HOME OFFICE

Report of the Committee on

DEATH CERTIFICATION AND CORONERS

Presented to Parliament by the Secretary of State for the Home Department
by Command of Her Majesty
November 1971

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WARRANT OF APPOINTMENT

I hereby appoint

Mr. Norman Brodrick, Q.C.

Professor W. M. Arnott, T.D., B.Sc., M.D., F.R.C.P., F.R.C.P.Ed., F.R.C.P.(C), F.C.Path.

Mr. F. H. Bell, B.Sc.

Mr. R. M. Bingham, Q.C., T.D., M.P.

Lady Dyer

Dr. D. L. Kerr, M.B., B.S., M.R.C.S., L.R.C.P., M.P.

Colonel P. H. Lloyd, T.D., D.L.

Dr. G. R. Osborn, M.B., M.R.C.P., F.C.Path.

Mr. D. Osmond, O.B.E.

to be a committee to review (*a*) the law and practice relating to the issue of medical certificates of the cause of death, and for the disposal of dead bodies and (*b*) the law and practice relating to coroners and coroners' courts, the reporting of deaths to the coroner, and related matters; and to recommend what changes are desirable.

And I further appoint Mr. Norman Brodrick, Q.C., to be Chairman, and Mr. G. I. de Deney of the Home Office to be Secretary of the Committee.

(signed) FRANK SOSKICE

17th March 1965

WARRANT OF APPOINTMENT

I hereby appoint

Mr. L. Rosen, LL.M., Ph.D.

in the place of the late Mr. F. H. Bell to be a member of the committee appointed on 17th March 1965, to review the law and practice relating to death certification and coroners and certain other related matters.

(signed) ROY JENKINS

23 July 1966

Mr. Norman Brodrick was appointed a Judge of the Central Criminal Court in 1967.

Professor W. M. Arnott was created a Knight Bachelor in January 1971.

Mr. F. H. Bell died on 27th January 1966.

Mr. R. M. Bingham did not seek re-election to Parliament in March 1966.

Dr. D. L. Kerr did not seek re-election to Parliament in October 1970.

Colonel P. H. Lloyd was appointed a Commander of the Order of the British Empire in 1968.

Mr. D. Osmond was appointed a Commander of the Order of the British Empire in 1968 and was created a Knight Bachelor in January 1971.

Mr. G. I. de Deney was succeeded as Secretary in May 1968 by Mr. A. P. Wilson.

The members of the committee with their current styles and titles are as follows:—

Judge N. J. L. Brodrick, Q.C. (Chairman)

Professor Sir Melville Arnott, T.D., B.Sc., M.D., F.R.C.P., F.R.C.P.Ed., F.R.C.Path., F.R.S.E.

Mr. R. M. Bingham, Q.C., T.D.

Lady Dyer

Dr. D. L. Kerr, M.B., B.S., M.R.C.S., L.R.C.P.

Colonel P. H. Lloyd, C.B.E., T.D., D.L.

Dr. G. R. Osborn, M.B., F.R.C.P., F.R.C.Path.

Sir Douglas Osmond, C.B.E., Q.P.M.

Mr. L. Rosen, LL.M., Ph.D.

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To the Rt. Hon. Reginald Maudling, M.P., Her Majesty's Principal Secretary of State for the Home Department.

INTRODUCTION

SIR,

1. We were appointed on 17 March 1965 with the following terms of reference:

> "To review (*a*) the law and practice relating to the issue of medical certificates of the cause of death and for the disposal of dead bodies, and (*b*) the law and practice relating to coroners and coroners courts, the reporting of deaths to the coroner, and related matters; and to recommend what changes are desirable."

We have the honour to submit our Report.

2. After a preliminary meeting, we wrote to a number of organisations inviting them to submit evidence. We also gave publicity in the press to our appointment and our desire to receive evidence from any interested organisation or individual. We received written and oral evidence from the persons and organisations listed in Appendix 1. We have held 70 meetings as a full Committee and 25 other meetings for sub-committee purposes. Some of us have visited coroners' courts to watch proceedings there and some of us have also visited pathological laboratories, crematoria and mortuaries for the purposes of our enquiries.

The reasons for our appointment

3. Several circumstances contributed to the decision that the various matters covered by our terms of reference should be examined together in a wide-ranging review. From time to time there had been criticism of particular features of law or practice arising, for example, out of the words or actions of individual doctors or coroners in particular circumstances, but, in 1964, a number of these criticisms were given national prominence by the publication of a report prepared for the Private Practice Committee of the British Medical Association by some of the members of its Forensic Medicine Sub-committee. The report, entitled " Deaths in the Community,"[1] had as its theme the argument that the existing law failed to ensure that causes of death were established with sufficient accuracy and it hinted that, in consequence of the deficiencies in the existing law, homicides might go undetected. Our own enquiries have left us firmly convinced that the attitude adopted in this report was unduly alarmist,[2] but the report performed a valuable function in drawing attention

[1] BMA, Tavistock House. 1964.
[2] Our reasons for this conclusion are set out in detail in Chapter 4 below.

both to the antiquity of much of the existing law and to some of its more obvious deficiencies. There had been no recent authoritative review of any of the matters dealt with in the British Medical Association publication.

4. Our enquiries have amply confirmed that the time was ripe for a comprehensive enquiry. The law relating to the certification of the cause of death has been developing since 1837 (when the Births and Deaths Registration Act 1836 came into force), but it has not been reviewed by an officially appointed independent body since 1893 (when the report of a Parliamentary Select Committee was published). The law relating to coroners is even older. In statute form it is chiefly contained in 19th century legislation, but much of this is, itself, only a consolidation of earlier and, in some cases, very obscure provisions.[1] The report of a House of Commons Select Committee on Coroners published in 1910 (Cd. 5004) resulted in legislation in 1926, but the title of this Act, the Coroners (Amendment) Act 1926, betrays the fact that, important though some of its provisions are, it left the 19th century legislation still predominantly intact. A departmental committee on coroners reported in 1936 (Cmd. 5070) and some of its recommendations passed into law in the Coroners Rules 1953, but the enquiry was concentrated on particular aspects of a coroner's work and did not subject the office itself to a fundamental review. Moreover this Committee was prevented by its terms of reference from considering related matters such as the law relating to the certification of the medical cause of death and the law relating to the disposal of dead bodies.

5. The general law covering the procedures to be followed before the disposal of dead bodies may be carried out is also old and has been in need of a comprehensive review. To a large extent, it exists only as a by-product of the law relating to registration of deaths and the reporting of deaths to coroners. The picture is also complicated by the fact that, superimposed on the general provisions relating to disposal, there is a completely separate procedure relating only to cremation. The law governing cremation has scarcely changed since 1903, when the report of a departmental committee (Cd. 1452) resulted in the making of Regulations under the Cremation Act 1902 to control what was then regarded as a rather bizarre method of disposal. The current cremation law is contained in Regulations made in 1930, which we have found to be widely regarded as being ill-drafted and in several ways unsuitable for present conditions. The Regulations were reviewed by an interdepartmental committee of officials in a report made to the Home Secretary in 1950 (Cmd. 8009), but this report did not look at the fundamental basis for a separate law relating to cremation and, although one or two minor additions and alterations have been made to the law since that date, the Committee's recommendations seem, as a whole, to have passed into oblivion. Representatives of the cremation organisations have, in recent years, made no secret of their desire to see a radical reform of cremation law.

[1] The coroners' jurisdiction over treasure trove is a case in point. The Coroners' Act 1837, section 36 enacts that "a coroner shall continue as heretofore to have jurisdiction to enquire of treasure that is found, who were the finders and who is suspected thereof." These words are an exact translation from the Latin of an earlier medieval statute.

The scope of our enquiry

6. Against this background, the terms of reference given to us were—predictably—much more extensive than those given to any previous enquiry. When we were appointed it was made clear to us, by the then Home Secretary, that we were to concern ourselves not only with the procedure for determining the medical cause of death and for investigating unusual or suspicious deaths, but also with such matters as the procedure for dealing with still-births and for disposing of dead bodies, as well as with related matters such as the effects of embalming, the provision of pathology services and mortuary accommodation. There are several reasons why it has taken longer than we expected to complete our investigations into all these matters, but not the least of these has been the necessity to uncover and examine their many and often complex inter-actions and relationships.

7. The subject matter of this report is death and its consequences. We have been concerned with aspects of death from the moment when it occurs up to the moment when the arrangements made for the disposal of the body of a deceased person are completed and even afterwards. We have enquired into where death happens, how it happens, why it happens and what happens to a body after death. But within the context of our enquiry, death is not an abstract term or even a statistical concept; our enquiries have been concerned with individual deaths and their consequences for other individuals and groups. Over half a million persons die in England and Wales every year: the consequences of their death affect several times that number of persons. Few people find themselves intimately concerned with the consequence of death on more than two or three occasions in their own lifetime. When they are so concerned, they are very naturally in a highly emotional state and seldom in a very objective state of mind. These intensely personal factors so influence what is, in the individual case, a poignant experience that reliable first-hand evidence of the working of the present procedures is difficult to obtain and assess. Throughout our enquiries therefore, we have had constantly in mind the way in which changes in the law and practice relating to the matters within our terms of reference might either increase or diminish the distress and anxiety which death almost inevitably brings to the bereaved.

The evidence

8. Our witnesses put few proposals to us for fundamental changes in the law. The evidence we received, taken as a whole, revealed no widespread or profound dissatisfaction with the existing arrangements which fell within our terms of reference. To our regret, however, this did not enable us to form for ourselves a clear view of how these arrangements worked in practice. In particular, we found ourselves without any clear idea of how the operation of existing law and practice affected people as individuals. We found it necessary therefore to supplement the evidence of our witnesses with information gleaned from a number of original enquiries or surveys which we either carried out ourselves or which we arranged to be carried out on our behalf.

9. In order to help us assess some of the general criticisms that have been made from time to time, about coroner's enquiries in particular, we asked the Home Office on our behalf to commission two surveys of public opinion. The

first, conducted by National Opinion Polls Limited, was a random survey of what the public knew and thought about the coroner and his responsibilities. Although the persons taking part in this survey were selected at random, they inevitably included a certain number who had, themselves, at one time been involved in coroners' proceedings. The second survey, conducted by Sales Research Services Limited, was concerned with the attitudes and feelings of the relatives of persons whose death had been reported to the coroner. The findings of these two public opinion polls form a very important part of our evidence and we are grateful to all those who co-operated to make their publication possible. We are also grateful to the O and M Branch of the Home Office who, at our request, conducted a study of the work of the coroner's officer in a representative sample of urban and rural jurisdictions and whose Report provided invaluable information about the working of the coroners' system on the ground. We draw extensively on the findings of the work study in Part V of this Report.[1] The other " special " enquiry which we should mention here is a survey of post-mortem examinations carried out for coroners in the last quarter of 1968 which identified the doctors carrying out the examinations and the places where they were performed. This provided us with a most helpful insight into the working of the existing law in this field and is referred to in more detail in Chapter 22 below.

10. Both our thinking and our conclusions are based on the evidence which has been put to us, but we have decided not to burden our Report with too many detailed references to the views and arguments of our witnesses. We identify the views of individual witnesses or organisations only where the context suggests that identification will be helpful. Our definitive recommendations are summarised on pages 346 to 360 below, but reference must be made to the appropriate places in the main text for a full explanation of our proposals.

What should the law seek to achieve?

11. The law which we were asked to review serves many different objectives. These have rarely been spelled out in detail either in previous reviews or in statements by Ministers and the objectives which we have noted may not always agree with the conscious aims of those who introduced the legislation.[2] The coroner, for example, had existed as an official in the English legal system for hundreds of years before any attempt was made to introduce a system of universal certification of death or to place the arrangements for disposal of the dead on a regular footing. In our view, the main aim of public policy in all the fields which we have reviewed should be to ensure that the cause of every death is determined and recorded as accurately as possible. The many different objectives served by the present law (e.g. the recording of causes of death for statistical or research purposes, the investigation of an unusual or accidental death, the identification of new hazards to life, or the provision of a safeguard against secret homicide) are all more likely to be achieved within a framework of law and administration which is designed with this purpose in

[1] Since much of the information obtained by the Work Study team was given in confidence we have not published their Report to us.

