable interested parties to be represented at an inquest (paragraph 16.60).

Written evidence

63. Subject to the same right of objection for properly interested persons as exists under the present law, coroners should in future have a general discretion to accept documentary evidence from any witness at an inquest (paragraph 16.63).

64. A " properly interested person " should have the right, and be given the opportunity, to object to the holding of an inquest based exclusively on documentary evidence (paragraph 16.66(a)).

65. Once an all-documentary inquest has been opened a properly interested person should have the same right as he now has in relation to any inquest at which documentary evidence is admitted to require that the inquest be adjourned so that a particular witness may give oral evidence (paragraph 16.66(d)).

66. A coroner should be obliged to give at least 48 hours notice of his intention to hold a " short " inquest (paragraph 16.66(b)).

67. Such notice should be given in two ways, by display on notice boards outside his office and outside the place or places most commonly used as a coroner's court, and by written notice to the person to whom he proposes to issue a certificate for disposal of the body (paragraph 16.66(c)).

The coroner's procedure in relation to particular categories of death

68. A coroner should continue to arrange for post-mortem examinations to be made whenever a suspected pneumoconiosis death is referred to him, that these post-mortem examinations should be carried out by pathologists attached to specialist thoracic centres, and that relevant pathological material should continue to be made available to the pneumoconiosis panels (paragraph 17.08).

69. Before giving consent to the use for transplant purposes of the heart of the victim of an accident whose death has been reported to him, the coroner should ascertain that the deceased has been the passive victim of violence (paragraph 17.12).

Coroners' certificates and records

70. There should be a new coroner's certificate of the fact and cause of death, which should be completed by the coroner in every case (paragraph 18.06).

71. Coroners should be required to make and retain a copy of the new certificate as the formal record of their action in respect of every death reported to them (paragraph 18.18).

72. The Registrar General should prescribe by regulation the information which the registrar of deaths should be obliged to copy into his register (paragraph 18.15).

Disclosure of documentary information by coroners

73. A coroner should have a wide discretion to make documents available as he thinks fit, within a general framework of guidance to be provided by the Home Office.

74. A coroner should be obliged to supply a copy of a post-mortem report to the deceased person's family doctor on request and no charge should be made for this service. The supply of copies of this report to other doctors and other persons who may ask for it should continue to be a matter for the coroner's discretion.

Appeals against inquest findings or decision not to hold an inquest

75. There should be wider rights of appeal against the findings of an inquest: an error in any part of the record of the findings of the coroner's court (including the findings as to the medical and circumstantial causes of death) should constitute a ground for an application for a fresh inquest (paragraphs 19.06 and 19.07).

76. These rights should be exercisable locally by application to a High Court Judge sitting at a major centre outside London; but the existing right of an aggrieved party to go to the Divisional Court should be preserved (paragraphs 19.08 and 19.09).

77. A coroner's discretion not to hold an inquest on a death that has been reported to him should be open to rapid challenge and the matter should be

capable of determination by a High Court Judge outside London (paragraph 19.12).

78. In such a case the High Court Judge should have power to order an autopsy and power to make an order suspending the operation of any burial or cremation order until the results of the autopsy are known (paragraph 19.13).

DEVELOPMENT OF THE CORONERS' SERVICE

Reorganisation of local government

79. As a transitional measure provision should be made in the forthcoming legislation on Local Government for coroners in England and Wales outside the Metropolitan areas to be appointed by the new county authorities and in the Metropolitan areas by the councils of the new Metropolitan areas (paragraph 20.20).

Coroners' areas

80. (i) The new county and metropolitan authorities should be statutorily required to submit for approval by the Home Secretary proposals for the organisation of a coroner service in their area.

(ii) Before submitting any proposals for a part-time jurisdiction the authority concerned should be statutorily required to consult the authority for any areas bordering on the proposed part-time jurisdiction with a view to enlarging that jurisdiction if possible to full-time status by inter-authority adjustment of the coroners' district boundaries.

(iii) The authorities should be under a statutory obligation to keep the distribution of coroners' districts under review and to consider any proposals made by the Home Secretary for alterations of districts; and to facilitate central oversight they should be statutorily obliged to send to the Home Office such information or reports on the work in individual coroner's districts as the Home Secretary may from time to time request.

(iv) The Home Secretary should have power to approve or reject proposals submitted to him; power, after consultation with the local authority or local authorities affected, to amend the proposals for coroners' districts and power to propose and impose alterations from time to time to any coroners' districts that seem to him to be unsatisfactory in size for the efficient working of the service (paragraph 20.23).

81. The statutory provisions as proposed in paragraph 77 above should be formulated in such a way that, if at some future stage it were desired to deploy coroners more flexibly than by static jurisdictions, e.g. by creating panels of coroners for special enquiries whenever they might occur or by giving hard-pressed coroners temporary reinforcement from other areas, these possibilities should not be frustrated (paragraph 20.24).

Appointment of coroners

82. Appointments of all coroners and of deputy coroners to whole-time posts should be made by the Lord Chancellor, after appropriate consultation with local authorities (paragraph 20.30).

83. Appointments of deputy coroners to part-time posts and of assistant deputy coroners should be made by the coroner with the approval of the Lord Chancellor (paragraph 20.31).

Removal from office

84. The power of removal should lie solely with the authority having the power of appointment, i.e. the Lord Chancellor (paragraph 20.32).

85. The power of removal should be exercisable only for incapacity or misbehaviour (paragraph 20.31).

86. The Lord Chancellor should be able to remove a coroner for *any* incapacity or misbehaviour which, in his judgment, renders the coroner unfit to continue in office (paragraph 20.33).

87. Investigation of the grounds for removal from office of a coroner should be carried out on behalf of the Lord Chancellor by the Home Secretary (paragraph 20.32).

Qualifications for appointment

88. Only barristers or solicitors of at least 5 years' standing in their profession should be eligible for future appointment as coroners, deputy coroners and assistant coroners. In order to preserve flexibility for the future, this new qualification should be prescribed by regulation rather than by statute (paragraph 20.41).

Residential requirements

89. Coroners who are appointed to county jurisdictions should no longer be required to reside within the district to which they are assigned, or within two miles of it. Instead, it should be a condition of appointment that a coroner, or in his absence his deputy or his assistant, should be readily available at all times to undertake coroners' duties (paragraph 20.43).

Retirement

90. Unless special circumstances necessitate an earlier retirement, a coroner should normally retire at the age of 65, but the Lord Chancellor should have power to extend the coroner's tenure of office annually in appropriate cases up to the age of 72. These conditions should also apply to deputy coroners and assistant deputy coroners (paragraph 20.45).

Coroners' salaries

91. Whole-time coroners should be paid standard salaries. An appropriate analogy to follow would be the salary of a stipendiary magistrate (paragraph 20.48).

Supporting staff for coroners

92. Police officers should no longer serve in the capacity of coroner's officer. They should be " phased-out " gradually and should be withdrawn by

chief officers of police only after the closest consultation with the coroner, local authorities, hospital and where appropriate other bodies (paragraphs 21.11 and 21.12).

93. Every coroner should be provided with the services of a civilian coroner's officer and where necessary the services of a secretary (paragraph 21.14).

Central government responsibility for staff and accommodation

94. The Home Secretary should be placed under a statutory duty to secure the provision of suitable and sufficient staff and accommodation for the performance by coroners of their statutory functions (including the holding of inquests). He should be empowered to make arrangements for other persons or bodies to act as his agents and to pay for the expenditure incurred by them on his behalf (paragraph 21.25).

PATHOLOGICAL AND RELATED SERVICES

95. Responsibility for selecting the appropriate pathologist or pathologists to investigate a particular death should cease to rest with the coroner; instead it should be entrusted to another authority, familiar with the services and resources which could be made available to assist the coroner and familiar also with the needs of coroners and the circumstances of their work (paragraph 23.06).

96. The provision of a pathology service for coroners should become the responsibility of the National Health Service (paragraph 23.08).

97. The appropriate National Health Service authority should designate for each coroner a senior pathologist (or failing this a senior medical administrator) among whose responsibility it would be to receive requests from each coroner for pathologist examinations, to select the pathologist to carry them out, and to satisfy himself that facilities, e.g. mortuary and laboratory facilities were available for their purposes (paragraph 23.20).

98. The designated officer (as described in paragraph 94 above) should:

(i) be prohibited from asking any member of a pneumoconiosis panel to carry out a post-mortem examination on behalf of the coroner in any case where pneumoconiosis is suspected to have caused the death; and

(ii) do what he can in such a case to encourage the closest liaison between the pathologist acting on behalf of the coroner and the pneumoconiosis panel members (paragraph 23.21).

99. A service in forensic pathology for the police (like the pathology services for coroners) should be firmly based in the N.H.S. (paragraph 24.04).

100. The general training framework for forensic pathology should be based on N.H.S. practice (paragraph 24.06).

101. The principal training schools in forensic pathology should continue, as at present, to be located in universities (paragraph 24.07).

102. The general supervision of post-graduate training in forensic pathology should be primarily the responsibility of the Royal College of Pathologists (paragraph 24.07).

103. The requirements for a national service in forensic pathology should be determined only by consultation between the Home Office, police authorities and Regional Hospital Boards or similar authorities (paragraph 24.09).

104. The Home Office should take responsibility for initiating the discussions referred to in paragraph 100 above, for representing the police requirements, and for making a financial contribution in respect of the provision ultimately made (paragraph 24.09).

Medical Certificates for the Disposal of Dead Bodies

Disposal of still-births

105. The procedure for the disposal of still-births should, in future, be the same as for dead bodies (paragraph 25.10).

Disposal certification procedure

106. A disposal certificate issued either by a registrar of deaths or by a coroner to whom a death has been reported should be sufficient authority for disposal by any method (paragraph 27.34).

107. The existing cremation forms and certificates and the office of medical referee should be abolished (paragraph 27.34).

108. The changes made necessary by the recommendations at 103 and 104 above should be introduced at the same time as the changes recommended in Part I of this Report, but if, for any reason, there is a likelihood that these latter changes may be deferred for a considerable period, we recommend that Form C (the confirmatory certificate) should be abolished without delay (paragraph 27.35).

Embalming

109. Preservative treatment should in future never be started before either (*a*) a death has been registered on the basis of a certificate given by a doctor qualified to issue such a certificate or (*b*) if the death has been reported to the coroner, the consent of the coroner has been obtained (paragraph 28.10).

Responsibility for issuing disposal certificates

110. The registrar should be responsible for issuing the certificate for the disposal of a dead body in all cases except where an inquest is held (paragraph 28.16).

111. In every case in which a coroner holds an inquest he should be obliged to issue a disposal certificate to a person who appears to him (i.e. the coroner) to be responsible for arranging the disposal of the body (paragraph 28.17).

112. When a body of someone who has died outside this country is brought back for disposal, the certificate authorising disposal of the body should be issued by the registrar of deaths unless the death is one on which a coroner has decided to hold an inquest (paragraph 28.22).

113. When a review of the registration service is next arranged, special study should be given to the question of whether a closer degree of integration could or should be sought between the two services (Conclusion, paragraph 5).

114. Consideration should be given to the appointment of an Advisory Committee representative of coroners, doctors and other relevant interests (Conclusion, paragraph 7).

We would like to record our profound gratitude and admiration for the assistance we have received, throughout our enquiry and in the preparation of this Report, from our two Secretaries. Our first secretary was Mr. Geoffrey de Deney and he was succeeded in the middle of 1968 by Mr. Austin Wilson. To both of them we extend our sincere thanks. We wish also to record our appreciation for the help we received from Mr. Francis Rooke-Matthews of the General Register Office, whose presence at our meetings made an inestimable contribution to our work. A number of members of the Home Office staff (notably Mr. Peter Beedle, Mr. Roy Harrington, Mr. Nigel Varney and Mr. Peter Curwen) assisted us at various times throughout our enquiry and we are happy to record our thanks for their help.

NORMAN BRODRICK
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DAVID KERR
P. H. LLOYD
GLADSTONE R. OSBORN
DOUGLAS OSMOND
LIONEL ROSEN

A. P. WILSON
Secretary

22nd September, 1971

APPENDIX 1

LIST OF WITNESSES WHO GAVE EVIDENCE

(*a*) Organisations and individuals who submitted written evidence.

Association of Anaesthetists
Association of Chief Police Officers of England and Wales
Association of Clinical Pathologists
Association of Clinical Pathologists: Caledonian Branch
Association of Crematorium Medical Referees
Association of Industrial Medical Officers
Association of Municipal Corporations
Association of Police Surgeons of Great Britain
Ministry of Aviation (now Ministry of Aviation Supply)
Dr. J. G. Benstead
Mr. J. F. Blythe
Board of Trade (now Department of Trade and Industry)
British Academy of Forensic Sciences
British Association in Forensic Medicine
British Medical Association
British Occupational Hygiene Society
British Paediatric Association
British Railways Board
Mr. H. Campbell
Dr. B. S. Cardell
Central Electricity Generating Board
Central Midwives Board and the Royal College of Midwives
Christian Science Committees on Publications
College of Pathologists (now the Royal College of Pathologists)
Commissioner of Police of the Metropolis
Confederation of British Industry
Coroners' Society of England and Wales
County Councils Association
Cremation Society
Crown Agent
Mr. A. G. Davies
Ministry of Defence
Director of Public Prosecutions
Electricity Council
Faculty of Anaesthetists
Mr. M. A. Falconer
Federation of British Cremation Authorities
Dr. C. P. de Fonseka
Friendly Societies Liaison Committee
Gas Council
Mr. D. J. Gee, on behalf of seven other forensic pathologists
General Register Office
Greater London Council
Guild of Mortuary Administration and Technology
Mr. F. G. Hails
Dr. V. F. Hall
Mr. J. A. Hogg
Ministry of Home Affairs for Northern Ireland
Ministry of Housing and Local Government (now Department of the Environment)
Institute of Actuaries

Institute of Burial and Cremation Administration
Mr. J. C. Jevans
Dr. J. E. Keen
Mr. H. H. Kenshole
Ministry of Labour (now the Department of Employment)
Law Society
Dr. W. M. Levitt
Life Offices' Association, the Associated Scottish Life Offices and the Industrial Life Offices' Association
Lloyds Underwriters
London Transport Board
Lord Chancellor's Office
Professor H. A. Magnus
Mr. W. E. J. Major
Dr. A. K. Mant
Dr. T. K. Marshall
Medical Protection Society
Medical Research Council
Mr. G. R. S. Morris, Q.C.
Motor Conference
National Association of Funeral Directors
National Coal Board
National Union of Boot and Shoe Operatives
National Union of General and Municipal Workers
National Union of Journalists
National Union of Mineworkers
Newspaper Proprietors Association
Newspaper Society
Paediatric Pathology Society
Ministry of Pensions and National Insurance (now the Department of Health and Social Security)
Police Federation of England and Wales
Police Superintendents Association of England and Wales
Ministry of Power (now the Department of Trade and Industry)
Proprietory Crematoria Association
Royal College of Obstetricians and Gynaecologists
Royal College of Physicians
Royal Society for the Prevention of Accidents
Rural District Councils Association
Society of Antiquaries
Society of Labour Lawyers
Professor W. G. Spector
Dr. H. Spencer
Mr. J. F. Stone
Mrs. N. Tate
Dr. A. B. Taylor
Trade Union Congress
Ministry of Transport, representing also the views of the Road Research Laboratory (now the Department of the Environment [Transport Industries])

(*b*) Organisations and individuals who gave oral evidence.

Association of Anaesthetists	Dr. H. J. V. Morton Dr. O. P. Dinnick
Association of Clinical Pathologists	Dr. A. C. Hunt Dr. E. M. Ward Dr. A. G. Marshall

Association of Crematorium Medical Referees	Dr. W. A. Parker Dr. J. Stevenson Logan
British Academy of Forensic Sciences	Professor F. E. Camps Mr. D. Napley
British Association in Forensic Medicine	Dr. A. K. Mant Professor C. J. Polson
British Medical Association	Professor C. K. Simpson Dr. P. H. Addison Dr. F. Hampson Dr. J. D. J. Havard Dr. C. H. Johnson Professor R. D. Teare Mr. R. Woods Dr. G. Macpherson Dr. A. Skene
Christian Science Committees on Publication	Mr. B. G. Pope Mr. W. R. Ainslie Miss E. A. Jameson Miss K. D. Phillips
College of Pathologists (now the Royal College of Pathologists)	Dr. A. G. Marshall Professor R. D. Teare Professor T. Crawford Professor C. K. Simpson Dr. E. M. Ward Dr. A. C. Hunt Dr. F. Hampson
Coroners' Society of England and Wales	Mr. P. D. Childs Mr. T. E. Gardiner Mr. M. R. E. Swanwick Dr. G. L. B. Thurston Mr. J. A. S. Williams
Cremation Society	Mr. K. G. Prevette Mr. H. Carter
Crown Office, Scotland	Mr. W. G. Chalmers Mr. A. Mcleod
Faculty of Anaesthetists and the Royal College of Surgeons	Dr. A. H. Galley
Federation of British Cremation Authorities	Mr. A. C. McMillan Mr. L. J. Evans Mr. H. G. Garrett
General Register Office	Mr. C. C. Spicer Mr. W. G. McDonald
General Register Office, Scotland	Mr. R. McLeod
Department of Health and Social Security	Sir George Godber, Chief Medical Officer
Institute of Burial and Cremation Administration	Mr. L. J. Evans Mr. H. G. Garrett
Lord Chancellor's Department	Mr. D. W. Dobson Mr. W. Bourne

Medical Research Council	Dr. W. R. S. Doll
National Association of Funeral Directors	Mr. H. Ebbutt Mr. L. H. Stringer Mr. P. G. Wilson
Police Federation	Chief Inspector R. J. Willatt Chief Inspector R. Light Sgt. R. H. Warrington Constable J. F. Quinn Mr. E. D. Hodgson (on behalf of the secretary)
Proprietary Crematoria Association	Mr. E. E. Field Mr. G. C. Scott
Royal College of Obstetricians and Gynaecologists	Dr. T. L. T. Lewis
Dr. A. H. Cameron Dr. J. A. Gavin Dr. M. A. Heasman Mr. D. Longmore Professor H. A. Magnus Professor S. Peart Professor W. G. Spector Professor H. Spencer	

APPENDIX 2

STATISTICS OF CORONERS WORK SINCE 1901

General

1. Coroners are required to make an annual return to the Home Secretary. These returns are made on a standard form which is issued to every coroner by the Home Office Statistical Branch at the end of each year. The completed returns are the main source of statistical information about coroners work. The contents of the returns have varied from time to time and these variations are reflected in the tables annexed to this appendix and to Appendix 4. So far as possible, for purposes of comparison, where information is basically the same it has been kept in the same column and changes in the heading of the column are indicated at the years where they occur.

2. Until 1938, individual returns were published in full in the annual volumes of the Criminal Statistics and the figures for 1901–1938 have been obtained from this source. No returns are available for years 1915–1917 inclusive or for the period of the Second World War.

3. Annual publication of these statistics was discontinued after the Second World War but the returns continued to be made to the Home Office and full summaries were made of them. Unfortunately, some of these summaries appear to have been destroyed and this is the explanation for the large gap covering the period 1946–1956 inclusive. The only figures for which there is almost a complete record are the number of deaths reported to coroners and the number of inquests held, but even these figures are missing for the year 1948. For some of the missing years, our tables include figures which have currently been provided for us by the Secretary of the Coroners' Society from his Society's records for this period. These are the figures which appear in brackets in our table and they are likely to be slight underestimates because a few coroners do not belong to the Society.

Column 1—Total number of deaths in England and Wales

4. These figures have been obtained from the Registrar General. There is a surprising constancy in the total number of deaths occurring annually over the seventy year period. The number of deaths occurring in 1966, for example, is almost exactly comparable with the number in 1901. Between these years the number of deaths declined very slightly until 1926 and after that year began slowly to rise again. As we shall see, however, the change in the pattern of deaths was rather more striking than the overall picture suggests.

Column 2—Deaths reported to Coroners

5. Until 1919, the total number of deaths reported to coroners does not seem to have been recorded. In theory, it ought to be possible to arrive at this number by adding the figures in column 5 (number of preliminary enquiries not followed by inquest) and column 8 (total number of inquests); but if this is done for the years 1919–1926 it will be found that the total is in fact smaller than the figure for the total number of deaths reported to coroners. We have been able to find no plausible reason for this discrepancy. However, in the light of this known discrepancy, it may be that a larger number of reports were made during the period 1901–1914 than the sum of the figures in columns 5 and 8 would indicate.

6. For the period 1927–1938, the number of deaths reported to coroners should correspond with the totals of columns 5, 7 (post-mortem examinations ordered by coroners in non-inquest cases) and 8. Here again, however, there is a discrepancy. The total of these three columns at the beginning of the period is smaller than the

total number of deaths reported to coroners. At the end of the period, however, the total of these three columns *exceeds* the total number of deaths reported. A possible explanation may be that in the return of deaths investigated where no inquest was held coroners included Pink Form B cases as well as Pink Form A cases. As the number of the former increased this would account for the rise in the total. The practice may also have varied from coroner to coroner which would explain why the excess of the sum of columns 5, 7 and 8 over column 2 amounts to only about half the figure in column 7.

7. After 1946, the figure of deaths reported to coroners appears to correspond fairly closely with the sum of the figures in the columns indicating the different ways in which coroners dealt with those deaths.

Column 3—Lunatics and mental defectives

8. The number of these deaths appears to have remained remarkably constant for the whole of the period for which figures of this are available. They are, of course, included in the total in column 2. The obligation to report such deaths ceased in 1959 and 1960 was the first full year in which the obligation did not apply. The abolition of a duty to report deaths of lunatics and mental defectives undoubtedly accounts for the slight decline in the total number of deaths reported to coroners in the years 1960 and 1961. But the existence of an underlying strong trend for the number of deaths reported to coroners to increase is clearly shown by the fact that, by 1962, the total number of deaths reported to coroners was well in excess of the figure for 1959.

Column 4—Other deaths reported to the coroner

9. The figures in this column give a better idea of the growth of coroners work. There is little doubt that, certainly in the later years, the automatic reporting of deaths of lunatics and mental defectives resulted in coroners treating their investigation into these deaths very much as a formality. Very few of these deaths were, in fact, certified by coroners: the great majority were dealt with by use of the Pink Form A procedure. Figures in column 3 remain fairly constant throughout the whole period for which they are available. The figures in column 4, on the other hand, reflect the general rise in deaths reported. This is particularly so for the year 1927 when the changes made by the Coroners (Amendment) Act 1926 and the Births and Deaths Registration Act 1926 came into effect. The increase in the number of deaths reported in 1927 over the previous year is over 6,000 of which over 5,000 are accounted for by deaths other than those of lunatics etc. The probable explanation for this increase is the tightening up of the registration procedures which took place in 1926. The same changes have relevance to the number of inquests, a point which is discussed below.

Column 5—Preliminary enquiries not followed by inquest

10. The figures in this column represent the "Pink Form" cases. Since 1926, these have fallen into two categories: A and B. But it is clear, not only from these statistics but also from certain remarks in earlier editions of Jervis and the Report of the Departmental Committee on Coroners in 1910, that a "Pink Form" procedure operated long before 1926. In theory, at least, the pre-1926 "Pink Form" procedure should correspond with the post-1926 Pink Form A procedure that is to say it should have been used in those cases in which, although a report has been made to the coroner, the action which he takes does not result in the death being certified upon his authority because he has notified the registrar that he does not propose to take any action. In these cases the death is registered on the basis of a medical certificate of the cause of death issued by a medical practitioner.

11. There might seem to be a case of putting the heading " Pink Form A " in this column between the years 1926 and 1927, since the present " Pink Form " procedure dates from 1926. But the figures in this column for the period 1927–1938 are suspiciously high and it seems very possible that, after 1926, Pink Form A and Pink Form B cases were not at first separated so that, for the period 1927–1938, the figures in column 5 in fact represent the sum of both procedures. For a period after 1946 it is possible to distinguish clearly between Pink Form A and Pink Form B cases. There seems little doubt that the reduction in the number of the "A" cases in the years 1961 onwards by about 10,000 in comparison with the years 1946–1949 is ascribable to the ending of the obligation to report deaths of lunatics and mental defectives which were only rarely registered on the basis of a certificate provided by a coroner.

Columns 6 and 7—Post-mortem examinations

12. There are two points to make about the figures in this column. First, it seems possible that some of the post-mortem examinations recorded as taking place during the period 1919–1926 may relate to cases included in column 5 as preliminary enquiries not followed by an inquest: there is certainly an element of double counting somewhere in these figures. The other significant fact is that, at least as late as 1926, more than half of the total number of inquests were not accompanied by a post-mortem examination.

13. After 1926, it is possible to distinguish between post-mortem examinations which accompanied inquests and those where no inquest was held. The latter category is, of course, the category of Pink Form B cases. The power to hold a post-mortem examination and then dispense with an inquest was first introduced in 1926. The figures for the following years show the way in which this power was increasingly utilised. Deaths dealt with by coroners in this way now account for about 75 per cent of all deaths which they certify.

Column 8—Number of inquests

14. Apart from those in column 1, the figures in this column are probably the most reliable over the whole period covered by the table. There has been a large fall in the number of inquests held from the beginning of the period to the end but, until very recently, this fall has not resulted from a steady decline. It has, in fact, taken place in two clearly defined steps each of which corresponds with the period of one of the two World Wars. During the period 1901–1914, the number of inquests averaged a fairly constant 36,000 a year; during the period 1919–1938 the number of inquests averaged a fairly constant 31,000 a year and during the period 1946–1966 the number averaged a fairly constant 26,000 a year. The number is now falling gradually every year although the number of deaths reported to the coroners continues to rise. There were no changes in the law during these two War periods which might have affected the number of inquests held and it seems probable that the pressure and general upheaval of periods of emergency has resulted in the breaking down of old practices and in the adoption of new ones more consistent with current needs.

15. No less striking than the impact of the two War periods on the number of inquests is the apparent absence of any effect on the number of the introduction of the Pink Form B procedure in 1926. Although the number of Pink Form B cases had reached 13,000 by 1938, there was no significant reduction at all in the number of inquests held. An explanation of this somewhat surprising fact can be found in the rise in the number of deaths reported to coroners after 1926 and from an examination of the statistics on verdicts. The number of deaths reported to coroners between 1927 and 1938 rose by about 10,000—a figure which does not fall very far short of

the increase in the number of Pink Form B cases during this period. The statistics of verdicts (see Appendix 4) show that until 1926 verdicts of accidental death and of death from natural causes were both averaging about 12,000 a year. In 1927, the number of natural death verdicts dropped by about 3,000 which corresponds with the number of Pink Form B cases in that year. Rather more surprisingly, in the same year, the number of verdicts of accidental death rose by about 3,000: the reasons for this sudden increase has eluded us.

16. As we see it, the introduction of the Pink Form B procedure had two consequences. First, while it did not result in any reduction in the number of inquests, it prevented a small rise which might otherwise have taken place. Secondly, it appears to have encouraged an increase in the number of deaths reported to coroners.

17. There has, of course, been a reduction in the number of inquests over the whole period covered in the table. A substantial factor in this appears to have been the decline in infant mortality. Although statistics of the age of the deceased were not kept in comparable form throughout the period (and no figures at all are available between 1919 and 1957), it is apparent that the number of inquests held on children under the age of one year has fallen from around 5,000 or 6,000 annually in the years 1901–1914 to around 600 or 700 in the period 1957–1969. This decline corresponds neatly with a drop in the annual infant mortality rates. In contrast, numbers of inquests held on the deaths of adults have remained much more constant. The Registrar General has told us that deaths for the age group 21–24 account for slightly over half of the totals shown in the top part of column 14 (youths between the age of 16 and 25). It follows that during the period 1901–1914 inquests on the deaths of those aged 21 and over ranged from about 23,000 to about 26,000. These figures are not substantially in excess of the figures for the period 1957–1969 where the number averages about 22,000 a year.