[2] In view of the haphazard way in which the legislation reached the statute book it would be surprising if either that legislation or its administration disclosed a fundamental purpose or underlying theme which would link the various matters within our terms of reference.

view. Moreover, it is through a procedure aimed at determining the cause of every death accurately that those kinds of deaths which may be preventable can be identified and the appropriate action taken.

How is this objective to be achieved?

12. At present, the responsibility for certifying causes of death in England and Wales is divided between medical practitioners and coroners. In approximately 4 out of 5 cases, a medical certificate of the cause of death is given by a medical practitioner who has attended the deceased person in his last illness on the basis of his clinical knowledge of his patient's illness, aided in an increasing number of cases by post-mortem investigations. In the remaining cases, the cause of death is certified by a coroner after either an autopsy or an inquest or both. (It is rare for an inquest to be held on any death which has not also been the subject of an autopsy.) An awareness of the growing inter-dependence of doctor and coroner as agents in the process of certifying the cause of death is vital to an understanding of the present situation.

13. There is still a tendency to regard the coroner's role as being primarily directed to the investigation of suspicious deaths and, in particular, possible homicides. This belief had some basis in fact a hundred years ago but is now completely out-moded. Well over three quarters of coroners' work at the present time serves the same purpose of routine certification of the medical cause of death as work undertaken by medical practitioners. The changes in the coroner's functions have taken place gradually, probably without any conscious intent, over a long period of time; this may explain why they have largely gone unrecognised by earlier reviews. We cannot too strongly emphasise our own conclusion that the coroner's primary function, at present, is to help to establish the cause of death in a wide range of situations, few of which have any criminal or even suspicious, overtones. In essentially the same way as the medical practitioner who signs a medical certificate, the coroner is concerned with establishing the cause of death.

14. For a number of reasons, there are occasions when it is either impossible or undesirable that the cause of death should be certified by a medical practitioner acting alone and unaided, for example when the doctor called to attend a dead person has no previous knowledge of that person's clinical history or when the doctor, although he has been treating the patient regularly before the death, has not expected the death to occur when it did. In circumstances such as these, and in others which we shall discuss in more detail later in this Report, it is desirable, in the interests of accurate certification of the causes of death, that the death should be certified after an autopsy. Coroners, who have power to arrange and pay for such an autopsy, and whose decision that an autopsy shall be performed is virtually beyond challenge, are now responsible for arranging approximately two-thirds of all autopsies performed in England and Wales every year. In theory, it might be possible for the coroners' functions in certifying the medical cause of death to be carried out by some other official and we have considered this possibility; but we have concluded, for reasons which will become clear later in this Report,[1] that

[1] See Part II, Chapter 9, below.

the balance of advantage lies in retaining and strengthening the link between the coroner and a doctor.

15. Those deaths whose causes are, at present, not certified by doctors and which are, instead, certified by coroners, fall roughly into two categories: those in which all that is required is an enquiry that will produce an accurate medical cause of death and those in which an investigation of the circumstances as well as the medical cause is needed. In theory, it might be possible for responsibility for enquiring into the two categories of death to be divided so that, for example, deaths in the first category might become the responsibility of an official with a medical background (either a doctor or an administrator) and responsibility for the second kind of enquiry might devolve upon someone with a legal background or perhaps even the police. But, in practice, such an arrangement could not work. The circumstances in which it is decided that a death shall not be certified by a medical practitioner do not always allow a simple, clear-cut distinction to be made between " natural " deaths in which all that is required is an autopsy to establish the medical cause of death and deaths in which, for whatever reason, some enquiry into the circumstances is also necessary. The distinction only becomes apparent after some enquiries have been made and sometimes only after the results of an autopsy are known. There must therefore be a procedure for identifying the unusual death and for ensuring that a preliminary investigation is made. The first task is carried out now, in fact if not in law, by doctors, with registrars of death acting as " long-stops," and the second by coroners. We propose that in future, both the doctor and the coroner should have a more clearly defined position in the procedure for certifying the causes of death and that the former should have a legal obligation to report certain deaths for further enquiry. The registrar should retain his " long-stop " function.

16. We have concluded that the major responsibility for identifying deaths which require further investigation should rest, in law as well as in fact, with the medical profession, although other persons should be required to report deaths in certain circumstances; and, secondly, that the existing coroner's service, subject to modification which we propose in Part III, is worthy of retention. But it will be clear from our discussion in Part II, of the way in which the coroner's several functions are carried out in other countries that the reasoning which led us to prefer a legal official, who could call on the necessary medical services, could equally have led us to prefer an administrator who could call on either medical or legal services. We suggest, in our Conclusion where we take a look at possible longer term developments, that there might be an advantage in establishing closer links between the coroner and a modified death registration service. We believe that the changes in the organisation and practice of coroners which we recommend in Part III and IV below would not be incompatible with such a development.

PART I

MEDICAL CERTIFICATION OF THE CAUSE OF DEATH

CHAPTER 1

THE FACTUAL BACKGROUND

1.01 The total *number* of deaths occurring in England and Wales every year is a fairly constant figure. It is very much the same now as it was at the beginning of this century, although the death *rate* has fallen considerably. Thus, in 1897, for example, there were 541,487 deaths in a population of 31,055,355 persons. Seventy years later, in 1967, there were 542,516 deaths in a population of 48,390,000. But it is not simply the death rate which has changed in seventy years. There have been great changes also in what we shall describe as the " pattern of death ", i.e. in the places in which death occurs, in the causes of death and in the relative number of deaths in which the cause has been ascertained and certified by a doctor or by a coroner, or with or without the aid of an autopsy. There has also been a radical change in the method of disposing of dead bodies: cremation,[1] which was only just beginning in this country at the turn of the century, is now the most common method of disposal. For the most part, as we shall see in the next chapter, the present law relating to the investigation and certification of the cause of death and to the disposal of dead bodies evolved at a time when the pattern of death, as well as the pattern of life, was very different from what it is today. It has been our task to consider whether, and if so how far, this law is still relevant to modern conditions. In this chapter we examine briefly the changes which have taken place.

TABLE A

The place of death, 1897–1967

Source: The Registrar General for England and Wales

	Lunatic Asylum	Hospitals	Workhouses	Elsewhere	Totals
1897	7,175 (1·3%)	23,836 (4·4%)	40,895 (7·6%)	469,581 (86·7%)	541,487
1907	10,541 (2%)	35,062 (6·7%)	52,673 (10%)	425,945 (81·3%)	524,221
.	.	.	.	.	.
.	.	.	.	.	.
.	.	.	.	.	.
1957	15,060 (2·9%)	225,345 (43·8%)	14,928 (2·9%)	259,537 (50·4%)	514,870
1967	16,708 (3·1%)	279,543 (51·5%)	19,165 (3·5%)	227,100 (41·9%)	542,516
	Psychiatric Hospitals	Other Hospitals	Other Institutions	Elsewhere	Totals

1.02 First there are changes in the *places* at which the predominant numbers of deaths occur. Table A above illustrates changes which have occurred between 1897 and 1967.

[1] We mean the modern practice of cremation. The burning of human remains was a practice followed in some parts of the country in pre-Christian times.

Although it has not been possible, for the early years, to identify deaths in the home separately from deaths that occurred elsewhere than in asylums, hospitals and workhouses, there can be no doubt that seventy years ago the great majority of deaths occurred at home because there were few satisfactory facilities in other places for the care of the dying. Seventy years later the position has changed remarkably: today well over half of all deaths occur in hospitals or other institutions and this proportion of total deaths continues to rise.

1.03 Changes in the principal *causes* of death over the seventy year period are even more striking. Table B below shows, for selected years, the number of deaths from those causes which in 1897, accounted for more than 10,000 deaths.

TABLE B

Selected causes of death, 1897–1967

Source: The Registrar General for England and Wales

	1897	1927	1947	1967
Measles	12,711	2,622	622	99
Whooping Cough	11,431	3,681	905	27
Dysentery	26,099	95	77	45
Cancer (Malignant Neoplasms) ...	24,443	54,078	77,649	110,072
Tuberculosis	47,080	38,173	23,075	2,043
Premature Birth	17,779	13,346	8,433	5,301
Old Age (Senility)	28,618	22,753	14,467	3,794
Apoplexy (Vascular Lesions)	17,837	25,238	58,224	77,147
Convulsions (Epilepsy)	18,384	2,285	1,576	645
Diseases of Circulatory System ...	50,243	97,778	164,015	201,915
Bronchitis	46,839	33,021	31,469	27,811
Pneumonia	34,833	37,242	32,659	32,126
Enteritis	13,267	6,197	5,658	1,673
Ill Defined Causes	23,057	1,085	457	108
TOTAL (all causes)	541,487	484,609	515,591	542,516

The figures in Table B cannot be regarded as completely accurate since, over the seventy year period, there have been changes in terminology, classification, and diagnosis. But the figures are accurate enough to give a clear indication of the major trends. In particular, they show that the infectious diseases which caused so many deaths around the turn of the century have now virtually disappeared while, in contrast, those diseases principally of later life, whose causes are slow-acting, such as heart disease, strokes and cancer, have shown a marked increase. The figures in Table B also give some indication of the improvement in diagnostic skills which has taken place over the same period. The number of deaths attributed to vague or unspecified causes has fallen steadily. In 1897 over 28,000 deaths were attributed to old age, compared with less than 4,000 assigned to senility in 1967, and there are today barely one hundred deaths of unspecified cause compared with over 23,000 ill-defined deaths at the end of the last century.

1.04 The present situation is illustrated in more detail in Table C opposite, which analyses deaths which occurred in 1969 by cause and by place of

TABLE C

Deaths by cause according to type of institution etc. in which they occurred, 1969

Source: The Registrar General for England and Wales

Cause of death	Total deaths	Psychiatric hospitals	Other hospitals and institutions for the care of the sick	Other institutions	At deceased person's own home	In other private houses and other places
Accidents, poisonings and violence (external cause)	23,300	447	11,907	102	4,827	6,017
All causes	579,378	17,877	308,267	19,896	201,213	32,125
Infective and parasitic diseases ...	3,922	143	2,686	56	911	126
Neoplasms	116,035	1,148	70,623	1,295	39,536	3,433
Endocrinic, nutritional and metabolic diseases	6,652	155	4,588	134	1,619	156
Diseases of blood and blood-forming organs	1,878	29	1,347	50	413	39
Mental disorders	1,329	548	572	37	147	25
Diseases of the nervous system and sense organs	6,357	355	4,191	262	1,412	137
Diseases of the circulatory system	293,757	8,486	134,295	13,409	118,720	18,847
Diseases of the respiratory system ...	86,156	5,779	46,975	3,542	27,263	2,597
Diseases of the digestive system ...	14,105	267	11,297	218	2,077	246
Diseases of the genito-urinary system	8,071	273	6,052	175	1,444	127
Complications of pregnancy, childbirth and the puerperium ...	155	3	131	—	11	10
Diseases of the skin and subcutaneous tissue	341	43	236	9	48	5
Diseases of the muscula-skeletal system and connective tissue ...	2,365	43	1,733	66	496	27
Congenital anomalies	4,472	66	3,776	18	486	126
Certain causes of perinatal morbidity and mortality	6,639	—	6,509	—	88	42
Symptoms and ill-defined conditions	3,844	92	1,349	523	1,715	165

occurrence. Table C shows that, taking deaths from all causes, most people die in hospitals or other institutions.

1.05 The most significant changes of all have taken place in the *process of certifying the cause of death.* At the beginning of this century, most deaths were certified by general practitioners without reference to a coroner and without the benefit of an autopsy to confirm a clinical opinion. Since that time, the hospital doctor has taken over from the general practitioner the leading role in the process of certifying the cause of death—a natural result of the fact illustrated in Table C that more deaths now take place in hospital than at home. But the coroner has also come to play an increasingly important part in the same process; and the proportion of all deaths whose cause is certified after an autopsy has risen to a figure of just over one in four (see Table D opposite which analyses deaths by method of certification).

1.06 Table D shows that the cause of death in nearly one fifth of all deaths which occurred in 1969 was registered on the authority of a coroner rather than on the basis of a certificate provided by a medical practitioner. It has not proved possible to provide a similar table illustrating the way in which deaths were certified at the beginning of this century, but the statistical information which has been made available to us by the Home Office and the General Register Office suggests that, at that time, about 10 per cent of all deaths occurring in England and Wales were the subject of enquiries by a coroner. An analysis of coroners' work since 1901 can be found in Appendix 2.

1.07 Table D also illustrates a situation to which we draw attention in more than one place in this Report, namely that the coroner is now a part of the ordinary process of certifying the medical cause of death and not simply an agent for enquiring into violent or suspicious deaths. Of all deaths certified by coroners in 1969, nearly 80 per cent were certified solely on the basis of the information provided by an autopsy, a procedure which a coroner is forbidden by law to follow if he has any reason to suppose that the death may be due to a violent or unnatural cause.[1] The table indicates that a very large number of the deaths whose cause was certified by coroners in 1969 were due to the common natural diseases—predominantly vascular diseases of the heart and central nervous system and cancer.

1.08 The number of deaths whose cause is certified after an autopsy has risen steadily in this century in line with the growth in pathological services, which had hardly begun to develop on a national scale at the beginning of this century. Table D indicates that, in 1969, about 153,000 deaths (over a quarter of the total occurring in that year) were certified in this way, either because an autopsy had been ordered by a coroner or because a " voluntary " autopsy had been performed in hospital. There were nearly 47,000 autopsies carried out otherwise than on the authority of a coroner.

[1] It is true that the Table indicates that certification after an autopsy and without an inquest was the procedure adopted in a small number of cases of violent death, e.g. under the heading " All other accidents." We asked the Registrar General to make some enquiries and we were informed that although the cause of death selected for statistical purposes implied violence in the technical sense, coroners had taken the view that " violence " was not a significant factor in these deaths. We understand that very much the same explanation applies to the inclusion of a few apparently " violent " deaths in the total certified by medical practitioners.

TABLE D

Analysis of selected deaths by method of certification, 1969

Source: The Registrar General for England and Wales

Cause of death	Total deaths	Coroner				Certifying medical practitioner				Total
		Inquest held		P.M. without inquest	Total	After P.M.	Operation mentioned on certificate	Other examination mentioned	No examination mentioned	
		With P.M.	Without P.M.							
All causes	*579,378	19,504	5,644	90,590	115,738	42,920	7,476	1,235	411,312	462,943
Enteritis and other diarrhoeal diseases	730	18	7	295	320	137	2	—	271	410
Tuberculosis of respiratory system	1,092	58	13	247	318	166	3	5	599	773
Other tuberculosis, including late effects	748	12	—	154	166	111	27	2	442	582
Meningococcal infection	117	1	2	51	54	29	—	—	34	63
Syphilis and its sequelae ...	226	1	—	76	77	25	—	—	124	149
All other infective and parasitic diseases	1,009	31	9	175	215	262	2	—	529	793
Malignant neoplasms	114,704	301	71	5,487	5,859	10,507	5,277	1,148	91,879	108,811
Benign neoplasms and neoplasms of unspecified nature	1,331	26	9	236	271	268	64	24	703	1,059
Diabetes mellitus	4,720	7	2	436	445	458	82	—	3,729	4,269
Avitaminoses and other nutritional deficiency	192	7	2	18	27	32	—	—	133	165
Anaemias	1,651	6	1	119	126	209	1	1	1,313	1,524
Meningitis	382	5	—	107	112	115	1	—	154	270
Active rheumatic fever	22	1	—	12	13	4	—	—	5	9
Chronic rheumatic heart disease	7,512	27	6	1,918	1,951	926	184	—	4,442	5,552
Hypertensive disease	10,949	29	10	2,597	2,636	663	1	1	7,632	8,297

* " Total deaths " slightly exceed the sum of those in the remaining columns since they include a small number of uncertified deaths.

TABLE D—*continued*

Analysis of selected deaths by method of certification, 1969

Source: The Registrar General for England and Wales

Cause of death	Total deaths	Coroner				Certifying medical practitioner				
		Inquest held		P.M. without inquest	Total	After P.M.	Operation mentioned on certificate	Other examination mentioned	No examination mentioned	Total
		With P.M.	Without P.M.							
Ischaemic heart disease	139,428	391	84	42,468	42,943	6,455	5	3	89,626	96,089
Other forms of heart disease ...	30,693	76	14	2,614	2,704	1,075	8	—	26,867	27,950
Cerebrovascular disease	79,728	103	21	6,135	6,259	3,262	13	2	70,137	73,414
Influenza	4,734	8	1	611	620	152	—	1	3,957	4,110
Pneumonia	41,081	135	25	5,447	5,607	2,947	—	1	32,513	35,461
Bronchitis, emphysema and asthma	33,957	325	44	5,142	5,511	1,765	4	2	26,652	28,423
Peptic ulcer	4,157	52	8	1,290	1,350	1,042	251	4	1,508	2,805
Appendicitis	375	12	1	108	121	96	49	—	108	253
Intestinal obstruction and hernia	2,506	36	6	805	847	515	270	2	871	1,658
Cirrhosis of liver	1,578	78	22	339	439	337	9	1	792	1,139
Nephritis and nephrosis	2,441	7	1	169	177	402	8	2	1,851	2,263
Hyperplasia of prostate	1,454	9	3	180	192	198	218	9	837	1,262
Abortion	35	21	5	7	33	1	—	—	1	2
Other complications of pregnancy, childbirth and the puerperium. Delivery without mention of complication	120	17	4	66	87	22	1	—	10	33
Congenital anomalies	4,472	37	4	1,005	1,046	1,449	84	5	1,880	3,418
Birth injury, difficult labour and other anoxic and hypoxic conditions	3,617	15	1	178	194	1,770	—	—	1,647	3,417

TABLE D—*continued*

Analysis of selected deaths by method of certification, 1969

Source: The Registrar General for England and Wales

Cause of death	Total deaths	Coroner				Certifying medical practitioner				
		Inquest held		P.M. without inquest	Total	After P.M.	Operation mentioned on certificate	Other examination mentioned	No examination mentioned	Total
		With P.M.	Without P.M.							
Other causes of perinatal mortality	3,022	7	—	59	66	719	—	—	2,224	2,943
Symptoms and ill-defined conditions	3,844	77	21	39	137	29	2	—	3,663	3,694
All other diseases	53,451	814	186	11,170	12,170	6,707	858	22	33,666	41,253
Motor vehicle accidents	6,628	5,325	1,284	7	6,616	2	—	—	2	4
All other accidents	11,545	7,477	2,638	809	10,924	56	52	—	499	607
Suicide and self-inflicted injuries ...	4,326	3,323	997	5	4,325	—	—	—	1	1
All other external causes ...	1,718	1,340	346	10	1,696	7	—	—	11	18

1.09 Under the existing law,[1] a coroner is required to investigate every violent or unnatural death or sudden death the cause of which is unknown. If he has reason to believe that the death was violent or unnatural he must hold an inquest, but if, after seeing the report of an autopsy he is satisfied that a death is not violent or unnatural, he may decide not to hold an inquest. Table D indicates how extensively coroners make use of this power to dispense with an inquest. It also suggests that, leaving aside the more obviously violent deaths, the deaths which are reported to and investigated by the coroner are not noticeably restricted to any specific causes of death. It would appear that a doctor usually reports a death to the coroner either because he feels unable to identify the cause with certainty or because the circumstances in which the death occurs are such as to bring it within a coroner's jurisdiction and that he only rarely makes a report because he considers that the cause of death itself is what makes an investigation by the coroner desirable. In Chapter 6, we consider in more detail both the type of death and the circumstances surrounding a death which in our view make it necessary for a doctor to decline to give a medical certificate of the cause of death.

1.10 Another major change in practice which has taken place rapidly in the last 25 years concerns the method of disposing of dead bodies. In 1945, under 8 per cent of all persons dying in England and Wales were cremated, but by 1970 the figure had risen to 56·7 per cent: cremation is now the more common method of disposing of dead bodies. In Part VI of our Report we examine the growth of cremation and consider, in detail, the changes needed in the medical certification required before disposal can be permitted.

[1] Section 3 of the Coroners Act 1887, as amended by section 21 of the Coroners (Amendment) Act 1926.

CHAPTER 2

HISTORY OF MEDICAL CERTIFICATION OF THE CAUSE OF DEATH

Introduction

2.01 To this day there is no specific statutory requirement that the cause of every death should be medically certified. Nevertheless, the number of uncertified deaths is now negligible. This situation is the result not of any express provision relating to medical certification as such, but of the interaction of a number of statutory requirements bearing on the registration of deaths and the disposal of bodies. For this reason the certification of the medical cause of death cannot be considered in isolation from death registration and disposal and the following historical review accordingly touches on all three subjects.

Births and Deaths Registration Act 1836

2.02 The first positive step towards the certification of the medical cause of every death was taken on 1 July 1837, when the Births and Deaths Registration Act 1836 came into operation. With regard to deaths, this Act had two main purposes: first, to facilitate legal proof of death and, secondly, to produce more accurate mortality statistics. The Act provided for the registration of every death which occurred in England and Wales and prescribed a form of register which included a space for "cause of death." There were, however, a number of factors which reduced the effectiveness of the Act.

2.03 The first weakness of the Act was that while it created a new central organisation by providing for the appointment of a Registrar General and for the establishment of a General Register Office, it entrusted the appointment of suitable registration officers to the Boards of Guardians recently established under the Poor Law Act of 1834 and gave the Clerks to those Boards the first option on the posts of superintendent registrar. Most of the Clerks accepted appointment and many of the junior posts of registrar were taken by minor officials of the Boards. Although the local officers held appointments during the pleasure of the Registrar General and were subject to his directions, their emoluments consisted of fees received from the public rather than payment from a central source. Since their main employment and sources of income came from outside the registration service, it was, perhaps, inevitable that their registration duties were sometimes regarded as little more than a side-line.

2.04 The second weakness of the Act of 1836 was that the particulars of cause of death to be recorded in the register were not required to be obtained from a medical practitioner but were merely part of the information to be given by the informant[1] or, in inquest cases, by the coroner. Even where the informants passed to the registrar particulars they had obtained from medical

[1] The person giving information to the registrar about the death.

practitioners, discrepancies arose from the varying descriptions of cause of death adopted by different practitioners.

2.05 The third weakness was that while the Act made registration compulsory in all cases, no penalties were prescribed for failure to carry out this duty and as a result a small proportion of deaths was not in practice registered —an omission made easier by the fact that burial could take place before registration.

Progress between 1837 and 1874

2.06 From the outset many of the shortcomings of the Act of 1836 were recognised and administrative steps were taken to reduce them. The medical profession, through the Presidents of the Royal Colleges and the Master of the Society of Apothecaries, was asked by the Registrar General to give to the relatives of any dead person whom they had treated during his last illness a written statement of the cause of death to be shown to the registrar. In his instructions to registrars, the Registrar General required them to attempt to obtain the cause direct from any medical attendant qualified to act as informant, but in any case to incorporate in the register entry any written statement of cause by a medical practitioner. In 1843, the Registrar General published a " Statistical Nosology"[1] designed to secure some uniformity of descriptions of causes of death. This document was distributed to the medical profession and to coroners. Two years later, the Registrar General sent out books of death certificate forms to about 10,000 medical practitioners in England and Wales and it is from this date that we may trace the beginning of the present system of death certification. Nevertheless, for many years a significant proportion of all deaths continued to be registered without a medical certificate. The report of the Registrar General in 1860 indicated that, in 1858, rather more than 11 per cent of the total registered deaths in the country were uncertified in this way.