Columns 9–17—Age of deceased

18. We have already discussed the significance of the figures in these columns in connection with the figures of the total inquests in column 8. The only additional comment it is necessary to make on these figures is to explain that the total shown at the bottom of column 12 is smaller than the total in column 8 because the former is based on the number of verdicts. As a result of the operation of section 20 of the Coroners (Amendment) Act 1926 (as extended by section 8 of the Road Traffic Act 1956) the coroner's inquest is adjourned whenever he is informed that criminal proceedings have been instituted for homicide or causing death by dangerous driving; after the conclusion of the criminal proceedings the coroner is not obliged to resume the inquest. There are about 400 or 500 of these cases a year. The figures in column 8 represent the total number of inquests *opened*; the figures at the bottom of column 12 represent the total number of *verdicts reached.*

Column 18—Number of jurisdictions

19. The number of coroners at any one time is always smaller than the total number of jurisdictions because some coroners act for more than one area. The report of the Departmental Committee in 1910 stated that there were 360 jurisdictions in that year but only 330 coroners (these figures were probably a slight underestimate). They noted 54 franchise coroners. The Coroners (Amendment) Act 1926 provided that when a vacancy occurred in a franchise coronership the jurisdiction should become a coroners district of the county. In 1936, the Wright Committee reported that there were then 354 coronerships held by 309 coroners. 44 of the coronerships were franchises, 18 having been brought to an end by the operation of the 1926

Act.[1] It is clear from the table that the bringing to an end of the franchises did not result in a corresponding reduction of the number of jurisdictions. A number of these franchises were, in fact, of a substantial size and their extinction resulted simply in the creation of an additional county district. In this respect, the interpretation of the figures on page 204 of Dr. Havard's book " The Detection of Secret Homicide " is faulty. The reduction in the number of franchise coronerships did not automatically entail a reduction in the number of coroners. On the other hand, a reduction in the number of coroners can be, and has been achieved, by a joint appointment to a borough and the surrounding county district without a reduction in the total number of jurisdictions. At present, only 3 franchise jurisdictions remain and two of these are not affected by the 1926 Act. The bulk of the franchise jurisdictions in fact came to an end before the mid-1950s. Since that time there has continued to be a reduction in the number of jurisdictions which has been faster than in the period before the Second World War. The present number of coroners is 229.

[1] The 1910 Committee's figure for franchise coroners did not include those franchise coroners who also held another county or borough jurisdiction in addition to the franchise.

Source: Coroners' Returns

Year	1 Total number of deaths in England and Wales	2 Deaths reported to Coroner: Total number	3 Deaths reported to Coroner: Lunatics and mental defectives	4 Deaths reported to Coroner: Other persons	5 Number of prelim. Inquiries not followed by Inquest	6	7	8 Total number of Inquests
1901	551,585				18,653			37,184
1902	535,538				18,841			36,092
1903	514,628				18,320			35,861
1904	549,784				19,399			36,269
1905	520,031				19,464			36,027
1906	531,281				19,170			36,570
1907	524,221				18,627			36,576
1908	520,456				19,054			37,092
1909	518,003				19,594			36,724
1910	483,247				19,509			35,417
1911	527,810				20,742			37,612
1912	486,939				20,932			37,098
1913	504,975				21,594			36,801
1914	516,742				23,618			38,129
					Deaths investigated by Coroner No Inquest held	Post-mortem examinations ordered by Coroner		
1919	504,203	59,179	14,964	44,215	18,338	11,570		31,756
1920	466,130	53,714	10,995	42,719	15,751	12,210		31,496
1921	458,629	51,426	10,933	40,487	15,421	11,604		29,716
1922	486,780	54,312	12,489	41,823	16,674	12,709		30,800
1923	444,785	52,623	10,766	41,857	15,464	12,736		31,264
1924	473,235	53,062	10,860	42,202	15,707	13,661		31,705
1925	472,841	55,011	11,357	43,653	16,293	14,268		33,178
1926	453,804	54,177	11,064	43,113	14,506	14,463		32,924
						In Inquest cases	In Non-inquest cases	
1927	484,609	60,511	12,108	48,403	20,808	12,904	3,616	32,438
1928	460,389	62,501	11,665	50,836	23,542	11,127	6,791	31,553
1929	532,492	67,259	12,564	54,695	26,581	11,468	7,906	32,612
1930	455,427	63,238	10,691	52,547	24,983	11,306	7,875	31,659
1931	491,630	65,082	11,554	53,528	27,358	11,069	8,458	30,801
1932	484,129	65,979	12,257	53,722	28,455	10,796	8,873	30,512
1933	496,465	67,458	11,806	55,652	29,277	11,561	9,647	31,669
1934	476,810	67,044	11,135	55,909	29,175	12,054	10,745	31,562
1935	477,401	67,646	11,557	56,089	30,178	11,728	11,058	31,032
1936	495,764	69,687	11,827	57,860	31,828	11,972	12,269	30,963
1937	509,574	71,628	12,125	59,503	33,069	12,771	13,212	31,575
1938	478,996	70,635	11,250	59,385	32,381	13,180	13,764	31,505
					Pink Form A			
1946	492,090	72,664			23,219	13,655	22,895	26,550
1947	517,615	81,316			25,426	14,854	27,881	28,009

to the Home Office

9	10	11	12	13	14	15	16	17	18
Number of Inquests									
Infants (Legitimate) Under 1 year	*Infants (Legitimate)* 1 year and under 7	*Infants (Illegitimate or unknown)* Under 1 year	*Infants (Illegitimate or unknown)* 1 year and under 7	*Children* 7 years and under 16	*Youths* 16 years and under 25	*Adults* 25 years and under 60	*Aged* 60 years and above	Age unknown	No. of jurisdictions
5,471	3,803	1,132	214	1,746	2,485	14,495	7,736	102	368
5,817	3,477	1,034	214	1,646	2,322	13,996	7,500	86	
5,583	3,553	1,070	212	1,463	2,261	14,209	7,422	88	
5,702	3,640	1,104	212	1,555	2,284	14,029	7,682	61	
5,187	3,569	1,077	213	1,626	2,307	14,332	7,652	64	
5,296	3,664	1,037	209	1,647	2,223	14,438	7,960	96	
5,171	3,624	943	215	1,598	2,244	14,666	8,226	69	
4,895	3,531	1,230	279	1,655	2,256	14,757	8,393	96	
5,018	3,531	1,032	206	1,665	2,221	14,538	8,458	55	
4,686	3,314	953	183	1,717	2,255	14,212	8,013	84	
4,700	3,494	883	226	1,887	2,495	15,062	8,793	74	
4,507	3,366	880	179	1,856	2,243	14,961	9,006	100	
4,363	3,204	971	194	1,855	2,331	14,778	9,042	63	
4,399	3,246	929	174	1,963	2,482	15,596	9,237	103	
									363
									353
									348
									345
Total		Under 1 year		1–13 years		14–20 years		21 years and over	
									333
									332

Source: Coroners' Returns

Year	1 Total number of deaths in England and Wales	2 Deaths Reported *to Coroner* Total number	3 Lunatics and mental defectives	4 Other persons	5 Number of prelim. Inquiries not followed by Inquest	6	7	8 Total number of Inquests
1948	469,898							
1949	510,736	75,844			22,538	13,897	28,865	24,441
1950	510,301	83,571						25,784
1951	549,380	89,587						27,256
1952	497,484	85,929						25,361
1953	503,529	88,128						25,521
1954	501,896	90,797			23,250	(17,304)	(41,564)	25,983
1955	518,864	94,914			24,761	(17,442)	(44,042)	26,111
1956	521,331	96,977			31,388	(15,086)	(39,399)	26,240
1957	514,870	10,671	10,671		28,654	(18,902)	(50,665)	25,752
1958	526,843	100,901	10,015		21,934	(19,759)	(53,031)	25,936
1959	527,651	102,182			21,012	20,982	54,788	26,382
1960	526,268	101,079			16,933	21,496	57,841	26,305
1961	551,752	101,667			13,162	22,229	62,329	26,176
1962	557,836	106,786			13,314	23,417	66,589	26,883
1963	572,868	113,001			13,245	24,179	72,443	27,313
1964	534,737	109,844			11,924	24,639	70,826	27,094
1965	549,379	116,267			12,639	24,914	76,604	27,024
1966	563,624	117,438			12,754	24,893	77,826	26,858
1967	542,519	117,935			12,964	23,918	79,364	25,607
1968	576,754	124,420			13,927	23,407	85,870	24,623
1969	579,378	131,639			14,506	24,101	92,003	25,130

to the Home Office

9	10	11	12	13	14	15	16	17	18
Number of Inquests									
Infants (Legitimate) Under 1 year	1 year and under 7	*Infants (Illegitimate or unknown)* Under 1 year	1 year and under 7	*Children* 7 years and under 16	*Youths* 16 years and under 25	*Adults* 25 years and under 60	*Aged* 60 years and above	Age unknown	No. of juris-dictions
									331
									330
									329
									327
									324
									321
									316
Total		Under 1 year		1–13 years		14–20 years		21 years and over	313
25,294		639		1,242		1,056		22,357	310
25,499		622		1,300		1,026		22,551	309
26,005		622		1,365		1,260		22,758	304
25,620		538		1,295		1,445		22,342	303
26,347		648		1,391		1,482		22,869	300
26,585		689		1,364		1,507		23,025	300
26,425		720		1,427		1,838		22,440	297
26,053		726		1,497		1,790		22,050	299
25,940		666		1,564		1,841		21,869	291
24,654		604		1,549		1,741		20,760	286
23,759		570		1,481		1,491		20,217	282
24,172		609		1,486		1,482		20,595	270
									270
									264

APPENDIX 3

Analysis of Post-mortem examinations Conducted on the Authority of Coroners 1969

Summary showing variation in the practice of individual coroners in having post-mortem examinations made

Source: Coroners Returns to the Home Office

Percentage of post-mortems in relation to number of deaths reported to coroners	Number of coroners in each percentage category
Under 40%	Nil
40%–49%	1
50%–59%	3
60%–69%	10 (4·3%)
70%–79%	37 (16·0%)
80%–89%	58 (25·2%)
90%–100%	121 (52·6%)
	230 = 100%

Analysis of Post-mortem Examinations Conducted on the Authority of Coroners 1969
Source: Coroners Returns to the Home Office

Coroner's jurisdiction (jurisdictions bracketed together are served by the same coroner)	Deaths reported	PM's *without* inquest	PM's *with* inquest	Percentage of all deaths reported in which PM's were held
Bedfordshire				
North Bedford Borough }	518	300	73	72
South	522	337	102	84
Berkshire				
North	167	132	31	91
East (not available)				
South Newbury Borough } ...	130	91	30	93
Reading Borough	444	274	76	79
Windsor Borough	41	30	10	97
Buckinghamshire				
Mid-Bucks & Aylesbury Oxfordshire South } ...	482	229	120	72
North	86	64	20	97
South	692	486	175	89
Cambridgeshire				
Cambridge County (not available)				
Isle of Ely (Northern) ...	132	87	37	94
Cambridge Borough	257	174	82	99
Cheshire				
Central	538	336	127	86
Eastern	1,004	778	197	97
Western	754	561	165	96
Chester Borough	259	137	86	86
Wallasey Borough	292	232	22	87
Birkenhead Borough... ...	368	246	73	88
Cornwall				
Bodmin	175	98	38	77
North & East	119	74	37	95
Truro	408	137	71	51
West	282	149	49	70
Penzance Borough	56	37	8	80
Isles of Scilly	—	—	—	—
Cumberland				
Eastern	122	55	25	65
Western	341	214	63	81
Carlisle Borough	184	126	38	89
Derbyshire				
South	448	377	55	98
High Peak	222	170	51	99
Scarsdale	713	474	176	91
Derby Borough	910	687	143	91
Devonshire				
East Exeter Borough }	583	370	159	90
North	137	102	32	97
South	273	217	33	91
Barnstaple Borough	51	33	14	85
Plymouth Borough	606	431	79	84
West	75	60	15	100
Torbay Borough	375	232	44	73

Post-mortem Examinations Conducted on the Authority of Coroners 1969
Source: Coroners Returns to the Home Office

Coroner's jurisdiction (jurisdictions bracketed together are served by the same coroner)	Deaths reported	PM's *without* inquest	PM's *with* inquest	Percentage of all deaths reported in which PM's were held
Dorset				
Central	332	190	50	72
Eastern	117	100	14	97
Western	47	38	8	99
Poole Borough	445	379	62	99
Durham				
East	617	324	107	70
South	594	434	112	92
North West	1,170	739	228	83
North East	439	272	62	76
Sunderland Borough	562	156	161	56
Essex				
County	2,408	1,637	335	82
Colchester Borough	178	109	46	86
Southend-on-Sea Borough	654	545	87	96
Gloucestershire				
Cotswold	452	356	85	98
Lower District / Bristol Borough	1,516	1,209	298	98
West Gloucestershire	168	118	49	99
Gloucester Borough	417	197	101	71
Hampshire				
Fareham	369	271	72	92
New Forest	423	336	77	97
Winchester	142	105	34	98
Bournemouth Borough	413	318	87	98
Portsmouth Borough	771	558	170	94
Southampton Borough	842	712	120	98
Winchester Borough	118	66	29	80
Basingstoke	439	329	98	97
Herefordshire				
North	53	36	7	81
South / Hereford Borough	311	184	57	77
Hertfordshire				
Hertford	299	251	48	100
Hemel Hempstead	173	126	33	92
Hitchin	289	175	72	85
St. Albans	448	247	52	67
Watford	349	238	81	91
Huntingdon and Peterborough				
Huntingdon	190	131	39	90
Peterborough	207	120	66	89
Kent				
East Canterbury Borough	889	739	145	99
North	796	679	113	99
South	144	109	27	94
West	481	377	70	93
Dover Borough	210	114	32	70
Folkestone Borough	158	105	30	85

Post-mortem Examinations Conducted on the Authority of Coroners 1969
Source: Coroners Returns to the Home Office