Births and Deaths Registration Act 1874

2.07 The Births and Deaths Registration Act 1874 confirmed the requirement to register all deaths and introduced penalties for failure to do so. This enhanced the reliability of the system. At the same time the Act placed a duty on any registered medical practitioner in attendance during a person's last illness to deliver to the registrar a written statement setting out the cause of death to the best of his knowledge and belief unless he knew that an inquest was to be held. The registrar was instructed that, where the death appeared to be due to violence or attended by suspicious circumstances, he should refer it to the coroner whether or not a medical certificate of cause of death was available, and should not register it until he had either been told that the coroner did not consider an inquest necessary or been notified of the verdict. The 1874 Act also did something to improve the quality of the certification of the cause of deaths of infant and still-born children. First, it made it an offence to bury the body of any deceased child as if it had been still-born; secondly, it provided that the body of a still-born child should not be buried without

[1] A classified list of causes of death.

production of a medical practitioner's certificate or a declaration by a parent or other qualified person or a coroner's order.

2.08 Although the 1874 Act went some way towards ensuring that the causes of deaths were subject to professional medical scrutiny and in appropriate cases to examination by a coroner, it fell far short of securing the certification of the cause of death in all cases prior to registration. One reason was that it restricted the giving of certificates for registration purposes to " registered " medical practitioners;[1] after 1874 any death which had been certified by an unregistered practitioner was classified as an " uncertified " death. Not surprisingly, in some areas there was an increase in the number of uncertified deaths. Moreover, while all deaths had to be registered whether their cause had been certified or not, there was still no obligation to effect registration before disposal of the body.

Progress between 1874 and 1893

2.09 In 1885, instructions from the Registrar General reiterated that in the absence of a medical certificate from a *registered* medical practitioner or a certificate from the coroner the cause of death should be entered on the best information available, if necessary on the basis of information contained in a certificate from an unregistered practitioner. In the same year, the Registrar General extended the rules for reference of deaths to the coroner. Registrars were required to refer to the coroner cases where the death was due to violence or involved suspicious circumstances, where the cause of death was stated to be " unknown " even if certified, or where the death was said to be " sudden " and was not certified by a *registered* medical practitioner. The coroner was expected to decide whether an inquest was necessary; he had, at that time, no power to dispose of a case otherwise than by holding an inquest. If he decided there was to be no inquest, registration then proceeded on the best information available. These new rules did not, however, eliminate the problem of the death which was not certified by a registered medical practitioner. In many cases, registrars still had no choice but to accept certificates issued by unregistered doctors, unqualified midwives or chemists.

Select Committee on Death Certification 1893

2.10 In 1893 a Select Committee of Parliament was appointed " to enquire into the sufficiency of the existing law as to the disposal of the dead, for securing an accurate record of the causes of death in all cases, and especially for detecting them where death may have been due to poison, violence or criminal neglect." The emphasis on the prevention of undetected crime reflected public concern at the time and this became manifest in the Committee's recommendations. These were designed to ensure that every suspicious case of still-birth and death was examined before disposal of the body. As we have noted, a considerable number of deaths were either uncertified or inadequately certified by a qualified medical practitioner—in 1891, the last year for which published statistics were available to the Committee, the proportion of uncertified deaths

[1] Previously certificates had been accepted if they had been given by *any* qualified practitioner, although many qualified practitioners did not come up to the standard required by the General Medical Council for registration. (The term " registered " medical practitioner owed its origin to the Medical Act of 1858, which set up the General Medical Council.)

was given as 2·7 per cent (or 16,152 out of a total of 587,925 deaths registered) —and the Committee produced recommendations intended to remedy this situation. They proposed that no death should be registered without production of a certificate of its cause by a registered medical practitioner or by a coroner after inquest; that before giving a certificate the medical practitioner should normally be required personally to inspect the body in order to establish the fact of death as well as its cause; and that in each district a qualified person should be appointed as "medical certifier" to deal with cases where the deceased had not been attended by a medical practitioner during his final illness. The Committee also recommended that still-births, which had not hitherto been registered at all or been subject to any control as regards disposal, should be treated in the same way as deaths. They were concerned by the possibility that deaths in early infancy might escape enquiry by being accepted as still-births. The remaining recommendations dealt with the disposal of dead bodies, over which there was at that time little control. The Committee proposed that burials should only be permitted on an order from the registrar after the death had been registered and this, coupled with the recommendations to ensure examination by a doctor before registration, would have meant that no corpse could be disposed of without some form of expert scrutiny.

Progress between 1893 and 1926

2.11 For many years very little action was taken on these important recommendations. The registration of uncertified deaths continued to be attacked by such bodies as the Public Control Committee of the LCC throughout the 1890s and the General Medical Council and the Institute of Undertakers. It was also deplored by the Departmental Committees on Cremation in 1903 and on Physical Deterioration in 1904. In 1905, the Registrar General issued new instructions, which repeated the basic rules of 1885 for reference to the coroner of particular categories of death, but reserved to himself a discretion in special cases to issue instructions to any registrar to report to the coroner *all* cases in which the cause of death was uncertified before registering such deaths. There is no evidence available to show how far the Registrar General exercised his discretion in subsequent years. In 1910 the Departmental Committee on Coroners found it necessary to urge again that all uncertified deaths should be reported to the coroner.

2.12 In 1914, administrative action was taken to ensure that in cases where a medical certificate was not provided by a doctor in attendance the death would be reported to the coroner. Legislative change had to wait until 1926. For a number of years previously, private Bills had been introduced with a view to implementing the recommendations of the 1893 Committee, but these regularly attracted criticisms that they would involve considerable public expenditure or were badly drafted or contained objectionable incidental matter. The 1926 Act also began life without Government support—it was taken over by the Government in the House of Lords.

Births and Deaths Registration Act 1926—Coroners (Amendment) Act 1926

2.13 The Births and Deaths Registration Act 1926 made it unlawful to dispose of the body of a dead person before a registrar's certificate or a coroner's

order had been issued. It required still-births to be registered and imposed restrictions on the disposal of the bodies of still-born children. Controls were also imposed on the removal of bodies into and out of England and Wales and certifying medical practitioners were required to give their certificates in the form prescribed by the Registrar General; they were not relieved of this duty because it was believed an inquest might take place.

2.14 Complementary provision was made in the Coroners (Amendment) Act of the same year, which provided that a coroner could require a post-mortem examination to be carried out on a dead body if he had reason to believe that the examination might prove that an inquest would be necessary. If the autopsy showed that the death was not violent or unnatural, the coroner could dispense with an inquest and report to the registrar the cause of death found by the person carrying out the post-mortem examination.

Progress since 1926

2.15 Backed by these new provisions, the Registrar General felt able (for the first time) to issue firm instructions to registrars to report all uncertified deaths to the coroner before registration. The list of other deaths to be reported despite the availability of a medical certificate was also extended. *Registration* of a death became virtually impossible without either a satisfactory medical certificate of cause of death issued by a registered medical practitioner or a notification from a coroner disclosing the cause of death as revealed by a post-mortem examination or a coroner's certificate after inquest. Since *disposal* of a dead body was impossible after 1926 except on the authority of a coroner or registrar—both of whom were concerned to see that the cause of death was properly established—and since relatives or other persons in charge of bodies have a natural desire to dispose of them, the end product of these changes was a situation in which the medical cause of death came to be established in virtually every case. There is still a small residue of "uncertified" deaths which are registered. They were about 1 per cent of all deaths in 1928, but, by 1967, they had fallen to 849 out of a total of 542,516 deaths (or less than 0·2 per cent). (These were cases in which the coroner, although deciding not to hold an inquest, did not see fit to have a post-mortem examination.) But the broad effect of the legislation passed in 1926 (which remains the law today) has been to produce a situation in which the cause of almost all deaths is medically certified by some competent person.

CHAPTER 3

REGISTRATION OF DEATHS—THE EXISTING LAW

3.01 In the previous chapter we have described the close interaction and interdependence between the procedure for certifying the cause of death (whether the certification is performed by a medical practitioner or a coroner) and the death registration system. This close relationship between the two systems of law sometimes seems to cause confusion about the difference between them. The use of the expression " death certificate " is a good illustration of this. The expression does not have any statutory significance and, as commonly used, has two meanings. It may be used to describe, first, the medical certificate issued by a medical practitioner (or the certificate issued by a coroner after an inquest) and, secondly, the copy of the entry in the death register which is usually issued to the informant at the time of registration and which commonly serves as a legal proof of death for insurance, probate and other purposes. An understanding of the process of registration (and the difference between the two kinds of certificate) is essential to any discussion of proposals for improvements in the certification process. In the following paragraphs, therefore, we give a brief description of the registration procedure, insofar as it bears on the subjects within our terms of reference.

3.02 Under the Births and Deaths Registration Act 1953, the death of every person dying in England and Wales and the cause of the death must be registered by the Registrar of Births and Deaths for the sub-district in which the death occurs. The local registrar must enter these particulars in a register kept for that purpose, from which certified copies may be supplied on request. Before a death can be registered, the cause of death must be certified by a doctor, or in certain circumstances, investigated by a coroner. A coroner may certify death in two ways. If he has held an inquest into any death, the coroner must send to the registrar within five days after the inquest finding is known a certificate giving information about the death and specifying the particulars required for registration. When he receives the coroner's " certificate after inquest," the registrar is required to register the death and the particulars as found at the inquest. If, on the other hand, a coroner decides after he has seen the results of the post-mortem examination, that it is not necessary to proceed to an inquest, he sends a notification of the cause of death as revealed by the post-mortem examination to the registrar on a form known as a Pink Form B.[1] In these cases, the registrar registers the cause of death as revealed by the autopsy.

Local registration service

3.03 Under the Registration Service Act 1953, registrars are appointed by the councils of counties, county boroughs and London boroughs. The finance for the service is provided by individuals (e.g. in fees for certificates),

[1] The " Pink Form " procedure is described in more detail later in this Report, see chapter 14 below.

Exchequer grant and, residually, from the rates. The present proportions are approximately: public–33%, Exchequer–39% and rates–28%. The offices in which registration takes place are provided and maintained by the local authority, the number and location of offices being fixed by that authority in the Local Registration Scheme, which is subject to the approval of the Secretary of State for Social Services. Hours of registrars' attendance are fixed by the Clerk to the Council, or Town Clerk, in accordance with the provisions of the Local Registration Scheme and subject to the requirements of the Registrar General, but registrars are expected, irrespective of their advertised hours of attendance, to register a death at any time if there is special urgency.

3.04 The duties of registrars are prescribed by Statute and by regulations made by the Registrar General with the approval of the Secretary of State for Social Services. Registrars are subject to the direction and control of the Registrar General in the performance of their duties and they hold office at his pleasure.

Particulars of deaths to be registered

3.05 The particulars prescribed by regulations[1] to be registered are—date and place of death, name and surname, sex (and maiden surname of a woman who has been married), occupation and cause of death, date and place of birth. The death must be registered by the registrar for the registration sub-district in which it occurred. Where a dead body is found and there is no information as to the place of death, registration is effected by the registrar for the sub-district in which the body was discovered.

Qualified informants

3.06 The persons qualified to give information for the registration of a death are specified in the Births and Deaths Registration Act 1953.[2] They are:

(*a*) any relative of the deceased present at the death or in attendance during the last illness;

(*b*) any other relative present in the sub-district where the death occurred;

(*c*) any person present at the death;

(*d*) the occupier or any inmate of the house where the death occurred, provided he knows of the death;

(*e*) a person causing the disposal of the body.

Additionally, where death does not occur in a house, any relative knowing the particulars to be registered and any person finding or taking charge of the body are qualified.

3.07 It is primarily the duty of the nearest relative qualified under (*a*) above to give information. If there is no such relative, the duty devolves onto each other qualified informant in turn until the death is registered.

[1] The Births, Deaths and Marriages Regulations 1968.
[2] Section 16.

3.08 The informant must attend personally before the registrar to give information for the registration of the death and to sign the register. Except where an inquest has been held (when the death is registered on the basis of a certificate issued by a coroner), there is no exception to the general rule that death cannot be registered without the personal attendance of a qualified informant before the registrar for the sub-district in which the death occurred.

3.09 Information for the registration is required to be given to the registrar in person by the informant within five days after death. If, however, within five days of death, the informant sends to the registrar a written notice of the death accompanied by a notice signed by the doctor that a medical certificate of cause of death has been signed, the five day period for personal attendance is extended to fourteen days.

The doctor's obligation

3.10 The doctor who attended the deceased person during his last illness is required to sign and deliver to the registrar a certificate in prescribed form stating the cause of death to the best of his knowledge and belief. At the same time, he is required to deliver to a qualified informant a notice to the effect that he has signed such a certificate. The means by which the medical certificate is to be delivered to the registrar are not prescribed. In practice, it is sometimes delivered by post but more often it is handed by the doctor to a qualified informant with instructions to take it to the registrar. There is no statutory obligation on a doctor to report any death to the coroner.

Reference to the coroner

3.11 It is the duty of the registrar to report a death to the coroner in cases where:—

(*a*) he is unable to obtain delivery of a duly completed medical certificate of the cause of death, e.g. because the deceased was not attended during his last illness by a registered medical practitioner;

(*b*) it appears from the medical certificate or otherwise that the deceased was seen by the certifying registered medical practitioner neither after death nor within fourteen days before death;

(*c*) the cause of death appears to be unknown or is expressed in terms which imply some doubt on the part of the certifier;

(*d*) he has reason to believe the death to have been unnatural, or directly or indirectly caused by any sort of accident, violence or neglect, or to have resulted from abortion or any form of poisoning, or to have been attended by suspicious circumstances;

(*e*) death appears to have occurred during an operation or before recovery from the effects of the anaesthetic;

(*f*) it appears from the medical certificate that death was due to industrial disease or industrial poisoning.

The registrar must also report to the coroner any alleged still-birth if he has reason to believe that the child was born alive. Further, if he has reason to believe that it is the duty of some other person or authority to report the death to the coroner, he has to satisfy himself that the death has been duly

reported or notified to the coroner. The registrar must refrain from registering any death which he has himself reported to the coroner, or which, to his knowledge, it is the duty of some other person or authority to notify, or which has been notified to the coroner, until he receives a coroner's certificate or a notification from the coroner that he does not intend to hold an inquest.[1]

3.12 Where a doctor reports a death to the coroner he is not relieved of his duty to issue a certificate of the cause of death but there is provision for him to state on the certificate that he has reported the death, so that the registrar will know that he must defer registration until he has heard from the coroner. Where no inquest is held but a post-mortem examination is made by direction of the coroner, the cause of death registered is that disclosed by the autopsy and conveyed to the registrar on the form known as Pink Form B.[2]

[1] This account of the registrar's obligations is a paraphrase of Regulation 51 of the Births, Deaths and Marriages Regulations 1968, as supplemented by the Registrar General's current instructions to registrars.

[2] See Chapter 14 below.

CHAPTER 4

WHAT IS WRONG WITH THE EXISTING ARRANGEMENTS FOR CERTIFYING DEATHS?

4.01 In the evidence we received we identified three main criticisms of the existing law and practice relating to the certification of the medical cause of death:

(i) the law does not require that the *fact* of death is always properly established;

(ii) the causes of death given on medical certificates of the cause of death and on the documents issued by the coroner to the registrar are not specified with sufficient accuracy;

(iii) violent or unnatural deaths (most notably, homicide) may be passed off as natural deaths.

We shall discuss each of these criticisms in turn.

A. *The fact of death*

4.02 The existing law does not *require* a doctor who has attended a deceased person during his last illness to see the body before issuing a medical certificate of the cause of death. For want of this safeguard, it has been suggested, a certificate may be given in respect of a person who is not dead.

4.03 We are aware of only two cases in which, without seeing a body, a doctor has given a medical certificate of the cause of death in the name of someone who was still alive. In one case, the doctor concerned gave a certificate in the wrong name.[1] In the other, a doctor relied on the statement of a lay person who was mistaken in supposing that death had occurred and who discovered her mistake soon afterwards.[2] The likelihood of a doctor mistaking the identity of a deceased person and giving a certificate should become extremely remote if steps are taken to implement the proposals which we put forward in Chapters 6 and 7. Which are designed to ensure that, before he issues a certificate, the doctor has greater personal knowledge of the deceased person than certifying doctors are now required to have.

4.04 We found general agreement among our witnesses that, in the vast majority of cases, death is not too difficult for a layman to recognise, so that, even if a doctor has not seen the body before issuing a certificate, the danger that a live person will be placed in a mortuary refrigerator or sealed in a coffin is extremely remote. The fact is, however, that in approximately 9 out of 10

[1] Taylor's Principles and Practice of Medical Jurisprudence, 11th Edition, 1956, Vol. 1, page 205. In this case, a doctor was informed of the death of an old lady who had been living in a house which was occupied by two old ladies. The doctor had been expecting the death of the other occupant, and, upon hearing that " the old lady has died," issued a certificate in the wrong name. Taylor does not say when this incident occurred.

[2] Lancet II, 1938, page 113.

of all cases[1] doctors do see the body before giving a certificate or, where the certifying doctor has not seen the body, some other doctor or responsible person has done so.

4.05 Some public concern has arisen from reports of persons being " certified " as dead who later proved to be alive, but, contrary to what seems to have been a general belief at the time, in none of these cases did a doctor give a medical certificate of the cause of death, let alone give such a certificate without seeing the body. In two of the three incidents about which we have seen reports a doctor called to deal with an apparently dead body, concluded, wrongly as it turned out, that the person was not dead. In the other case a judgment that death had occurred was made not by a doctor but by relatives, who called in a funeral director before informing the doctor. In this case it was the funeral director's staff who discovered that life was still present. The importance of these reported incidents is that they have drawn attention to the difficulties[2] that sometimes confront a doctor in determining that death has occurred when the person concerned has *not* been under continuous medical attention for a reasonable period.

B. *The Accuracy of Death Certification*

4.06 The suggestion that there is a considerable degree of error in the majority of certificates given by doctors was prominently featured by the British Medical Association in their Report " Deaths in the Community ". The main evidence on which the BMA based[3] this criticism was a paper published in 1962 by Dr. M. A. Heasman,[4] who was, at that time, a medical statistician in the General Register Office. Dr. Heasman's paper discussed a series of tests carried out in 75 hospitals, in which a comparison was made between a clinical diagnosis of the cause of some 9,500 deaths and the results of subsequent autopsies in the same cases. The object of the investigation was to estimate the likely effects on mortality statistics of an increase in the number of autopsies. In view of the importance of the conclusions which the BMA Committee saw fit to draw from this study, we made careful enquiry into its design. We set out the details in the following paragraphs.

4.07 For the purpose of the study, it was intended that for every death in each of the 75 hospitals taking part there should be completed by one of the clinicians who had been concerned in the treatment of the deceased person a "dummy " medical certificate of the cause of death. On the dummy death certificate, the clinician was asked to record the cause of death to the best of

[1] See Table E on page 41.

[2] It may be significant that two of the three recently reported cases of patients recovering after having once been given up for dead have concerned persons who, before their bodies were examined by doctors, had taken large quantities of tablets containing barbiturates. Barbiturate tablets are widely prescribed as sedatives and to relieve insomnia; and barbiturate poisoning is one of the common cases of coma. In extreme cases, we are advised, such a coma could be mistaken for death because it appears to eliminate breathing and heart beat, chills the body and produces deep unconsciousness with weak or totally non-existent reflexes. It is outside our competence to advise on clinical procedures or tests which a doctor should carry out before he satisfies himself that death has occurred, but we hope that doctors will not be slow to draw the appropriate conclusions from these widely reported although most infrequent occurrences.

[3] But see paragraph 4.12 below.

[4] Heasman, M. A., *Proc. Roy. Soc. Med.*, Vol. 55 (1962), page 733.

his knowledge and belief, but he was also given the opportunity to record any second opinion which he might have as to an alternative cause of death and to express a view on the certainty of his diagnosis. The completion of the dummy death certificate was followed in as many cases as possible by an autopsy. The pathologist who carried out the autopsy was invited to complete another certificate and it was intended that this second certificate should have been completed only after a full discussion between the pathologist and the clinician. It did not prove possible to determine in how many cases this discussion had, in fact taken place. Thus, in the words of the author of the Report, " although the pathologist's certificate was almost certainly more right more often than the clinician's, it would be wrong to assume that the pathologist's certificate was free from error ".[1]

4.08 All the certificates which were completed in the course of this exercise were sent to the General Registrar Office, where they were coded in the normal way using the International Classification of Causes of Death and the international rules of assignment. This meant that every death was assigned to a single underlying cause.

4.09 The two sets of certificates resulting from the investigation were then compared. If the cause of death on both certificates, as coded under the International Classification, was the same, the case was recorded as one of agreement regardless of any other variations in the conditions noted on the two certificates. Where the assignment was not the same, the " disagreements " were divided into two groups: those in which they appeared to be due to differences of fact and those which could be regarded as difference of opinion or wording. A disagreement of fact was recorded if the pathologist's underlying cause either revealed something not mentioned on the clinician's certificate or differential diagnosis or, alternatively, if the clinician's underlying cause was not found on the pathologist's certificate or notes of his findings. Some differences of opinion were judged by the researcher to be the result of an error in the completion of the certificate by either the clinician or the pathologist; others were judged to be due solely to the differences in wording in which, although both doctors had given different assignments, they had in fact been trying to say the same thing; and the remainder were cases in which, although the clinician and the pathologist had chosen different underlying causes, their statements satisfied the researcher that they were each aware of the condition chosen by the other.

4.10 Although 14,600 deaths were eligible for inclusion in the investigation, autopsies were performed in only 9,500 cases and the comparison was therefore limited to the smaller number. A comparison of the two sets of completed certificates showed that there had been complete agreement between the clinician and the pathologist in 45·3 per cent of the total number of deaths included in the survey. The autopsy revealed new facts in 25 per cent of the deaths in the survey, but the clinician had indicated that he was not particularly confident of his diagnosis in 2 out of every 5 of these cases. Thus, many of the cases in which there was disagreement as to fact were those in which the clinician was much less than certain in his opinion and, it may

[1] Heasman, M. A., *Op. Cit.*, page 733.

reasonably be held, would not, outside the conditions of the research project, necessarily have been prepared to complete a genuine medical certificate of the cause of death without further investigation, e.g. by asking the relatives of the deceased to agree to an autopsy being performed in the hospital or by reporting the death to the coroner instead of giving a certificate.

4.11 In his oral evidence, the author of the report gave as his opinion that the errors in diagnosis revealed by his investigation were not very serious from a statistical point of view because, in many cases, they evened themselves out. More importantly, he has strongly discouraged us from drawing from the figures mentioned in his report any direct conclusions as to the accuracy of death certification in general. From what he said to us we are satisfied that his report provides no support for the contention of the British Medical Association[1] that

> " It is unlikely that certification by general practitioners under domiciliary conditions would be any more accurate "

than the clinical diagnosis made by hospital clinicians for the purpose of this investigation. The general practitioner often deals with the more obvious causes of death and may have the advantage of a full clinical history of the patient, including perhaps the view taken by consultants during hospital treatment.

4.12 After giving very careful consideration to the written account of Dr. Heasman's investigations and after hearing his oral evidence, we have concluded that his findings reveal no grounds for widespread alarm about the general standards of certification by doctors. Nevertheless, two points of great importance to our own enquiry were very clearly revealed by his investigation. First, his study revealed that there was scope for improvement in the diagnosis of death from certain diseases. The propensity to error appeared to be greatest when the suspected cause of death was a cerebrovascular disease[2]—where over 40 per cent of cases showed a variation between the clinical diagnosis and the diagnosis after autopsy. Cancers, too, were fairly frequently assigned to the wrong primary site. Lung cancer was underdiagnosed for this reason rather than because of a misdiagnosis to one of the other respiratory diseases. It was also noteworthy that the tendency to error increased with the age of the patient.