Coroner's jurisdiction (jurisdictions bracketed together are served by the same coroner)	Deaths reported	PM's *without* inquest	PM's *with* inquest	Percentage of all deaths reported in which PM's were held
Kent—continued				
Gravesend Borough	100	76	15	91
Maidstone Borough	262	154	46	79
Margate Borough	264	200	22	83
Rochester Borough	267	214	49	98
Lancashire				
Blackburn	675	465	72	80
Bury	1,002	647	349	99
Preston / Walton le Dale	1,143	703	362	93
Rochdale	638	482	114	93
Furness / Barrow-in-Furness Borough	152	53	62	75
Salford	1,208	1,011	162	97
West Derby	1,748	1,157	485	93
Lancaster	425	273	97	87
Blackburn Borough	430	312	82	91
Blackpool Borough	638	468	130	93
Bolton Borough	407	297	110	100
Burnley Borough	367	199	112	84
Liverpool Borough	2,362	1,333	519	80
Manchester Borough ...	2,929	1,413	328	60
Oldham Borough	539	433	66	92
Salford Borough	485	309	141	92
Wigan Borough	253	102	151	100
Leicestershire				
Framland	55	45	3	87
Northern	227	119	50	74
Southern	329	234	41	83
Leicester Borough	1,218	680	208	73
Lincolnshire—Kesteven				
West	15	15	—	100
North	64	44	12	87
East	43	27	7	79
South	59	34	16	84
Grantham Borough	88	52	36	100
Lincolnshire—Lindsey				
Caistor	144	80	36	80
Kirton...	304	150	53	66
Lincoln North / Lincoln Borough	335	193	54	74
Louth	97	63	18	83
Spilsby	123	77	22	81
Grimsby Borough	240	152	33	77
Lincolnshire—Holland				
Boston	80	26	29	68
Spalding	91	66	14	90
London—City	193	146	38	95
London—Inner				
West	3,865	2,916	698	93
North	3,116	2,382	538	93

Post-mortem Examinations Conducted on the Authority of Coroners 1969
Source: Coroners Returns to the Home Office

Coroner's jurisdiction (jurisidictions bracketed together are served by the same coroner)	Deaths reported	PM's *without* inquest	PM's *with* inquest	Percentage of all deaths reported in which PM's were held
London—Inner—continued				
South	4,596	4,010	543	99
The Queens Household ...	1	1	—	—
London				
Northern	3,907	3,322	533	98
Eastern	3,425	2,262	361	77
Southern	2,969	2,586	343	98
Western	4,063	3,538	456	97
Monmouthshire				
Monmouth	643	475	141	95
Newport Borough	314	224	82	97
Norfolk				
Dereham	115	77	19	83
Diss	93	67	21	94
King's Lynn	90	61	20	90
Norwich	330	199	49	75
Great Yarmouth Borough ...	171	130	35	96
Norwich Borough	411	313	89	98
King's Lynn Borough ...	149	56	27	55
Northamptonshire				
Eastern	416	327	78	97
Western	173	107	31	78
Northampton Borough ...	465	297	101	85
Northumberland				
North	255	122	63	82
South	783	374	157	68
Newcastle upon Tyne Borough	885	559	262	92
Nottinghamshire				
Newark Nottingham Newark Borough	1,125	912	203	99
Retford	279	213	53	95
Nottingham Borough ...	1,717	1,188	285	86
Oxfordshire				
Central Oxford Borough	503	307	184	97
North Western Banbury Borough	173	128	32	92
Rutland	36	26	8	94
Shropshire				
Bradford North	41	30	8	92
Bradford South & Brimstree	153	101	23	81
Ford Shrewsbury Borough ...	185	86	90	100
Oswestry & Pimhill	103	58	34	89
South	87	42	28	82
Maelor Hundred (Flint) ...	3	2	1	100
Somerset				
Northern	643	423	189	96

Post-mortem Examinations Conducted on the Authority of Coroners 1969
Source: Coroners Returns to the Home Office

Coroner's jurisdiction (jurisdictions bracketed together are served by the same coroner)	Deaths reported	PM's *without* inquest	PM's *with* inquest	Percentage of all deaths reported in which PM's were held
Somerset—continued				
South Eastern	243	182	45	93
Western	319	213	76	90
Bath Borough	329	223	96	97
Bridgwater	61	47	10	93
Staffordshire				
Eastern Burton Borough	309	189	70	83
Northern	319	192	61	79
Southern	196	135	52	95
Stafford	487	364	105	96
Newcastle-under-Lyme Borough	163	124	18	87
Stoke-on-Trent Borough ...	1,850	1,381	386	95
Walsall—Borough	570	448	112	96
Warley Borough	286	253	23	96
West Bromwich Borough ...	490	315	73	79
Wolverhampton Borough ...	613	468	131	81
East Suffolk				
Eastern	56	42	10	93
Southern	174	131	40	97
Northern Ipswich	533	408	118	98
West Suffolk				
Newmarket & Haverhill Bury St. Edmunds—Liberty	196	136	47	93
Sudbury	28	26	2	100
Bury St. Edmunds	82	56	19	91
Surrey				
County	2,327	1,886	387	97
Guildford Borough	233	178	53	99
Sussex—East				
Lewes	1,168	765	229	85
Rye Hastings Borough	509	358	81	86
Brighton Borough	615	351	126	77
Sussex—West				
County	1,388	1,193	163	97
Warwickshire				
Northern	560	406	152	100
Central	422	283	134	98
South Western	329	225	75	100
Coventry Borough	969	558	145	72
Birmingham Borough ...	3,795	2,075	526	68
Westmorland				
East and West	18	8	6	77
Kendal	139	72	48	86
Wiltshire				
County Salisbury Borough ...	1,000	560	262	82

Post-mortem Examinations Conducted on the Authority of Coroners 1969
Source: Coroners Returns to the Home Office

Coroner's jurisdiction (jurisdictions bracketed together are served by the same coroner)	Deaths reported	PM's *without* inquest	PM's *with* inquest	Percentage of all deaths reported in which PM's were held
Worcestershire				
Middle	165	102	36	84
North	519	391	106	95
South	54	32	14	85
Dudley Borough	515	376	101	94
Worcester Borough	166	102	58	96
Yorkshire—East Riding				
Buckrose	126	101	25	100
Howdenshire	187	127	44	91
Holderness	122	87	33	98
Kingston-upon-Hull Borough	940	688	101	84
Yorkshire—North Riding				
North-Eastern	283	199	64	93
Ryedale	104	73	29	98
Western	138	67	39	76
Teesside Borough	1,127	659	224	78
Scarborough Borough ...	172	113	41	89
York City / York Castle	320	212	108	100
Yorkshire—West Riding				
Craven	639	405	181	91
Halifax / Halifax Borough	1,239	986	237	98
Doncaster / Doncaster Borough ...	969	672	286	98
Claro	414	277	110	91
Bradford Borough	1,069	739	129	81
Wakefield / Rotherham Borough ...	2,039	1,362	435	88
Rotherham / Sheffield Borough	1,632	1,228	356	97
Huddersfield Borough ...	416	317	99	100
Leeds Borough	2,505	1,784	354	85
Anglesey	69	38	21	85
Brecon	130	96	21	90
Caernarvonshire				
North	430	122	71	47
South	65	25	22	72
Cardiganshire				
North	65	35	12	72
Mid and South	48	24	13	77
Carmarthenshire				
East and West	281	164	94	90
Three Commots	336	252	70	98
Denbighshire				
East	256	168	55	87
West	216	119	46	72
Flint	348	241	90	95

Post-mortem Examinations Conducted on the Authority of Coroners 1969
Source: Coroners Returns to the Home Office

Coroner's jurisdiction (jurisdictions bracketed together are served by the same coroner)	Deaths reported	PM's *without* inquest	PM's *with* inquest	Percentage of all deaths reported in which PM's were held
Glamorgan				
Eastern	1,165	710	147	73
Gower	170	118	13	77
Northern	701	559	57	88
Ogmore				
Western	604	368	78	73
Cardiff Borough	971	664	119	80
Merthyr Tydfil Borough ...	339	194	30	66
Swansea Borough	464	299	77	81
Merioneth	84	30	22	62
Montgomery	60	38	14	85
Pembrokeshire				
Northern	30	11	10	70
Southern	151	69	32	68
Radnor	29	17	5	76
Totals	131,639	92,003	24,101	88%

APPENDIX 4

ANALYSIS OF VERDICTS SINCE 1901

1. Statistics of the verdicts returned at coroners' inquests annually since 1901 are set out in the table annexed to this appendix. The source of this information is the returns made by coroners to the Home Office. There are no figures for the years 1915–1917 inclusive or for the years 1939–1956 inclusive. However, the absence of figures for these years does not materially affect the picture of the general trend.

Column 1—Total number of verdicts

2. The total number of verdicts only began to be published in the Criminal Statistics in 1919 but before that date the total number of verdicts was the same as the total number of inquests—the figures for which are given in column 8 of the table annexed to Appendix 2. The totals remain identical for the period 1919–1928 inclusive. After that year the effect of the major change in the law made by the provisions of section 20 of the Coroners (Amendment) Act 1926 can begin to be seen. Before that year, even in those cases in which it was known that criminal proceedings might result against some person in respect of a death, the coroner's inquest went ahead regardless of any independent proceedings before the magistrates. The Coroners Committee which reported in 1910 recommended that, where the Director of Public Prosecutions so requested, the coroner should postpone his committal until the magistrates had themselves committed the accused. Section 20 of the 1926 Act went further than this and, to all intents and purposes, required the coroner to adjourn the inquest if he had been informed that some person had been charged before examining justices with murder, manslaughter or infanticide (this provision was extended to the offence of causing death by dangerous driving by the Road Traffic Act 1956). Moreover, section 20 (4) of the 1926 Act enabled an inquest which had been adjourned in these circumstances not to be resumed, with the result that no verdict is returned. Accordingly, after 1926, the total number of verdicts is less than the total number of inquests by the number of inquests which have been adjourned in this way and not resumed. Until 1938 the number of inquests not resumed in these circumstances was fairly small, but, since the extension of this provision to the offence of causing death by dangerous driving in 1956 the numbers have grown much larger. An analysis of these figures for the years 1957–1969 inclusive is given at the foot of columns 20–24.

Columns 2–8—Death by wilful or criminal acts

3. The effect of the provisions of section 20 of the 1926 Act is also illustrated by the figures in columns 2 and 3 (murder and manslaughter). Before 1926 these figures relate to all victims. After 1926 fewer inquests on the victims of murder or manslaughter were completed and the verdicts relate in the main to those deaths where although the death has clearly resulted from murder or manslaughter the offender has either not been found or, more frequently, has taken his own life.

4. The figures in columns 7 and 8 show a gradual increase in the number of suicides. Until 1938 there were still a few verdicts of *felo de se*. Some time after 1945 the return was changed (in line with a recommendation of the Wright Committee) to eliminate this as a separate category. The category of *felo de se* was itself eliminated by the Suicide Act 1961.

Columns 10–14—Death by neglect, exposure, etc.

5. The distinction between columns 10 and 11 is that the first relates to neglect by others and the second to self-neglect by the deceased. This distinction has been removed in returns made in more recent years.

6. There are no precise definitions of chronic alcoholism or addiction to drugs but the terms are discussed on pages 89 and 178 of the 9th Edition of Jervis on Coroners. In recent years it seems probable that references to drug addiction are related to drugs to which the Dangerous Drugs legislation applied but this cannot always have been the case.

Column 16—Accidental deaths

7. The number of verdicts of accidental death returned at coroners inquests has remained fairly constant through the period. At present these verdicts comprise about two-thirds of the total. In 1901, an only slightly smaller number of accidental death verdicts constituted less than two-fifths of the total. There are one or two interesting trends shown by the figures in this column. The first is the sudden increase in the verdicts of accidental death in the years following 1926. As indicated in paragraph 15 of Appendix 2, this rise in the number of accidental deaths dealt with by coroners in this period provides part of the explanation for the fact that the number of coroners inquests did not decrease after 1926 as, with the introduction of the Pink Form B procedure, they might otherwise have been expected to do. The rise in the number of verdicts of accidental death corresponds with a rise in the number of deaths reported to the coroner after 1926. Before 1926 it was by no means the rule for a coroner always to hold an inquest in respect of deaths which no doctor was able to certify. A number of accidental deaths must have come into this category and remained uncertified. Part of the object of the 1926 legislation was to reduce the number of uncertificated deaths registered and the changes introduced by the two Acts may provide the explanation of the increase in the number of accidental deaths dealt with by coroners after 1926.

8. The other interesting feature of the number of verdicts of accidental death is the drop in the number after 1930. The passing of the Road Traffic Act 1930 which created a number of driving offences and diminished the number of road fatalities is probably the explanation.

9. About 8,000 of the total number of accidental deaths are deaths in the home and other residential institutions. Of these 4,000 are falls of which 3,700 are experienced by persons aged 65 or more. This is a category where it is known that there is a good deal of variation in the classification of death by coroners. In some areas these falls followed by pneumonia are treated as natural deaths. A decision to take these deaths out of a coroner's jurisdiction or to introduce a uniform system of classification of them could accordingly have a considerable effect on the coroners' figures although there would not be any real change in the number of this kind of death.

Column 17—Natural causes

10. The figures of verdicts of death from natural causes show the most dramatic trend in this table. The effect of the Pink Form B procedure introduced by the Coroners (Amendment) Act 1926 is clearly illustrated. Verdicts of death from natural causes averaged about 14,000 a year in the period 1901 to 1914 when they accounted for about two-fifths of all verdicts. From 1919 to 1926 they averaged about 12,000 a year and from 1927 to 1938 they declined steadily falling to about 6,000 a year in 1938. They now account for under 1,500 verdicts a year—less than a tenth of the total.

Column 18—Stillbirths

11. The drop in the number of verdicts of stillbirths is as dramatic as that in respect of deaths from natural causes but the figures are very much smaller. The reason

for the drop is also quite dissimilar. The reduction in the number of natural causes verdicts illustrates a change in coroners practice resulting from a change in the law. The drop in the number of stillbirth verdicts reflects a real drop in infant mortality.

Columns 19–22—Open verdicts

12. Until 1938 open verdicts were broken down as shown in the table. The returns from 1957 have not been broken down in the same way. A certain number of open verdicts are probably " concealed " suicides where the evidence was insufficient to determine the intention of the deceased.