4.13 Secondly, Dr. Heasman's study drew attention to the very great value of an autopsy as an instrument in the certification of the cause of death, especially when the autopsy is made by a pathologist with full knowledge of the deceased person's clinical history. At present, over one-quarter of all deaths in the community are certified after an autopsy but the Registrar General's statistics show that there is considerable variation in the proportion of deaths certified after autopsy according to the apparent cause of death and the age and place of death of the deceased person. The proportion ranges from a 90 per cent autopsy rate for deaths from delivery and complications of pregnancy, child-bearing and puerperium to a 12 per cent rate for vascular

[1] " Deaths in the Community," BMA, Tavistock House, London, 1964, para. 43.
[2] In this situation the satisfactory differentiation between cerebral haemorrhage and cerebral thrombosis is difficult both on clinical and pathological grounds.

lesions affecting the central nervous system. Deaths of very young children are usually certified after autopsy: 53 per cent of the deaths of children under five occurring in hospital are certified in this way and this figure rises to 78 per cent in respect of deaths occurring outside hospital. For the deaths of children outside hospital which are due to respiratory diseases, the proportion is about 90 per cent. Generally, the percentage of autopsies is lowest for deaths after age 65, where it is 25 per cent for deaths in hospital and 15 per cent for deaths occurring elsewhere.

4.14 These figures suggest that certifying medical practitioners are already aware of the special desirability of autopsies to establish the cause of death in certain circumstances and that they report deaths to the coroner in order that an autopsy may be performed; but Dr. Heasman's findings provide cogent evidence for the view that great care is necessary in deciding whether or not it is safe to certify the cause of death on the basis of clinical diagnosis alone. The recommendations which we put forward in the later chapters of this Part of our Report are intended to increase the number of autopsies performed in doubtful cases and in this way to improve the accuracy of the certification process.

C. *Undetected Homicide*

4.15 The existing law has been criticised on the ground that, under its provisions, deaths which are really homicide may be recorded as natural deaths. The main arguments are that it is possible under the existing law for a doctor to give a medical certificate of the cause of death without seeing the body and that there is a lack of any clear obligation on a doctor to bring any doubts which he may have about the cause of death to the attention of a responsible authority. More generally, there has been criticism of a lack of care by doctors in the completion of certificates and serious inaccuracy in the diagnosis of the cause of death. These arguments were forcefully expressed in a book published in 1960 by Dr. Havard,[1] and repeated in the BMA Report " Deaths in the Community " published in 1964.[2] Both publications contain some alarming assertions. Thus Dr. Havard in the introduction to his book wrote as follows:

> "... in practice, a substantial proportion of cases of homicide are accompanied by an attempt to get the death certified and registered and to get the body disposed of through the normal channels as a natural death."[3]

And, in the BMA Report, the statement was made that

> "the issue of a death certificate from ' natural causes ' is a fairly common finding in cases which are afterwards found to have been cases of homicide, e.g. on exhumation."[4]

Dr. Havard's book was cited as authority for this statement. Statements such as these, coming from eminent and respectable sources, have not unnaturally

[1] Havard, J. D. J., " The Detection of Secret Homicide," *Cambridge Studies in Criminology*, Vol. XI, 1960.
[2] " Deaths in the Community," BMA, Tavistock House, London. 1964.
[3] Havard, *op. cit.* Introduction p. xiii.
[4] BMA Report, *op. cit.*, paragraph 9.

aroused concern amongst the press and public and we therefore thought it right to examine the justification for them as carefully as possible. The successful detection of homicide is a matter of great public importance.

4.16 Certain preliminary points can be made at once.

(i) The evidence discussed in Dr. Havard's book is not extensive. Much of it is very old. Some of the cited cases are taken from evidence given to the Select Committees on the Protection of Infant Life, which reported in 1871, and on Death Certification, which reported in 1894. Other evidence quoted by Dr. Havard comes from that given to the Departmental Committee on Cremation (which reported in 1903) and on Coroners which reported in 1910. The Seddon case occurred in 1914. Half a dozen or so other cases were of more recent date but in some of these a doctor saw the body after death and refused to give a certificate—a circumstance which seems to us to indicate the efficacy of the existing arrangements rather than the reverse.

(ii) The important study by Dr. Heasman of 9,507 hospital deaths (to which we have referred in paragraphs 4.6–4.14 above and which did not disclose *any* cases of previously unsuspected violent death) was an exercise carried out in somewhat artificial conditions for a particular purpose. Dr. Heasman's own conclusions do not support the contention that there is a general lack of care by doctors in issuing medical certificates of the cause of death and none of our witnesses produced cogent evidence to support such an allegation.

(iii) While there is no obligation upon the certifying doctor to see the body before giving his certificate, the body is, in fact, seen after death in 9 out of every ten deaths occurring in England and Wales every year.[1]

(iv) Although there is no legal obligation upon doctors to report deaths to the coroner, the majority of cases reported to coroners are notified to them by doctors.

(v) The number of cases in which homicide has been discovered after exhumation (and, indeed, the number of exhumations) has always been extremely small.[2]

4.17 Although our witnesses did not give us any significant evidence on the matters raised by the British Medical Association we considered that they were much too important to be left in an inconclusive state; it could, for example, be argued that the absence of any evidence merely indicated that attempts to conceal a homicide as a natural death are invariably successful. Instead, we thought that, if there were an " iceberg " of secret homicide, the tip of it should be visible somewhere and we looked for this in three areas of enquiry:

(*a*) How often is unsuspected homicide revealed by an autopsy? Since the perpetrator of a disguised homicide will scarcely ever be in any

[1] See Table E on page 41.
[2] The significance of exhumations in the context of a discussion on secret homicide is discussed in more detail in paras. 24–31 below.

position to know whether the body of his victim will be subjected to autopsy, it seems probable that the proportion of unsuspected homicide will be similar both for deaths where there is an adequate post-mortem examination and deaths where there is not.

(*b*) How many deaths from homicide within a given period were originally registered as being due to natural causes?

(*c*) How often is suspicion of homicide a factor in the decision to order an exhumation?

(*a*) *How often is unsuspected homicide revealed by an autopsy?*

4.18 So far as we could discover (and we took evidence from police officers and pathologists on this point) very few previously unsuspected homicides are discovered after an autopsy. Our attention was drawn expressly to a review[1] of all the 28,108 autopsies carried out on behalf of coroners by the staff of the Department of Forensic Medicine at the London Hospital Medical College in the five year period 1963–1967. These autopsies led to 5,038 findings of unnatural death. 263 findings of unnatural death (i.e. about 5 per cent of all the unnatural deaths reviewed) were singled out for special mention in the published study because, it was explained, in these cases the initial report (from a doctor or a coroner's officer) either suggested that the death had been due to natural causes or did not indicate any contrary opinion. Among these 263 findings of what could be described as previously unsuspected unnatural deaths, there was 1 case of homicide (an old man of seventy-seven who had been smothered with a pillow) and 17 other cases (all deaths of infants) in which violence appeared to play a part.

4.19 It is necessary to emphasise that all these deaths had been reported to the coroner and therefore " caught by the system ". These were not deaths in which the first view of the doctor or other person dealing with the case was that all was in order: on the contrary they were reported to the coroner because a doctor was either unwilling or unable to give a certificate and the result of the autopsy in each case confirmed the correctness of the decision to make a report. In other words, the operation of the existing law and practice relating to the certification of death had been capable of identifying those deaths which needed special investigation. It should be reassuring that out of 28,108 deaths investigated in a five year period, only 1 case of homicide was found and that this was discovered as a result of the operation of the existing arrangements for reporting deaths to the coroner. It should also be reassuring that 17 deaths of young children in which violence appeared to have played a part were similarly " picked up by the system " and subjected to autopsy because of the operation of the existing law. We observed with regret that the treatment in the press of the report of this review reflected a completely different interpretation. We hope that our own statement of the context in which the review was carried out will help to put the quoted figures into their true perspective.

4.20 Taken by themselves the results of the survey carried out in the London Hospital have an important negative significance: they give no

[1] H. R. M. Johnson, *Medicine, Science and the Law* (Official Journal of the British Academy of Forensic Sciences), Vol. 9, No. 2, page 102.

support whatever to any contention that the problem of undetected homicide is potentially substantial. More positively, by demonstrating the possibility that a first judgment as to the cause of death may be proved wrong by a judgment following an autopsy, they add weight to the view (which we develop in some detail in Chapter 6) that doctors should report for further investigation all deaths about whose cause they may have the slightest doubt. The prime importance of the survey lies in the attention which it draws to the value of a thorough autopsy as an instrument of enquiry into all unusual deaths or deaths from an unknown cause.

(*b*) *How many registrations of deaths from homicide within a given period were originally registered as being due to natural causes?*

4.21 We noted the claim in the Report[1] published by the British Medical Association that it was " fairly common " in homicide cases to find that a certificate of death from natural causes was issued before suspicions were aroused. Our second enquiry, therefore, involved an examination of the way in which all deaths investigated by the police as possible homicides in a given period were initially certified and registered. We wanted to see whether in some of the cases which later came before the coroner or were the subject of criminal proceedings there was evidence indicating attempts to go through the normal processes of medical certification, registration and disposal as if the deaths had been natural. We readily accepted that if the assertions of Dr. Havard and the British Medical Association could be established by a survey over a reasonable period there would be grounds for believing that there are other cases where certification is followed by registration and disposal without arousing any suspicion.

4.22 At our request the General Register Office looked at all cases of homicide or suspected homicide investigated by the police in 1965 and again in 1967 to establish in what proportion of these the death was originally certified as natural and registered as such before any investigation was begun. In all the cases examined (more than 400) not one was found in which the death had been prematurely or wrongly registered as a natural one. In every case it appeared that an investigation into the circumstances of the death was begun before any of the steps normal in cases of natural death was taken. What inference can be drawn from these results? It could of course be claimed that, in this period, every attempt to pass off an unnatural death as a natural one was completely successful. No test can disprove a contention that is itself based on the absence of evidence. However, the results of our own enquiries have convinced us that suspicious deaths are invariably investigated well before the procedures for certification, registration and disposal are far advanced. Taken in conjunction with the evidence from autopsies that we have examined above (paragraphs 4.19–4.21), our enquiries lead us to conclude that the claim in the British Medical Association Report is not borne out by the facts.

(*c*) *How often is suspicion of homicide a factor in the decision to order an exhumation?*

4.23 We asked the Home Office to provide details of exhumations (whether ordered by a coroner or by the Home Secretary) over a convenient ten-year

[1] *Op. cit.* paragraph 9.

period in case this information might provide some kind of measure of the number of cases in which death is first certified in the normal way but some suspicion is subsequently aroused. It seemed reasonable to suppose that the number of such cases might be relevant to the question of undetected or unsuspected homicide in two ways: first, as an indication of suspicions only coming to light after burial and, secondly, as an indication how often these suspicions were justified. These details were given to us for the period 1959–1968. We accepted that this information would be of more limited significance than our first two enquiries. For example, it could have no relevance for what might have occurred where bodies had been cremated. It could give no positive guide to homicides in which no suspicions were ever aroused, nor to what might have been the position in other periods of comparable length. Nevertheless, we thought that it might provide an additional pointer to the possible existence of undetected homicide, as well as an indication of how far exhumation and subsequent post-mortem examinations serve a useful purpose.

4.24 A total of 20 exhumations were authorised in the period under review. They can be tabulated as follows:

	Exhumations ordered by coroners		Exhumations authorised by the Home Secretary for the purposes of justice	Total
	for the purposes of ascertaining the cause of death	for other reasons		
1959	2	1	1	4
1960	—	2	—	2
1961	1	—	—	1
1962	1	3	—	4
1963	—	—	—	—
1964	2	—	1	3
1965	2	1	—	3
1966	—	—	—	—
1967	1	—	—	1
1968	2	—	—	2
Total	11	7	2	20

Exhumations ordered by coroners for reasons not connected with the ascertainment of the cause of death are not relevant to this chapter and no further reference will be made to them. A summary of the available information about the other 13 cases is reproduced as an Annex to this chapter.

4.25 The grounds for the exhumation in the remaining 13 cases can be analysed as follows:

1. Doubt about cause of death, not amounting to imputation of homicide ... ... 5 (3, 7, 11, 12, 13)[1]
2. Allegations amounting to homicide:
   (*a*) by other persons 5 (2, 4, 6, 8, 9)
   (*b*) confession by person claiming to be responsible 2 (5, 10)
3. For defence purposes in proceedings for murder 1 (1)

[1] The figures in brackets relate to the Table of Exhumations reproduced as an Annex to this chapter.

4.26 Only the 7 cases listed at 2 are relevant to the question of undetected or unsuspected homicide. The outcome of the post-mortem examination in these cases was as follows:

1. The death was attributable to natural causes or was not inconsistent with such a diagnosis ... 4 (2, 4, 6, 9)
2. The condition of the body made it impossible to ascertain the cause of death 1 (5)
3. The autopsy confirmed foul play 1 (8)
4. There was a possibility of foul play 1 (10)

No proceedings were taken in any of the 5 cases listed at 1 and 2. In the other 2 cases criminal proceedings resulted in 1 conviction and 1 acquittal.

4.27 On the general question of the medical value of post-mortem examinations after exhumation, it is relevant that positive information about the cause of death was obtained as a result of exhumation in 10 of the 13 cases under review. The cause of death was definitely established to be natural or accidental in 8 cases and to be due to foul play in 2 cases. In the remaining 3 cases, the post-mortem examinations did not establish the exact cause of death because of insufficient evidence in two cases (10 and 11) and because the state of the body was such that no definite conclusion could be reached in the other (5). In the latter case, the body had been interred for 6 months. The exhumations where the body had been interred for 2 months or less (2, 3, 4, 6, 7, 8, 11, 12, 13) were the most revealing.

4.28 As part of this survey, the Home Office attempted to obtain information about the effects of embalming on the value of an exhumation, but the results were inconclusive. It was established that the bodies were not embalmed in 8 cases and that the body was embalmed in 1 case; in the remaining 4 cases this information was not available. In the one case where there certainly had been an embalming, it was suggested (by the coroner) that this was probably the reason for the good preservation of the tissues. It seems clear that the value of an exhumation diminishes as time passes, although it is worth noting that, in the majority of cases, sufficient information was obtained to establish whether or not suspicions of homicide were justified.

4.29 What significance is to be attached to the results of this survey? It would be wrong to conclude from the survey that it is impossible for a murder to be registered as a natural death. In 1958—that is outside the period of

our review—as a result of evidence gained from autopsies conducted after exhumations, a woman who may have murdered four husbands was found guilty of murdering two of them.[1] But the true significance of these figures can be appreciated only in their total context. In the ten year period we surveyed there were approximately 5,500,000 deaths, and 2,350,000 burials. Only twice in this period did the finding of an autopsy following exhumation indicate the possibility of homicide. In both cases there were criminal proceedings and in one case there was a conviction. But the circumstances of the latter case were such as to suggest that it should be excluded from our analysis. The death in question was from the beginning treated as a homicide—the original diagnosis showed the cause of death as asphyxia following injuries—and there was an autopsy before burial. It was only *after* a man had been committed for trial that it was decided to exhume the body in the hope of finding further medical evidence. In the other case, in which the man charged was also before the courts on other unrelated charges, a certificate of death from natural causes given by the deceased person's doctor was not shown to be wrong by the autopsy following exhumation. On no occasion in this ten year period was the finding of the autopsy after exhumation a sufficient justification in itself for the institution of proceedings for homicide.

4.30 Taken in conjunction with the results of the other enquiries we have discussed above, the findings from the survey of exhumations seem to us to confirm the indications that the statutory machinery has not permitted the concealment of unnatural death to any significant extent. Our considered view is that nothing revealed by our survey of exhumations goes any way to justify the contention of Dr. Havard and the British Medical Association[2] that " the issue of a death certificate from ' natural causes ' is a fairly common finding in cases which are afterwards found to have been cases of homicide ".

The opportunity for secret homicide

4.31 It was suggested to us that persons who are chronically ill (particularly if they are also old) are more likely than most other sections of the community to become the victims of undetected homicide. It was argued that since many chronically ill elderly people may be expected to die anyhow, there is an opportunity for them to be unlawfully killed by relatives or other persons allegedly caring for them, who may have the opportunity to disguise a homicide as a natural death. Because of the nature of the crime that is being alleged, the argument in support of the theory of secret homicide among the chronically ill must be based upon supposition allied to the existence of an opportunity rather than upon hard facts; but we must record that we were informed by protagonists of the theory of secret homicide that " the proportion of deaths from violence among persons suffering from chronic disease has been shown to be greater than amongst the general population "[3].

[1] R. *v.* Wilson, Leeds Assizes, 30th March, 1958.
[2] " Deaths in the Community," page 8.
[3] The quotation is from paragraph 12 of the B.M.A. Report, " Deaths in the Community," 1964, and reference was made to it by some of those who gave oral evidence to us.

4.32 We were puzzled about the precise significance that our witnesses wished us to attach to this statement. It would seem all too likely that old people and, particularly, old people who are also chronically sick, will provide a disproportionate number of vicitims in the various categories of death from *accidental* violence. This is, in fact, the situation. Statistics published by the Registrar General clearly indicate the importance of age as a factor in certain types of violent death, particularly accidents in the home and on the roads. Of the total number of fatal accidents in the home in 1968, nearly 70 per cent concerned persons aged 65 and over. For falls at home, the figure was over 90 per cent. For road accidents, deaths in this age group were not so predominant but they still accounted for nearly 50 per cent of pedestrian deaths and for over 25 per cent of all road user deaths. The Registrar General's figures do not distinguish between the aged and the aged who are also chronically ill, but common sense would suggest that the ailing or infirm (particularly the aged ailing or infirm) are more likely than the normal healthy population to be knocked down by motor cars or to fall down stairs, or be the victims of other straightforward accidents.

4.33 The source for the statement by the British Medical Association which we have already quoted was an article by Dr. Turkel, the coroner for the City and County of San Francisco published in the Journal of the American Medical Association in 1955.[1] Dr. Turkel's article contained the statement that " as a matter of fact, the proportionate incidence of certain types of violent death is higher in this group [persons suffering from hypertension, cardiac disease or carcinoma] than in the general healthy population ". Dr. Turkel did not elaborate this statement in his article or suggest what significance should be attached to it. However, believing that a matter of some importance might be involved, we asked our Secretary to write to Dr. Turkel in San Francisco in order to establish the context in which the statement was made. We were informed that the statement in Dr. Turkel's article referred only to deaths from suicide and that it was never his intention that it should be taken out of context and applied to violent homicidal deaths. We are satisfied that the statement quoted by the British Medical Association has no relevance to a discussion on undetected homicide.

4.34 All that we know about the deaths of the chronic sick which are, in fact, proved to be homicides[2] suggests that in these homicide cases, as in most other, the killer apparently makes little or no effort to disguise the fact that murder has been committed or his own part in the crime. It mostly happens in this type of case that the person responsible commits suicide after committing the murder or makes an immediate confession of his guilt. With the help of records made available to us by the Home Office we have examined the case histories of certain deaths which *prima facie* might have been concealed (i.e. in which there was a possible non-detectable method of killing readily available) but in all of these the killer appears to have chosen deliberately not to conceal his crime.

[1] H. W. Turkel, *Journal of the American Medical Association* (1955), Vol. 158, page 1485.
[2] See in particular Blom-Cooper, L. and Morris, T. C., *A Calendar of Murder*, Criminal Homicide in England since 1957, London: Michael Joseph, 1964.

4.35 We accept that the killing of a relative may sometimes be deliberately premeditated (as it certainly appears to have been in the case of Mrs. GRO-C [1] and GRO-C [2]) but we think it unlikely that anyone has been or could be influenced towards committing a premeditated murder by any knowledge he might have of defects in the law relating to the certification of death. A person planning such a murder in the expectation that he will be able to disguise the death as one from natural causes is likely to start from a position of great uncertainty as to what will happen to his victim's body after death. He is most unlikely to know for certain whether the doctor will look at or examine the body before deciding whether or not to issue a certificate. Similarly he is unlikely to know or to have any control over whether the doctor will report the death to the coroner. Finally, and most importantly, he is unlikely to know whether there will be an autopsy. If he has any knowledge of statistical probabilities he will know that there is at least a 90 per cent chance that the body will be looked at after death; that coroners now make enquiries into one-fifth of all deaths occurring in England and Wales; and that autopsies are carried out in respect of over one quarter of all deaths occurring in England and Wales every year. Common sense suggests to us that the calculating murderer who assesses the probable consequences of any course of action is likely to conclude that the risks involved in attempting to pass off murder for a natural death are not worth taking.

4.36 We are satisfied that there is no greater prospect that murderers will escape detection by disguising the nature of their victims' death and allowing the ordinary certification procedure to take its course than by disposing of their victims' body in some unconventional way, or by leaving the body and relying on other factors to save them from arrest. The certification procedure has never provided the only way of detecting that a homicide has occurred; the circumstances of a death, about which other persons besides doctors are likely to be aware, are often much more important in "triggering off" a police investigation.

Conclusion

4.37 Our general conclusions are that the risk of secret homicide occurring and remaining undiscovered as a direct consequence of the state of the current law on the certification of death has been much exaggerated, and that it has not been a significant danger at any time in the past 50 years. We have reached these views after examining all the statistical evidence which might have been expected to give an indication as to the existence of a number of secret homicides and after taking evidence from doctors, lawyers, police officers and criminologists. We do not say that there is no possibility whatever of a homicide being concealed under the present procedure for certifying deaths. What we do say is that, balancing all the relevant factors and observable probabilities, there is no requirement to strengthen the present machinery of death certification simply in order more efficiently to prevent or detect secret homicide. So far as detection of homicide is a relevant objective, the

[1] Leeds Assizes, 30 March, 1958.
[2] Leeds Assizes, 13 December, 1967.

present certification system has worked as satisfactorily as any modern community could reasonably expect. Advances in medical science (and forensic medicine) are likely to maintain that position. Our task, therefore, has been to make sure that, in the future system of death certification, an autopsy will be performed in all cases in which there is any doubt about the medical cause of death or suspicion about the circumstances in which the death occurred. In the next two chapters we put forward our proposals for changes in law and practice to achieve this result.