Columns 23 and 24—Inquests on bodies of new born children

13. The figures in these two columns are not additional to the figures in the earlier columns in the table. They simply analyse separately the causes of death of young children where inquests were held. They reflect continuing public concern in the early years of this century with infant mortality and they ceased to be shown separately after 1914.

Foot of Columns 20–24—Adjourned inquests not resumed

14. An explanation of these figures has already been given in paragraph 2 above.

Source: Coroners' Returns

Year	1 Total	2 Death by wilful or criminal acts: Murder	3 Manslaughter	4 Infanticide	5 Justifiable homicide	6 Executed	7 Suicide: While insane	8 Suicide: Felo de se	9 Attempted or self-induced abortion	10 Death by neglect: Lack of care	11 Want, exposure etc.	12 Excessive drinking
1901		208	130		5	15	3,057	49		154	256	1,002
1902		173	127		1	22	3,197	42		153	230	987
1903		189	111		2	27	3,441	39		174	205	885
1904		191	126		1	16	3,252	75		166	217	811
1905		183	103		4	17	3,389	126		166	189	803
1906		155	110		3	8	3,337	97		156	220	787
1907		142	110		7	10	3,359	118		152	230	346
1908		182	109		8	12	3,362	119		143	255	699
1909		165	102		4	19	3,407	137		120	240	617
							Other cases of suicide					
1910		171	88		4	16	3,400	129		135	227	581
1911		156	92		10	16	3,474	89		105	196	611
1912		192	97		5	10	3,490	115		97	231	586
1913		194	99		4	19	3,386	89		97	162	677
1914		170	76		16	15	3,590	107		83	168	687
1919	31,756	208	76		8		3,109	141		22	120	133
1920	31,496	192	89		6		3,236	137		28	88	148
1921	29,716	168	72		3		3,585	130		19	98	171
1922	30,800	138	64		3	17	3,727	117		19	99	120
1923	31,264	157	67	16	5	14	3,818	101		15	84	130
1924	31,705	141	74	17	3	10	3,614	65		20	83	118
1925	33,178	163	76	26	2	17	3,987	67		34	122	99
1926	32,924	164	88	20	4	17	4,330	78		30	96	86
1927	32,438	121	42	7	1	8	4,770	93		27	100	91
1928	31,553	76	66	7	1	21	4,758	88		17	95	84
1929	32,610	81	47	5	2	8	4,844	65		32	133	160
1930	31,521	84	46	6	—	3	4,886	86		22	93	133
1931	30,638	71	31	4	—	10	4,987	105		30	79	119
1932	30,357	76	40	4	—	9	5,587	70	29	18	50	127
1933	31,476	73	39	3	1	9	5,472	71	42	14	71	115
1934	31,374	83	48	3	—	9	5,431	55	46	19	51	112
1935	30,850	75	53	1	2	11	5,090	66	36	5	57	120
1936	30,737	71	36	3	—	7	4,920	87	43	13	61	142
1937	31,358	53	32	1	2	9	5,061	44	45	10	67	182
1938	31,292	55	50	3	5	5	5,210	53	35	10	61	166
												Chronic alcoholism
1957	25,294	76	17	4	1	2	5,313		15	40		70
1958	25,499	58	17	2	—	4	5,237		12	54		63
1959	26,005	71	21	4	1	6	5,206		7	66		90
1960	25,785	50	23	2	—	10	5,119		12	46		89
1961	25,620	53	27	3	—	7	5,212		15	39		79
1962	16,347	66	19	1	2	3	5,583		17	52		85
1963	26,627	60	25	2	2	2	5,727		13	67		74
1964	26,425	62	21	3	2	2	5,565		8	53		83
1965	26,053	65	28	4	—	—	5,187		16	53		131
1966	25,940	55	26	3	—	—	5,013		8	75		109
1967	24,680	58	24	3	1	—	4,735		7	37		122
1968	23,759	59	28	1	—	—	4,569		9	47		126
1969	24,172	42	26	2	—	—	4,369		3	55		123

13	14	15	16	17	18	19	20	21	22	23	24
Exposure or excess							Open verdicts			Inquest on bodies of newborn children	
Addiction to drugs	Want of attention at birth	Deaths from industrial diseases	Deaths by accident or misadventure	Deaths from natural causes	Still born	Death from injuries	Death from drowning	Death from other known causes	Death from causes unascertainable	Number of inquests	Cases in which a verdict of wilful murder was returned
	164		14,001	14,594	270	393	1,234	440	262	736	44
	189		14,202	14,305	264	354	1,159	408	279	834	38
	214		14,083	13,924	271	383	1,255	415	233	848	45
	193		14,419	14,338	250	339	1,139	523	213	873	49
	219		14,406	13,845	281	308	1,171	593	224	832	37
	233		14,805	14,293	223	360	1,061	502	210	888	43
	237		14,891	14,324	119	271	1,113	489	228	830	34
	219		14,939	14,184	306	336	1,165	511	243	851	43
	279		14,518	14,824	297	299	997	498	202	975	36
	248		14,175	14,016	290	247	1,025	475	195	880	46
	296		15,425	14,702	260	292	1,154	537	197	925	23
	275		15,118	14,458	255	322	1,125	502	220	901	41
	253		15,213	14,226	245	292	1,091	530	224	875	50
	288		16,305	14,330	258	397	1,024	434	181	936	34
	292		13,486	12,151	272	257	904	392	173		
	277		13,441	11,748	337	241	921	380	191		
	274		12,022	11,241	310	248	833	344	187		
	247		12,107	12,325	305	262	766	342	142		
	235		12,606	12,213	271	219	785	393	135		
	259		13,235	12,282	263	237	746	396	142		
	218		13,964	12,617	275	231	737	410	133		
	295		13,851	12,117	262	258	678	412	138		
	231		15,135	9,998	210	228	762	369	155		
	217		16,485	7,783	207	279	701	398	121		
12	189		17,452	7,825	154	262	669	408	114		
8	189		17,532	6,736	160	308	686	435	108		
6	182		16,711	6,660	153	290	682	423	96		
9	199		16,120	6,308	153	318	674	465	101		
12	145		17,136	6,618	121	290	619	540	80		
12	179		17,345	6,360	121	327	580	478	115		
10	160		17,024	6,431	104	340	602	573	110		
5	117		17,365	6,162	104	336	590	571	104		
6	149		17,804	6,147	144	308	643	574	77		
12	154		17,415	6,066	500	360	598	834	100		

Inquests adjourned under s. 20 of the Coroners' (Amendment) Act 1926, which it has been decided not to resume				
Total	Murder	Manslaughter	Infanticide	Dangerous Driving
497	95	60	10	332
560	109	50	15	386
596	94	75	18	409
596	94	75	18	409
688	111	68	14	495
619	116	66	20	417
707	122	59	14	512
871	137	66	18	650
933	173	84	15	661
933	173	84	15	661
998	175	85	14	724
860	187	92	17	564

4	42	874	15,088	2,440	21	1,290					
5	41	757	15,581	2,367	30	1,261					
4	40	737	16,042	2,279	36	1,365					
2	24	784	16,201	2,039	21	1,363					
1	35	954	16,878	1,860	19	1,392					
4	23	914	16,298	1,853	34	1,393					
5	39	1,012	16,522	1,501	40	1,490					
8	26	853	16,651	1,575	22	1,507					
12	47	934	16,596	1,519	27	1,447					
11	31	882	16,670	1,541	25	1,491					
16	31	747	15,843	1,566	36	1,454					
19	29	771	15,111	1,517	23	1,450					
37	15	783	15,520	1,563	32	1,602					

APPENDIX 5

Statistics of Work by Jurisdictions, 1969

Source: Coroners' Returns to the Home Office

Coroner's jurisdiction (jurisdictions bracketed together are served by the same coroner)	1 Deaths reported	2 No inquest and no PM (Pink Form A)	3 PM's *without* inquest (Pink Form B)	4 PM's *with* inquest	5 Inquest no PM
Bedfordshire					
North Bedford Borough } ...	518	145	300	73	—
South	522	79	337	102	4
Berkshire					
North	167	4	132	31	—
East (not available)					
South Newbury Borough } ...	130	9	91	30	—
Reading Borough ...	444	93	274	76	1
Windsor Borough ...	41	1	30	10	—
Buckinghamshire					
Mid-Bucks & Aylesbury Oxfordshire South }	482	133	229	120	—
North	86	2	64	20	—
South	692	31	486	175	—
Cambridgeshire					
Cambridge County (not available)					
Isle of Ely (Northern) ...	132	7	87	37	1
Cambridge Borough ...	257	1	174	82	—
Cheshire					
Central	538	75	336	127	—
Eastern	1,004	29	778	197	—
Western	754	28	561	165	—
Chester Borough	259	36	137	86	—
Wallasey Borough ...	292	2	232	22	36
Birkenhead Borough ...	368	49	246	73	—
Cornwall					
Bodmin	175	34	98	38	5
North & East	119	8	74	37	—
Truro	408	197	137	71	3
West	282	84	149	49	—
Penzance Borough ...	56	11	37	8	—
Isles of Scilly	—	—	—	—	—
Cumberland					
Eastern	122	41	55	25	1
Western	341	64	214	63	—
Carlisle Borough ...	184	20	126	38	—
Derbyshire					
South	448	16	377	55	—
High Peak	222	1	170	51	—
Scarsdale	713	63	474	176	—
Derby Borough	910	80	687	143	—
Devonshire					
East Exeter Borough } ...	583	38	370	159	16
North	137	2	102	32	1
South	273	18	217	36	2
Barnstaple Borough ...	51	2	33	14	2
Plymouth Borough ...	606	96	431	79	—
West	75	—	60	15	—

Statistics of Work by Jurisdictions, 1969
Source: Coroners' Returns to the Home Office

Coroner's jurisdiction (jurisdictions bracketed together are served by the same coroner)	1 Deaths reported	2 No inquest and no PM (Pink Form A)	3 PM's *without* inquest (Pink Form B)	4 PM's *with* inquest	5 Inquest no PM
Devonshire—continued					
Torbay Borough	375	97	232	44	2
Dorset					
Central	332	92	190	50	—
Eastern	117	3	100	14	—
Western	47	1	38	8	—
Poole Borough	445	4	379	62	—
Durham					
East	617	186	324	107	—
South	594	41	434	112	7
North West	1,170	198	739	228	5
North East	439	79	272	62	26
Sunderland Borough ...	562	166	156	161	79
Essex					
County	2,408	436	1,637	335	—
Colchester Borough ...	178	23	109	46	—
Southend-on-Sea Borough	654	22	545	87	—
Gloucestershire					
Cotswold	452	11	356	85	—
Lower District / Bristol Borough ...	1,516	9	1,209	298	—
West Gloucestershire ...	168	1	118	49	—
Gloucester Borough ...	417	119	197	101	—
Hampshire					
Fareham	369	36	271	72	—
New Forest	423	9	336	77	1
Winchester	142	3	105	34	—
Bournemouth Borough ...	413	8	318	87	—
Portsmouth Borough ...	771	42	558	170	1
Southampton Borough ...	842	10	712	120	—
Winchester Borough ...	118	21	66	29	2
Basingstoke	439	12	329	98	—
Isle of Wight	313	73	201	39	—
Herefordshire					
North	53	10	36	7	—
South / Hereford Borough ...	311	42	184	57	28
Hertfordshire					
Hertford	299	—	251	48	—
Hemel Hempstead ...	173	14	126	33	—
Hitchin	289	13	175	72	29
St. Albans...	448	149	247	52	—
Watford	349	30	238	81	—
Huntingdon and Peterborough					
Huntingdon	190	10	131	39	10
Peterborough	207	21	120	66	—
Kent					
East / Canterbury Borough ...	889	4	739	145	1

Statistics of Work by Jurisdictions, 1969
Source: Coroners' Returns to Home Office

Coroner's jurisdiction (jurisdictions bracketed together are served by the same coroner)	1 Deaths reported	2 No inquest and no PM (Pink Form A)	3 PM's *without* inquest (Pink Form B)	4 PM's *with* inquest	5 Inquest no PM
Kent—continued					
North	796	4	679	113	—
South	144	7	109	27	1
West	481	34	377	70	—
Dover Borough	210	49	114	32	15
Folkestone Borough ...	158	23	105	30	—
Gravesend Borough ...	100	9	76	15	—
Maidstone Borough ...	262	60	154	46	2
Margate Borough ...	264	42	200	22	—
Rochester Borough ...	267	4	214	49	—
Lancashire					
Blackburn...	675	138	465	72	—
Bury	1,002	5	647	349	1
Preston / Walton le Dale ...	1,143	78	703	362	—
Rochdale	638	42	482	114	—
Furness / Barrow-in-Furness Borough ...	152	15	53	62	22
Salford	1,208	35	1,011	162	—
West Derby	1,748	—	1,157	485	106
Lancaster	425	55	273	97	—
Blackburn Borough ...	430	36	312	82	—
Blackpool Borough ...	638	22	468	130	18
Bolton Borough	407	—	297	110	—
Burnley Borough ...	367	46	199	112	10
Liverpool Borough ...	2,362	510	1,333	519	—
Manchester Borough ...	2,929	1,188	1,413	328	—
Oldham Borough ...	539	39	433	66	1
Salford Borough	485	35	309	141	—
Wigan Borough	253	—	102	151	—
Leicestershire					
Framland	55	5	45	3	2
Northern	227	57	119	50	1
Southern	329	45	234	41	9
Leicester Borough ...	1,218	272	680	208	58
Lincolnshire—Kesteven					
West	15	—	15	—	—
North	64	7	44	12	1
East	43	9	27	7	—
South	59	7	34	16	2
Grantham Borough ...	88	—	52	36	—
Lincolnshire—Lindsey					
Caistor	144	28	80	36	—
Kirton	304	98	150	53	3
Lincoln North / Lincoln Borough ...	335	88	193	54	—
Louth	97	16	63	18	—
Spilsby	123	24	77	22	—
Grimsby Borough ...	240	55	152	33	—
Lincolnshire—Holland					
Boston	80	19	26	29	6

Statistics of Work by Jurisdictions, 1969
Source: Coroners' Returns to the Home Office

Coroner's jurisdiction (jurisdictions bracketed together are served by the same coroner)	1 Deaths reported	2 No inquest and no PM (Pink Form A)	3 PM's *without* inquest (Pink Form B)	4 PM's *with* inquest	5 Inquest no PM
Lincolnshire—Holland—contd.					
Spalding	91	11	66	14	—
London—City	193	9	146	38	—
London—Inner					
West	3,865	251	2,916	698	—
North	3,116	194	2,382	538	2
South	4,596	43	4,010	543	—
The Queens Household	1	—	1	—	—
London					
Northern	3,907	52	3,322	533	—
Eastern	3,425	802	2,262	361	—
Southern	2,969	40	2,586	343	—
Western	4,063	69	3,538	456	—
Monmouthshire					
Monmouth	643	23	475	141	4
Newport Borough	314	8	224	82	—
Norfolk					
Dereham	115	19	77	19	—
Diss	93	4	67	21	1
King's Lynn	90	4	61	20	5
Norwich	330	82	199	49	—
Great Yarmouth Borough	171	6	130	35	—
Norwich Borough	411	9	313	89	—
King's Lynn Borough	149	65	56	27	1
Northamptonshire					
Eastern	416	11	327	78	—
Western	173	35	107	31	—
Northampton Borough	465	67	297	101	—
Northumberland					
North	255	66	122	63	4
South	783	202	374	157	50
Newcastle upon Tyne Borough	885	23	559	262	41
Nottinghamshire					
Newark, Nottingham, Newark Borough	1,125	10	912	203	—
Retford	279	13	213	53	—
Nottingham Borough	1,717	244	1,188	285	—
Oxfordshire					
Central, Oxford Borough	503	12	307	184	—
North Western, Banbury Borough	173	13	128	32	—
Rutland	36	2	26	8	—
Shropshire					
Bradford North	41	3	30	8	—

Statistics of Work by Jurisdictions, 1969
Source: Coroners' Returns to the Home Office

Coroner's jurisdiction (jurisdictions bracketed together are served by the same coroner)	1 Deaths reported	2 No inquest and no PM (Pink Form A)	3 PM's *without* inquest (Pink Form B)	4 PM's *with* inquest	5 Inquest no PM
Shropshire—continued					
Bradford South and Brimstree	153	29	101	23	—
Ford } Shrewsbury Borough } ...	185	9	86	90	—
Oswestry and Pimhill ...	103	11	58	34	—
South	87	17	42	28	—
Maelor Hundred (Flint)	3	—	2	1	—
Somerset					
Northern	643	31	423	189	—
South Eastern	243	16	182	45	—
Western	319	30	213	76	—
Bath Borough	329	10	223	96	—
Bridgwater	61	4	47	10	—
Staffordshire					
Eastern } Burton Borough } ...	309	50	189	70	—
Northern	319	62	192	61	4
Southern	196	9	135	52	—
Stafford	487	18	364	105	—
Newcastle-under-Lyme Borough	163	21	124	18	—
Stoke-on-Trent Borough	1,850	83	1,381	386	—
Walsall Borough ...	570	10	448	112	—
Warley Borough	286	10	253	23	—
West Bromwich Borough	490	102	315	73	—
Wolverhampton Borough	613	6	468	131	8
East Suffolk					
Eastern	56	4	42	10	—
Southern	174	3	131	40	—
Northern } Ipswich }	533	7	408	118	—
West Suffolk					
Newmarket and Haverhill } Bury St. Edmunds } Liberty	196	13	136	47	—
Sudbury	28	—	26	2	—
Bury St. Edmunds ...	82	7	56	19	—
Surrey					
County	2,327	54	1,886	387	—
Guildford Borough ...	233	2	178	53	—
Sussex—East					
Lewes	1,168	165	765	229	9
Rye } Hastings Borough } ...	509	70	358	81	—
Brighton Borough ...	615	77	351	126	61
Sussex—West					
County	1,388	32	1,193	163	—
Warwickshire					
Northern	560	2	406	152	—

Statistics of Work by Jurisdictions, 1969
Source: Coroners' Returns to the Home Office

Coroner's jurisdiction (jurisdictions bracketed together are served by the same coroner)	1 Deaths reported	2 No inquest and no PM (Pink Form A)	3 PM's *without* inquest (Pink Form B)	4 PM's *with* inquest	5 Inquest no PM
Warwickshire—continued					
Central	422	5	283	134	—
South Western	329	29	225	75	—
Coventry Borough	969	266	558	145	—
Birmingham Borough	3,795	1,085	2,075	526	109
Westmorland					
East and West	18	1	8	6	3
Kendal	139	18	72	48	1
Wiltshire					
County / Salisbury Borough	1,000	178	560	262	—
Worcestershire					
Middle	165	26	102	36	1
North	519	2	391	106	20
South	54	5	32	14	3
Dudley Borough	515	38	376	101	—
Worcester Borough	166	1	102	58	5
Yorkshire—East Riding					
Buckrose	126	—	101	25	—
Howdenshire	187	16	127	44	—
Holderness	122	2	87	33	—
Kingston-upon-Hull Borough	940	118	688	101	33
Yorkshire—North Riding					
North Eastern	283	20	199	64	—
Ryedale	104	2	73	29	—
Western	138	26	67	39	6
Teesside Borough	1,127	244	659	224	—
Scarborough Borough	172	9	113	41	9
York City / York Castle	320	—	212	108	—
Yorkshire—West Riding					
Craven	639	52	405	181	1
Halifax / Halifax Borough	1,239	16	986	237	—
Doncaster / Doncaster Borough	969	5	672	286	6
Claro	414	27	277	110	—
Bradford Borough	1,069	201	739	129	—
Wakefield / Rotherham Borough	2,039	242	1,362	435	—
Rotherham / Sheffield Borough	1,632	11	1,228	356	37
Huddersfield Borough	416	—	317	99	—
Leeds Borough	2,505	367	1,784	354	—
Anglesey	69	7	38	21	3
Brecon	130	6	96	21	7
Caernarvonshire					
North	430	227	122	71	10

Statistics of Work by Jurisdictions, 1969
Source: Coroners' Returns to the Home Office

Coroner's jurisdiction (jurisdictions bracketed together are served by the same coroner)	1 Deaths reported	2 No inquest and no PM (Pink Form A)	3 PM's *without* inquest (Pink Form B)	4 PM's *with* inquest	5 Inquest no PM
Caernarvonshire—continued					
South	65	16	25	22	2
Cardiganshire					
North	65	18	35	12	—
Mid and South	48	11	24	13	—
Carmarthenshire					
East and West	281	20	164	94	3
Three Commots ...	336	14	252	70	—
Denbighshire					
East	256	30	168	55	3
West	216	39	119	46	12
Flint	348	17	241	90	—
Glamorgan					
Eastern	1,165	308	710	147	—
Gower	170	35	118	13	4
Northern	701	85	559	57	—
Ogmore					
Western	604	141	368	78	17
Cardiff Borough	971	188	664	119	—
Merthyr Tydfil Borough	339	115	194	30	—
Swansea Borough ...	464	85	299	77	3
Merioneth	84	22	30	22	10
Montgomery	60	7	38	14	1
Pembrokeshire					
Northern	30	9	11	10	—
Southern	151	41	69	32	9
Radnor	29	7	17	5	—
TOTALS ...	131,639	14,506	92,003	24,101	1,029

APPENDIX 6

DEATHS REPORTED TO CORONERS AS A PROPORTION OF ALL DEATHS 1965 COUNTIES AND COUNTY BOROUGHS

(*Source:* The Registrar General for England and Wales and Coroners' Returns to the Home Office)

District Counties and boroughs	Coroners' boroughs included in county totals	Total no. of deaths	Deaths reported to coroner
Bedfordshire	Bedford	3,808	787 (20·4)
Berkshire	Newbury, Windsor	3,438	673 (19·6)
Reading		1,798	346 (19·3)
Buckinghamshire		4,262	887 (20·8)
Cambridgeshire and Isle of Ely ...	Cambridge	3,243	586 (18·0)
Cheshire		13,187	2,125 (16·1)
Birkenhead		1,794	316 (17·6)
Chester		907	218 (24·0)
Cornwall	Penzance	4,821	769 (16·0)
Cumberland		2,479	439 (17·7)
Carlisle		1,169	175 (15·0)
Derbyshire		6,395	1,255 (19·7)
Derby		2,751	659 (24·0)
Devon	Barnstaple	7,486	1,048 (14·0)
Exeter		1,554	211 (13·6)
Plymouth		2,856	563 (19·7)
Dorset	Poole	3,808	746 (19·6)
Durham		14,919	2,797 (18·5)
Sunderland		2,246	424 (18·8)
Essex	Colchester—Included in Greater London and Environs		
Southend		1,829	579 (31·7)
Gloucestershire		4,491	774 (17·2)
Bristol		5,906	1,053 (17·8)
Gloucester		1,209	336 (27·8)
Greater London and Environs ...		136,997	32,616 (23·8)
Hampshire	Winchester	9,249	1,641 (17·7)
Bournemouth		2,503	440 (17·6)
Portsmouth		3,601	756 (21·0)
Southampton		2,619	580 (22·1)

DEATHS REPORTED TO CORONERS AS A PROPORTION OF ALL DEATHS 1965
COUNTIES AND COUNTY BOROUGHS

(*Source:* The Registrar General for England and Wales and Coroners' Returns to the Home Office)

District Counties and boroughs	Coroners' boroughs included in county totals	Total no. of deaths	Deaths reported to coroner
Herefordshire	Hereford	993	241 (24·3)
Hertfordshire	Included in Greater London and Environs		
Huntingdon and Peterborough		1,554	304 (19·6)
Kent	Rochester, Gravesend, Dover, Folkestone, Maidstone, Margate — Included in Greater London and Environs		
Canterbury		866	126 (14·6)
Lancashire		33,092	6,225 (18·8)
Barrow		923	106 (11·5)
Blackburn		2,163	421 (19·5)
Blackpool		2,850	556 (19·5)
Bolton		1,583	346 (21·7)
Burnley		1,762	411 (23·4)
Liverpool		9,997	1,830 (18·3)
Manchester		9,048	2,373 (26·2)
Oldham		2,051	476 (23·2)
Salford		2,251	472 (21·0)
Wigan		1,328	232 (17·4)
Leicestershire		3,312	500 (15·1)
Leicester		4,172	943 (22·6)
Lincs.—Holland		1,135	159 (14·2)
Lincs.—Kesteven	Grantham	1,547	229 (14·8)
Lincs.—Lindsey		3,350	675 (20·1)
Grimsby		1,283	227 (17·0)
Lincoln		1,236	243 (19·6)
London City		1,002	197 (19·7)
Norfolk	Kings Lynn	4,511	580 (12·8)
Great Yarmouth		1,038	164 (15·8)
Norwich		2,050	372 (18·1)

DEATHS REPORTED TO CORONERS AS A PROPORTION OF ALL DEATHS 1965
COUNTIES AND COUNTY BOROUGHS

(*Source:* The Registrar General for England and Wales and Coroners' Returns to the Home Office)

District Counties and boroughs	Coroners boroughs included in county totals	Total no. of deaths	Deaths reported to coroner
Northamptonshire		2,892	517 (17·9)
Northampton		1,853	357 (19·3)
Northumberland		6,377	933 (14·6)
Newcastle-upon-Tyne		4,520	742 (16·4)
Nottinghamshire	Newark	5,396	1,314 (24·3)
Nottingham		4,773	1,342 (28·1)
Oxfordshire	Banbury	1,774	323 (18·2)
Oxford		1,994	366 (18·3)
Rutland		212	31 (14·6)
Shropshire	Shrewsbury	3,467	537 (15·5)
Somerset	Bridgwater	6,638	1,075 (16·2)
Bath		1,553	318 (20·5)
Staffordshire	Newcastle-under-Lyme	8,608	1,674 (19·4)
Burton-on-Trent		910	168 (18·6)
Smethwick		424	115 (27·4)
Stoke-on-Trent		3,909	1,555 (39·8)
Walsall		1,668	355 (21·3)
West Bromwich		1,226	305 (24·8)
Wolverhampton		2,332	378 (16·2)
East Suffolk		2,437	417 (17·0)
Ipswich		1,651	307 (18·6)
West Suffolk	Bury St. Edmunds	1,714	265 (15·5)
Surrey	Guildford—Included in Greater London and Environs		
Sussex (East)		6,446	1,068 (16·6)
Brighton		3,281	669 (20·4)
Hastings		1,788	286 (16·0)
Sussex (West)		6,203	1,238 (20·0)
Warwickshire		6,190	1,133 (18·3)
Birmingham		13,212	3,306 (25·0)

DEATHS REPORTED TO CORONERS AS A PROPORTION OF ALL DEATHS 1965 COUNTIES AND COUNTY BOROUGHS

(*Source:* The Registrar General for England and Wales and Coroners' Returns to the Home Office)

District Counties and boroughs	Coroners' boroughs included in county totals	Total no. of deaths	Deaths reported to coroner
Coventry		2,593	635 (24·4)
Westmorland		793	154 (19·5)
Wiltshire	Salisbury	4,516	742 (16·4)
Worcestershire		4,158	652 (15·9)
Dudley		560	203 (36·2)
Worcester		1,087	159 (14·6)
Yorks.—North Riding	Scarborough	4,621	1,148 (24·8)
Middlesbrough		1,776	466 (26·2)
York City		1,634	291 (17·8)
Yorks.—East Riding		2,875	386 (13·4)
Hull		3,369	917 (27·2)
Yorks.—West Riding		19,427	4,008 (20·7)
Bradford		4,364	865 (19·8)
Doncaster		1,390	357 (25·7)
Halifax		2,005	312 (15·5)
Huddersfield		1,831	412 (22·5)
Leeds		6,641	1,849 (27·8)
Rotherham		1,197	256 (25·3)
Sheffield		6,727	1,065 (15·7)
Anglesey		641	96 (15·0)
Brecon		650	130 (20·0)
Caernarvonshire		1,889	359 (19·0)
Cardiganshire		777	116 (15·0)
Carmarthenshire		2,302	548 (23·0)
Denbighshire		2,452	423 (17·3)
Flintshire		1,867	342 (18·3)
Glamorgan		8,929	2,300 (25·8)
Cardiff		2,902	836 (28·8)
Merthyr Tydfil		992	255 (25·8)
Swansea		2,484	417 (16·8)

DEATHS REPORTED TO CORONERS AS A PROPORTION OF ALL DEATHS 1965 COUNTIES AND COUNTY BOROUGHS

(*Source:* The Registrar General for England and Wales and Coroners' Returns to the Home Office)

District Counties and boroughs	Coroners' boroughs included in county totals	Total no. of deaths	Deaths reported to coroner
Merioneth		398	62 (15·5)
Monmouthshire		3,329	573 (17·2)
Newport		1,452	298 (20·6)
Montgomeryshire		463	78 (17·0)
Pembrokeshire		1,057	167 (15·8)
Radnorshire		183	15 (8·2)

APPENDIX 7

THE PLACE IN WHICH CORONERS AUTOPSIES ARE PERFORMED

Autopsies Performed for Coroners 1 October 1968—31 December 1968

Jurisdiction	Hospital mortuary	Public mortuary	Total
East Midlands			
Derbyshire			
County Districts	137	115	252
Boroughs	182	2	184
Total:	355	117	436
Huntingdon and Peterborough			
County Districts	80	—	80
Total:	80	—	80
Leicestershire			
County Districts	97	—	97
Boroughs	198	—	198
Total:	295	—	295
Lincolnshire			
County Districts	146	49	195
Boroughs	124	—	124
Total:	270	49	319
Norfolk			
County Districts	129	—	129
Boroughs	112	27	139
Total:	241	27	268
Northamptonshire			
County Districts	154	—	154
Boroughs	99	—	99
Total:	253	—	253
Nottinghamshire			
County Districts	172	71	243
Boroughs	167	205	372
Total:	339	276	615
TOTAL			
County Districts	915	235	1,150
Boroughs	882	234	1,116
West Midlands			
Herefordshire			
County Districts	28	1	29
Boroughs	—	22	22
Total:	28	23	51
Oxfordshire			
County Districts	65	—	65
Boroughs	129	—	129
Total:	194	—	194

THE PLACE IN WHICH CORONERS AUTOPSIES ARE PERFORMED

Autopsies Performed for Coroners 1 October 1968—31 December 1968

Jurisdiction	Hospital mortuary	Public mortuary	Total
Shropshire			
County Districts	44	35	79
Boroughs	50	—	50
Total:	94	35	129
Staffordshire			
County Districts	112	121	233
Boroughs	550	325	875
Total:	662	446	1,108
Warwickshire			
County Districts	240	68	308
Boroughs	359	467	826
Total:	599	535	1,134
Worcestershire			
County Districts	317	44	361
Boroughs	177	12	189
Total:	494	56	550
TOTAL			
County Districts	806	269	1,075
Boroughs	1,265	826	2,091
North West			
Cheshire			
County Districts	299	210	509
Boroughs	157	58	215
Total:	456	268	724
Cumberland			
County Districts	94	—	94
Boroughs	35	—	35
Total:	129	—	129
Lancashire			
County Districts	912	630	1,542
Boroughs	993	587	1,580
Total:	1,905	1,217	3,122
Westmorland			
County Districts	33	—	33
Total:	33	—	33
TOTAL			
County Districts	1,338	840	2,178
Boroughs	1,185	645	1,830
North East			
Durham			
County Districts	567	16	583
Boroughs	64	—	64
Total:	631	16	647

THE PLACE IN WHICH CORONERS AUTOPSIES ARE PERFORMED

Autopsies Performed for Coroners 1 October 1968—31 December 1968

Jurisdiction	Hospital mortuary	Public mortuary	Total
Northumberland			
County Districts	136	15	151
Boroughs	202	—	202
Total:	338	15	353
Yorkshire E.R.			
County Districts	69	28	97
Boroughs	52	121	173
Total:	121	149	270
Yorkshire W.R.			
County Districts	586	360	946
Boroughs	666	642	1,308
Total:	1,252	1,002	2,254
Yorkshire N.R.			
County Districts	97	—	97
Boroughs	312	—	312
Total:	409	—	409
TOTAL			
County Districts	1,455	419	1,874
Boroughs	1,296	763	2,059
South West			
Cornwall			
County Districts	47	84	131
Boroughs	17	—	17
Total:	64	84	148
Devon			
County Districts	158	1	159
Boroughs	193	70	263
Total:	351	71	422
Dorset			
County Districts	80	10	90
Boroughs	85	—	85
Total:	165	10	175
Gloucestershire			
County Districts	148	77	225
Boroughs	75	211	286
Total:	223	288	511
Somerset			
County Districts	266	2	268
Boroughs	88	—	88
Total:	354	2	356

THE PLACE IN WHICH CORONERS AUTOPSIES ARE PERFORMED

Autopsies Performed for Coroners 1 October 1968—31 December 1968

Jurisdiction	Hospital mortuary	Public mortuary	Total
Wiltshire			
County Districts	175	—	175
Boroughs	25	—	25
Total:	200	—	200
TOTAL			
County Districts	874	174	1,048
Boroughs	483	281	764
South Eastern			
Bedfordshire			
County Districts	184	31	215
Boroughs	(included with Bedford North District)		
Total:	184	31	215
Berkshire			
County Districts		(not available)	
Boroughs	113	—	113
Total:	113	—	113
Buckinghamshire			
County Districts	209	42	251
Boroughs	—	—	—
Total:	209	42	251
Cambridge/Ely			
County Districts	105	—	105
Boroughs	77	—	77
Total:	182	—	182
Essex			
County Districts	455	49	504
Boroughs	186	—	186
Total:	641	49	690
Hampshire/I.O.W.			
County Districts	219	138	357
Boroughs	147	343	490
Total:	366	481	847
Hertfordshire			
County Districts	345	—	345
Boroughs	—	—	—
Total:	345	—	345
Kent			
County Districts	405	67	472
Boroughs	318	29	347
Total:	723	96	819

THE PLACE IN WHICH CORONERS AUTOPSIES ARE PERFORMED

Autopsies Performed for Coroners 1 October 1968—31 December 1968

Jurisdiction	Hospital mortuary	Public mortuary	Total
Suffolk, East			
County Districts	110	—	110
Boroughs	88	—	88
Total:	198	—	198
Suffolk, West			
County Districts	45	—	45
Boroughs	31	—	31
Total:	76	—	76
Surrey			
County Districts	317	185	502
Boroughs	—	58	58
Total:	317	243	560
Sussex, East			
County Districts		(not available)	
Boroughs	95	88	183
Total:	95	88	183
Sussex, West			
County Districts	121	218	339
Boroughs	—	—	—
Total:	121	218	339
TOTAL			
County Districts	2,515	730	3,245
Boroughs	1,055	518	1,573
Greater London	2,717	3,606	6,323
City of London	—	52	52
Wales			
Anglesey			
County Districts	23	—	23
Total:	23	—	23
Brecknockshire			
County Districts	18	6	24
Total:	18	6	24
Cardiganshire			
County Districts		(not available)	
Total:			
Carmarthenshire			
County Districts	121	—	121
Total:	121	—	121

THE PLACE IN WHICH CORONERS AUTOPSIES ARE PERFORMED

Autopsies Performed for Coroners 1 October 1968—31 December 1968

Jurisdiction	Hospital mortuary	Public mortuary	Total
Caernarvonshire			
County Districts	52	—	52
Total:	52	—	52
Denbighshire			
County Districts	47	9	56
Total:	47	9	56
Flintshire			
County Districts	46	36	82
Total:	46	36	82
Glamorganshire			
County Districts	429	18	447
Boroughs	260	47	307
Total:	689	65	754
Merionethshire			
County Districts	9	—	9
Total:	9	—	9
Montgomeryshire			
County Districts	23	—	23
Total:	23	—	23
Pembrokeshire			
County Districts	34	—	34
Total:	34	—	34
Radnorshire			
County Districts	5	—	5
Total:	5	—	5
Monmouthshire			
County Districts	110	20	130
Boroughs	78	—	78
Total:	188	20	208
TOTAL			
County Districts	917	89	1,006
Boroughs	338	47	385
GRAND TOTAL			
England and Wales			
County Districts	—	—	11,566
Boroughs (incl. London) ...	—	—	16,193

APPENDIX 8

CREMATION REGULATIONS 1930 (AS AMENDED BY REGULATIONS OF 1952 AND 1965)

Definitions

" Cremation Authority " means any burial authority or any company or person by whom a crematorium has been established.

" Medical Referee " means a medical referee or a deputy medical referee appointed in pursuance of Regulation 10.

" The Act of 1926 " means the Births and Deaths Registration Act 1926.

Maintenance and inspection of crematoria

1. Every crematorium shall be:—

(*a*) maintained in good working order;

(*b*) provided with a sufficient number of attendants; and

(*c*) kept constantly in a cleanly and orderly condition;

Provided that a crematorium may be closed by order of the Cremation Authority if not less than one month's notice be given by advertisement in two newspapers circulating in the locality and by written notice fixed at the entrance to the crematorium.

The Cremation Authority shall give notice in writing to the Secretary of State of the opening or closing of any crematorium.

2. Every crematorium shall be open to inspection at any reasonable time by any person appointed for that purpose by the Secretary of State or by the Minister of Health.[1]

Conditions under which cremations may take place

3. No cremations of human remains shall take place except in a crematorium of the opening of which notice has been given to the Secretary of State.

6. Except where an inquest has been opened or a post-mortem examination has been made in pursuance of Section 21 (1) of the Coroners (Amendment) Act 1926, and a certificate given by a Coroner in Form "E " (see Regulation 8), no cremation shall be allowed until the death of the deceased has been duly registered or a certificate has been given in pursuance of Section 2 (2) of the Act of 1926 that the death of the deceased is not required by law to be registered in England.

The production of a duplicate which has been duly issued in pursuance of Section 2 (4) of the Act of 1926 may be accepted in lieu of the production of the original certificate in sub-section (1) or sub-section (2).

7. (1) No cremation shall be allowed to take place unless application therefor has been made in Form " A " set out in the Schedule hereto and the information requested in that form duly furnished, the following provisions of this Regulation having been complied with.

(2) The application shall be signed by an executor or the nearest relative of the deceased, so, however, that it may be signed by some other person if the cremation authority is satisfied that that person is a proper one to have signed, and a satisfactory reason is given on the application why it is not signed by an executor or the nearest relative but by that other person.

(3) The application shall be verified by being countersigned by a householder to whom the applicant is known who shall certify that the applicant is known to him

[1] Now the Secretary of State for the Environment.

or her and that he or she has no reason to doubt the truth of any of the information furnished by the applicant.

8. Except as hereafter provided, no cremation shall be allowed to take place unless

(*a*) A certificate in Form " B " has been given by a registered medical practitioner who has attended the deceased during his last illness and who can certify definitely as to the cause of death, and a confirmatory medical certificate in Form " C " has been given by another medical practitioner who must be qualified as prescribed in Regulation 9; or

(*b*) A post-mortem examination has been made by a medical practitioner expert in pathology appointed by the Cremation Authority (or in case of emergency appointed by the Medical Referee), and a certificate given by him in Form " D "; or

(*c*) A post-mortem examination has been made and the cause of death has been certified by the Coroner under Section 21 (2) of the Coroners (Amendment) Act 1926 and a certificate has been given by the Coroner in Form " E "; or

(*d*) An inquest has been opened and a certificate has been given by the Coroner in Form " E "

(*e*) In relation to a person whose body has undergone anatomical examination pursuant to the provisions of the Anatomy Act 1832, a certificate in Form H has been given by a person licensed under section 1 of that Act that the body has undergone such examination.

No cremation shall take place except on the written authority of the Medical Referee given in Form " F ".

9. The confirmatory medical certificate in Form " C ", if not given by the Medical Referee, must be given by a registered medical practitioner of not less than five years' standing, who shall not be a relative of the deceased or a relative or partner of the doctor who has given the certificate in Form " B ".

10. Every Cremation Authority shall have a Medical Referee and a Deputy Medical Referee, who must be registered medical practitioners of not less than five years' standing and must possess such experience and qualifications as will fit them for the discharge of the duties required of them by these Regulations. The Medical Referee or Deputy Medical Referee if otherwise qualified may be a person holding the office of Coroner or Medical Officer of Health.

The Deputy Medical Referee shall act in the absence of the Medical Referee and in any case in which the Medical Referee has been the medical attendant of the deceased.

The Secretary of State shall appoint as Medical Referee and Deputy Medical Referee such fit persons as may be nominated by the Cremation Authority.

Any Medical Referee or Deputy Referee appointed by the Secretary of State may in case of emergency act as the Medical Referee or Deputy Medical Referee of a Cremation Authority other than that for which he has been appointed.

11. It shall be lawful for the Medical Referee if he has personally investigated the cause of death to give a certificate in Form " C ", and if he has made the post-mortem examination to give a certificate in Form " D ". The Medical Referee, if a Coroner, may himself give the Coroner's certificate in Form " E ".

12. The duties of the Medical Referee shall be as follows:—

(1) He shall not (except where a post-mortem examination has been made under Regulation 8 (c), or an inquest has been opened, and a certificate given

by a Coroner in Form " E ") allow any cremation to take place unless he is satisfied:—

(*a*) by the production of a certificate in pursuance of Section 2 (1) of the Act of 1926 that the death of the deceased has been duly registered; or

(*b*) by the production of a certificate in pursuance of Section 2 (2) of the Act of 1926 that the death of the deceased is not required by law to be registered in England.

The production of a duplicate which has been duly issued in pursuance of Section 2 (4) of the Act of 1926 may be accepted in lieu of the production of the original certificate under sub-section (1) or sub-section (2).

(2) He shall, before allowing the cremation, examine the application and certificates and ascertain that they are such as are required by these Regulations and that the inquiry made by the persons giving the certificate has been adequate. He may make any inquiry with regard to the application and certificates that he may think necessary.

(3) He shall not allow the cremation unless he is satisfied that the application is made by an executor or by the nearest surviving relative of the deceased, or, if made by any other person, that the fact that the executor or nearest relative has not made the application is sufficiently explained, and that the person making the application is a proper person to do so.

(4) He shall not allow the cremation unless he is satisfied that the fact and cause of death have been definitely ascertained; and in particular, if the cause of death assigned in the medical certificates be such as, regard being had to all the circumstances, might be due to poison, to violence, to any illegal operation, or to privation or neglect, he shall require a post-mortem examination to be held, and if that fails to reveal the cause of death, shall decline to allow the cremation unless an inquest be opened and a certificate given by the Coroner in Form " E ".

(5) If it appears that death was due to poison, to violence, to any illegal operation or to privation or neglect, or if there is any suspicious circumstance whatsoever, whether revealed in the certificates or otherwise coming to his knowledge, he shall decline to allow the cremation unless an inquest be opened and a certificate given by the Coroner in Form " E ".

Provided that if in any case to which the foregoing rule applies it is shown to the satisfaction of the Secretary of State that by reason of any special circumstances it is impracticable or undesirable that an inquest shall be held, he may by order under his hand authorise the Medical Referee to allow the cremation without an inquest being opened and certificate given by the Coroner.

(6) If a Coroner has given notice that he intends to hold an inquest on the body, the Medical Referee shall not allow the cremation to take place until the inquest has been opened.

(7) He may in any case decline to allow the cremation without stating any reason.

(8) He shall make such reports to the Secretary of State as may from time to time be required.

In the case of the remains of a person who has died in Scotland, the medical referee may accept an application and certificates made or given in accordance with

regulations made in pursuance of section seven of the Cremation Act 1902, as amended by the Cremation Act 1952, and having effect in Scotland. In the case of the remains of a person who has died in any other place out of England or Wales, the medical referee may accept an application containing the particulars prescribed in Form " A " if it be accompanied by a declaration by the applicant that all the particulars given therein are true to the best of his or her knowledge and belief, made before any person having authority in that place to administer an oath or take a declaration; and he may accept certificates in Forms " B ", " C ", and " D ", if they be signed by any medical practitioners who are shown to his satisfaction to possess qualifications substantially equivalent to those prescribed in the case of each certificate by these Regulations.

In any such last mentioned case the Secretary of State, if satisfied that the case is one in which cremation may properly take place, may by order under his hand authorise the Medical Referee to allow the cremation without the production of Forms " B " and " C ".

13. The foregoing Regulations 5 to 12 shall not apply to the cremation of the remains of a deceased person who has already been buried for not less than one year. Such remains may be cremated, subject to such conditions as the Secretary of State may impose in the exhumation licence granted by him or otherwise; and any such cremation in which those conditions are not observed shall be deemed a contravention of these Regulations.

14. In the case of any person dying of plague, cholera, or yellow fever on board ship or in a hospital or temporary place of reception of the sick provided by a Port or other Local Authority under the Public Health Acts or by a Hospital Committee under the Isolation Hospital Acts, the Medical Referee, if satisfied as to the cause of death, may dispense with any of the requirements of Regulations 4, 5, 6, 7, 8, 9 and 12. These Regulations may also be temporarily suspended or modified in any district during an epidemic or for other sufficient reason by an order of the Secretary of State on the application of a Local Authority.

15. Notwithstanding the foregoing Regulations 6 to 12, the Medical Referee may permit the cremation of the remains of a stillborn child if it be certified to be stillborn by a registered medical practitioner after examination of the body, and if the Referee after such inquiries as he may think necessary is satisfied that it was stillborn, and that there is no reason for further examination; but, before permitting such cremation, the Medical Referee shall, except where an inquest has been opened and a certificate given by a Coroner in Form " E ", require the production of a certificate in pursuance of Section 7 (4) of the Act of 1926 that the stillbirth has been duly registered.

The production of a duplicate which has been duly issued in pursuance of Section 2 (4) of the Act of 1926 may be accepted in lieu of the production of the original certificate in sub-section (1) or sub-section (2).

Disposition of ashes

16. After the cremation of the remains of a deceased person the ashes shall be given into the charge of the person who applied for the cremation if he so desires. If not, they shall be retained by the Cremation Authority, and, in the absence of any special arrangement for their burial or preservation, they shall either be decently interred in a burial ground or in land adjoining the crematorium reserved for the burial of ashes, or shall be scattered thereon. In the case of ashes left temporarily in the charge of the Cremation Authority and not removed within a reasonable time, a fortnight's notice shall be given to the person who applied for the cremation before the remains are interred or scattered.

Registration of cremations, etc.

17. Every Cremation Authority shall appoint a registrar who shall keep a register of all cremations carried out by the Cremation Authority in Form " G ". He shall make the entries relating to each cremation immediately after the cremation has taken place, except the entry in the last column, which he shall make as soon as the remains of the deceased have been handed to the relatives or otherwise disposed of.

18. Any certificate given by a Coroner in Form " E " shall have attached thereto a detachable portion (which shall be in the form set out in the Schedule to these Regulations) for use by the registrar in pursuance of the following Regulation.

19. (1) (*a*) Subject to the provisions of paragraphs (2) and (3) of this Regulation the registrar shall, within ninety-six hours of the cremation of the body of any deceased person, send to the registrar of births and deaths for the sub-district in which the death took place or, if the death took place elsewhere than in England, to the registrar of births and deaths for the sub-district in which the crematorium is situated, a notification of the cremation of the body and the date and place of such cremation.

(*b*) Where the body has been cremated without inquest, the notification shall be sent in the manner for the time being prescribed by the Registrar-General under the Act of 1926, for notifications under Section 3 (1) of that Act.

(*c*) Where the body has been cremated after inquest or a post-mortem examination made in pursuance of Section 21 (1) of the Coroners (Amendment) Act 1926, such notification as aforesaid shall be sent upon the detachable portion of the certificate given by the Coroner in Form " E ".

(2) This Regulation shall not apply to any cremation of human remains which has taken place under Regulation 13.

(3) Where any cremation of human remains has taken place under Regulation 14, the registrar shall (subject to the provisions of any order made by the Secretary of State under that Regulation) within ninety-six hours of the cremation forward to the Registrar-General a copy of the relative entry in the register of cremations together with particulars of the place of death of the deceased and the cause of death as established to the satisfaction of the Medical Referee.

20. All applications, certificates and other documents relating to any cremation shall be marked with a number corresponding to the number in the register, shall be filed in order, and shall be carefully preserved by the Cremation Authority. Provided that the Cremation Authority may, if they think fit, destroy any such applications, certificates or other documents (but not the register of cremations or any part of such register):—

(*a*) after the expiration of fifteen years from the date of the cremation to which they relate;

(*b*) after two years if a photographic copy thereof is made.

Any such copy shall be retained until the expiration of the said period of fifteen years.

All such registers and documents shall be open to inspection at any reasonable hour by any person appointed for that purpose by the Secretary of State, the Minister of Health or the Chief Officer of any Police Force.

21. When any crematorium is closed as provided in Regulation 1, the Cremation Authority shall send all registers and documents relating to the cremations which have taken place therein to the Secretary of State, or otherwise dispose of them as he may direct.

SCHEDULE

FORM A

APPLICATION FOR CREMATION

1. (Name of applicant) .....

(Address) .....

(Occupation) .....

apply to the .....

to undertake the cremation of the remains of .....

(Name of deceased) .....

(Address).....

(Occupation) .....

(Age) ..... (Sex) .....

(Whether married, widow, widower, or unmarried) .....

The true answers to the questions set out below are as follows:—

1. Are you an executor or the nearest surviving relative of the deceased?

2. If not, state
   (*a*) Your relationship to the deceased (*a*)
   (*b*) The reason why the application is made by you and not by an executor or any nearer relative (*b*)

3. Have the near relatives[1] of the deceased been informed of the proposed cremation?

4. Has any near relative of the deceased expressed any objection to the proposed cremation? If so, on what ground?

5. What was the date and hour of the death of the deceased?

6. What was the place where deceased died? (Give address and say whether own residence, lodgings, hotel, hospital, nursing home, etc.)

[1] The term "near relative" as here used includes widow or widower, parents, children above the age of 16, and any other relative usually residing with the deceased.

7. Do you know, or have you any reason to suspect, that the death of the deceased was due, directly or indirectly to
   (*a*) violence;
   (*b*) poison;
   (*c*) privation or neglect?

8. Do you know any reason whatever for supposing that an examination of the remains of the deceased may be desirable?

9. Give name and address of the ordinary medical attendant of the deceased.

10. Give names and addresses of the medical practitioners who attended deceased during his/her last illness.

I declare that to the best of my knowledge and belief the information given in this application is correct and no material particular has been omitted.

Date..... (Signature).....

The applicant is known to me and I have no reason to doubt the truth of any of the information furnished by the applicant.

Date..... (Signature).....

(Capacity in which signatory has signed).....

(Address).....

.....

.....

FORM B

CERTIFICATE OF MEDICAL ATTENDANT

I am informed that application is about to be made for the cremation of the remains of .....

(Name of deceased) .....

(Address) .....

(Occupation) .....

Having attended the deceased before death, and seen and identified the body after death, I give the following answers to the questions set out below:—

1. On what date, and at what hour did he or she die?

2. What was the place where the deceased died? (Give address and say whether own residence, lodging, hotel, hospital, nursing home, etc.)

3. Are you a relative of the deceased? If so, state the relationship.
4. Have you, so far as you are aware, any pecuniary interest in the death of the deceased?
5. Were you the ordinary medical attendant of the deceased? If so, for how long?
6. Did you attend the deceased during his or her last illness? If so, for how long?
7. When did you last see the deceased alive? (Say how many days or hours before death)
8. How soon after death did you see the body, and what examination of it did you make?
9. What was the cause of death?

I

Immediate cause ..... *a* .....

Morbid conditions, if any, giving rise to immediate cause (stated in order proceeding backwards from immediate cause). due to *b*..... due to *c* .....

II

Other morbid conditions (if important) contributing to death but not related to immediate cause. ....

10. What was the mode of death? (Say whether syncope, coma, exhaustion, convulsions etc.) What was its duration in days, hours or minutes?
11. State how far the answers to the last two questions are the result of your own observations, or are based on statements made by others. If on statements made by others, say by whom.
12. Did the deceased undergo any operation during the final illness or within a year before death? If so, what was its nature, and who performed it?
13. By whom was the deceased nursed during his or her last illness? (Give names, and say whether professional nurse, relative, etc. If the illness was a long one, this question should be answered with reference to the period of four weeks before the death.)

14. Who were the persons (if any) present at the moment of death?
15. In view of the knowledge of the deceased's habits and constitution do you feel any doubt whatever as to the character of the disease or the cause of death?
16. Have you any reason to suspect that the death of the deceased was due, directly or indirectly to
    (*a*) violence;
    (*b*) poison;
    (*c*) privation or neglect?
17. Have you any reason whatever to suppose a further examination of the body to be desirable?
18. Have you given the certificate required for registration of death? If not, who has?

I hereby certify that the answers given above are true and accurate to the best of my knowledge and belief, and that I know of no reasonable cause to suspect that the deceased died either a violent or an unnatural death or a sudden death of which the cause is unknown or died in such place or circumstances as to require an inquest in pursuance of any Act.

(Signature)

(Address)

(Registered qualifications)

(Date)

NOTE—This certificate must be handed or sent in a closed envelope by the medical practitioner who signs it to the medical practitioner who is to give the confirmatory certificate below.

FORM C

CONFIRMATORY MEDICAL CERTIFICATE

I, being neither a relative of the deceased, nor a relative or partner of the medical practitioner who has given the foregoing medical certificate, have examined it and have made personal inquiry as stated in my answers to the questions below:—

1. Have you seen the body of the deceased?
2. Have you carefully examined the body externally?
3. Have you made a post-mortem examination?
4. Have you seen and questioned the medical practitioner who gave the above certificate?
5. Have you seen and questioned any other medical practitioner who attended the deceased?
6. Have you seen and questioned any person who nursed the deceased during his last illness, or who was present at the death?
7. Have you seen and questioned any of the relatives of the deceased?

8. Have you seen and questioned any other person?
(In the answers to questions 5, 6, 7 and 8, give names and addresses of persons seen and say whether you saw them alone).

I am satisfied that the cause of death was

and I certify that I know of no reasonable cause to suspect that the deceased died either a violent or an unnatural death or a sudden death of which the cause is unknown or died in such place or circumstances as to require an inquest in pursuance of any Act.

(Signature)

(Address)

(Date)

(Registered qualifications)

(Office)

NOTE—The Certificates in Forms B and C must be handed or sent in a closed envelope to the Medical Referee by one or other of the medical practitioners by whom they are given.

FORM D

CERTIFICATE AFTER POST-MORTEM EXAMINATION

I hereby certify that, *acting*[1] *on the instructions of* Medical Referee to the I made a post-mortem examination of the remains of

(Name)

(Address)

(Occupation)

The result of the examination is as follows:—

I am satisfied that the cause of death was and that there is no reason *for making any toxicological analysis*[2] *or* for the holding of an inquest.

(Signature)

(Address)

(Date)

(Registered qualifications)

---

[1] Where the Medical Referee himself gives this certificate, strike out the words in italics and insert " as ".

[2] The words in italics should be omitted where a toxicological analysis has been made and its result is stated in this certificate or in a certificate attached to it.

FORM E

CORONER'S CERTIFICATE

I certify that:—

*(*a*) I have opened an inquest on the body of the undermentioned deceased person:

*Delete whichever is inapplicable.

*(*b*) A post-mortem examination of the body of the undermentioned deceased person has been made by my direction or at my request and as a result thereof I am satisfied that an inquest is unnecessary.

I am satisfied that there are no circumstances likely to call for a further examination of the body.

PARTICULARS OF DECEASED PERSON

Full names (if known)	
Sex	
Age	
Date of death	
Place of death	
Registration district and sub-district in which the death is to be registered.....	

Date..... Signature.....

Coroner for the..... of.....

Notification of Cremation

(For use by the registrar appointed by the Cremation Authority)

This is to notify that the body of .....

deceased, who died on ..... at.....

..... was cremated on (*a*)

.....at (*b*).....

Witness my hand this..... day of.....

....., 19.....

(Signature) .....

on behalf of.....

(*a*) Here state date of cremation. (*b*) Here state place of cremation.