Table of Exhumations
Source: Home Office

Annex to Chapter 4

Place of exhumation	Case No.	Cause of death on original death certificate	Circumstances of certification	Circumstances leading to exhumation	Time interred	Embalmed or not	Result of post-mortem	Criminal proceedings	Other information
Plymouth	1. Woman aged 59	Death caused by multiple head injuries including severe fracture of skull.	Post-mortem after husband had reported that his wife had fallen from his shooting brake and been run over by the rear wheels.	Pathologist thought injuries could not have been caused by fall from car; no injuries to other parts of body. Husband charged with murder and defence applied for exhumation to provide expert evidence on their side.	Feb. 1959 to 10.6.59	Not known	Injuries could not have been caused by fall from car. Some could have been caused by wheel crushing head but most by blows from heavy instruments.	Yes	Husband found guilty and sentenced to life imprisonment.
City of London Cemetery	2. Man aged 48	Cerebral-embolism due to rheumatic valvular disease.	Doctor saw day before death and after.	Complaint by relatives and rumours brought to the attention of the police.	11.6.59 to 27.7.59	No	Cerebral-embolism, valvular disease of the heart.	No	A woman had come to keep house for the bachelor and made him sign a will leaving his entire estate to her when he was ill. A tin of Rodine rat poison was found in her suitcase.
Merthyr Tydfil, Glamorganshire	3. Man aged 81	Cardiac failure due to bronchial asthmatic attacks.	Locum tenens had seen deceased before and after death.	It became known that "doctor" was not a medical practitioner and rumours developed.	d. 2.11.59 to 26.11.59	Not known	Cor pulmonale emphysema.	No	The "doctor" had the dec'd's medical card and his guess was fairly accurate.
East Ham	4. Woman aged 79	Coronary thrombosis, arterio-sclerosis and senility.	Doctor saw one week before death.	Suggestions were made that dec'd had been forced into marriage with a man of 84, and made to buy property against her will by his son. Police made enquiries.	24.1.61 to 16.3.61	No	Cause of death: in keeping with senile degeneration of the myocardium.	No	
Brixham, Devon	5. Woman aged 77	Coronary thrombosis.	Had been confined to bed for some time. Doctor saw body soon after death.	Her son confessed to killing her by suffocation.	March 1962 to 13.9.62	Not known	No evidence of suffocation but unlikely that death caused by coronary thrombosis. State of body such that no positive evidence either way.	No	Jury returned a verdict of death by natural causes and confirmed death certificate.

Place of exhumation	Case No.	Cause of death on original death certificate	Circumstances of certification	Circumstances leading to exhumation	Time interred	Embalmed or not	Result of post-mortem	Criminal proceedings	Other information
East Suffolk	6. A still-born child	Stillborn	Doctor saw mother on day of birth, who told him that she thought she was going to have a miscarriage, but she had in fact already given birth to the child. He arranged for the attendance of a nurse.	There were rumours locally and at the husband's place of employment. Husband noticed a piece of tape tied round child's neck.	5.8.64 to 10.8.64	No	Full term female with a pronounced constriction mark round the neck, but no evidence to show that traction had been applied, lungs showed half expansion and cause of death was probably due to lack of attention to mother during labour.	No	
Hitchin, Herts.	7. Man	Coronary thrombosis.	Doctor had seen about 10 days before and after death	Widow took note to police; she said it was written by her husband and it intimated that he intended to take his own life.	8.6.64 to 19.8.64	No	Cause of death was coronary thrombosis.	No	

Cambridge Cemetery	8. Woman aged 58	Asphyxia following injuries.	Certification after p.m.	Man committed to trial accused of murder of deceased. Further medical information sought.	About 22.7.64 to 8.9.64	Not known	Confirmed original certification.	Yes	Man found guilty of manslaughter by reason of diminished responsibility.
Cornwall	9. Child	Acute broncho pneumonia.	Not known	Later child died showing signs of "battered baby syndrome." Police suspicions aroused.	3.8.63 to 20.2.65	No	No sign of any fractures. Appearance of normal child.	No	
Lambeth Cemetery, Tooting	10. Man aged 82	Thought to be broncho pneumonia.	Coroner not informed—no p.m.	Man who had relationship with wife of deceased confessed to murder.	31.1.63 to 23.3.65	Yes—thought by coroner to be reason for good preservation of tissues.	Barbiturates were present in the body. The coroner thought it probable that death was accelerated by barbiturate poisoning but did not feel able to substantiate this because even larger amounts of barbiturates than found could have been used for therapeutic reasons.	Yes—with further unrelated charges	Man acquitted of murder for reasons explained by coroner. The original charge was one of rape of a small girl. It is thought that his shame brought him to confess to the murder in the hope that a more serious charge would be made against him.

Place of exhumation	Case No.	Cause of death on original death certificate	Circumstances of certification	Circumstances leading to exhumation	Time interred	Embalmed or not	Result of post-mortem	Criminal proceedings	Other information
Denbighshire	11. Woman aged 55	(*a*) Acute left ventricular failure, due to (*b*) Rheumatic heart disease.	Doctor saw day before death. Not known whether examination was made after death.	Complaint by husband that wife had been given the wrong tablets.	21.6.67 to 25.6.67	No	Antecoagulant therapy could have contributed to the cause of death. It had previously been ascertained that a stronger antecoagulant than intended may have been used.	No	Coroner considered exhumation clearly established Pharmicist made a careless mistake by issuing wrong tablets.
Denbighshire	12. Man aged 52	(*a*) Massive collapse of left lung. (*b*) Laceration of left lung. (*c*) Fracture of left sixth rib.	Certification after p.m.	Relatives critical of the medical practitioner in whose care deceased had been.	About 24.4.68 to 23.5.68	No	Death clearly due to natural causes.	No	

Stafford	13. Woman aged 84	Cerebral thrombosis.	Deceased transferred from local Infirmary to Old People's Home 3 weeks prior to death. Doctor certifying death failed to appreciate deceased had been involved in a road traffic accident and treated death as one of natural causes. Death not reported to coroner.	Deceased's family solicitors wrote to coroner for information as the family were claiming damages for road accident.	14.2.68 to 22.2.68	No	Death thought to have been due to:— (1) contusion and oedema of the brain, (2) generalised arteriosclerosis, (3) status after head injury and fractures.	No	Verdict of jury at inquest "Accidental Death."

CHAPTER 5

CERTIFYING THE FACT AND CAUSE OF DEATH —THE ROLE OF THE DOCTOR

5.01 Strictly speaking, there is, in law, no such thing as a certificate of the *fact* and cause of death. A registered medical practitioner who has attended a deceased person during his last illness is required to give a medical certificate of the *cause* of death " to the best of his knowledge and belief " and to deliver that certificate forthwith to the registrar.[1] The certificate is in a prescribed form on which the doctor is required to state the last date on which he saw the deceased person alive and whether or not he has seen the body after death. Although, therefore, a doctor is not required to certify the fact of death, it is implicit in his legal obligation to give a certificate, as well as in the form of the certificate itself, that he is satisfied that death has occurred. He is not obliged to view the body, but good practice requires that, if he has any doubt about the fact of death, he should satisfy himself in this way. The form of the certificate includes provision for the doctor to state whether or not he has reported the death to the coroner, but it contains no guidance as to the circumstances in which it might be appropriate for the doctor to take this action.

5.02 Doctors differ in their interpretation of the precise nature of the obligation which the law places upon them. Some evidently believe that they are absolved from the requirement to give a certificate if it is clear that the deceased person has died a violent death and the death has been reported to the coroner. Others take what we believe to be the more correct view that the obligation to give a certificate after an attendance during a last illness is an absolute one. So far as we are aware, the obligation is in no way affected by the degree of knowledge (or lack of knowledge) of the cause of death. It would scarcely be surprising, however, if there were not sometimes a conflict in a doctor's mind between his duty to give a certificate (which will arise if he has attended the deceased in his last illness, however slender is his knowledge of the cause of death) and any feeling he may have that his best course might be to report the death for further enquiry. He need do no more in such an event than frame his certificate in an equivocal fashion and leave the rest to the registrar.

5.03 There are a number of circumstances in which the *registrar*, when he receives the certificate, is himself required to report the death to a coroner and to defer his registration of the death until the outcome of the coroner's investigations is known. The registrar's instructions are so drawn that, if he is to register a death without reference to a coroner, then not only must the certifying practitioner have attended the deceased person during his last illness, he must also either have seen the body after death or attended the deceased person within the 14 days preceding death.[2] In practice, this means

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

[2] Births, Deaths and Marriages Regulations 1968, regulation 51.

that, before a doctor can give a certificate which will be accepted by a registrar, he must be " qualified " *either* by attendance within 14 days of the death *or* by a sight of the body after death. This situation, in which a registrar may accept without further enquiry a certificate from a doctor who has seen the body after death but who may not have seen his patient for several months, is quite indefensible.

5.04 Three features in the present law were extensively criticised by our witnesses and it will be convenient if we examine each of these in turn. They are:—

(*a*) the medical qualification of the doctor obliged to give a certificate;

(*b*) the meaning of the expression " attendance during the last illness "; and

(*c*) the fact that a doctor is not required by law to look at the body before giving a certificate of the medical cause of death.

(a) *Medical Qualification of the Certifying Doctor*

5.05 The term " registered medical practitioner " is interpreted for the purpose of giving medical certificates of the cause of death as including provisional registration.[1] No official advice has been issued to suggest which doctor should act when there are several qualified to give the certificate, e.g. in hospitals where more than one doctor has treated the patient. It has been suggested to us (by doctors) that the accuracy of the certification of death in hospitals could be improved if the certification were not completed, as we understand it often is at present, by the least experienced member of the hospital staff, who is frequently only in his year of provisional registration. We are advised that it would be practicable for all certificates in hospitals to be completed by fully registered medical practitioners. In these circumstances, we feel justified in recommending that full registration should be part of a new minimum qualification for giving a medical certificate of the fact and cause of death.

(b) *Attendance during the last illness*

5.06 The expression " attendance during the last illness ", which first appeared in the Births and Deaths Registration Act 1836 and which has been reproduced in subsequent similar enactments, has never been properly defined. In 1893, the Select Committee on Death Certification drew attention to the different ways in which the expression was being interpreted by doctors at that time. They concluded that some further definition was necessary and recommended that the expression should be defined as meaning " personal attendance by the person certifying upon at least two occasions, one of which should be within eight days of death ". Various efforts have been made since the 1893 Committee reported to produce a statutory definition along these lines, but they have all foundered in Parliament. It is a fact that coroners pay some regard to the times when a doctor has seen a patient when they are considering whether a doctor is likely to have a reasonable basis for his opinion as to the cause of death, but they do not work with

[1] The status accorded to a doctor for one year after graduation in medicine and which allows the holder to work in an approved hospital post. Satisfactory completion of this year qualifies for full registration.

any hard and fast rules. On the other hand, registrars, on whom lies a more explicit responsibility to consider the worth of medical certificates delivered to them, have no means of knowing whether the number of visits has been more than one and they do not, therefore, reject certificates for registration purposes on the ground that the " attendance " has been insufficient.

5.07 Quite apart from the question of how many " visits " are implied by " attendance ", the expression " last illness " is, in itself, imprecise. Difficulties can arise particularly from the fact that some " last illnesses ", especially in older persons, can last a long time. In consequence, a medical practitioner may be obliged to give a certificate even though his regular attendance on the deceased person has ceased many months before death. Provided that the doctor has seen the body after death his certificate will be accepted by the registrar unless some other circumstance requires him to refer the death to the coroner. Moreover, we think it doubtful whether the existing law even goes so far as to make it an absolute requirement that the doctor, in order to certify, must have attended the deceased for the condition from which, in his view, the patient died; it seems possible that it is open to him to certify that the patient died from a condition which has in fact arisen since his last attendance.

5.08 Attendance at any time during the last illness together with a sight of the body after death should not continue to be a sufficient qualification for a doctor to give a certificate which a registrar may accept without further enquiry. Neither a sight of the body after death nor even a detailed external examination of it can be relied upon as a basis for an accurate diagnosis of the cause of death in the absence of first-hand knowledge of the patient's condition before death. Leaving aside the possibility of an autopsy, the most important single factor in securing an accurate diagnosis of the medical cause of death is recent clinical observations. Moreover, if, as we believe, accurate diagnosis of the cause of death should be the primary objective of the certification procedure, it follows that a recent clinical attendance on the deceased before death should be part of a new qualification for giving a certificate. The conditions of his attendance on the deceased must ensure that the certifying doctor will have recent knowledge of the deceased person's illness but it should not seek to dictate to him the precise frequency of his visits.

5.09 We asked the General Register Office for some information which would help us to determine what this limit should be. Table E below shows for a random sample of deaths registered in the March quarter of 1967 the interval between death and the date the *certifying* practitioner last saw the deceased alive: it shows also whether or not he saw the deceased person after death. Deaths in 74 registrar's districts were included in the survey. The districts were selected from the Registrar General's topographical list commencing with District No. 7 and taking every seventh district thereafter. The provisional number of deaths registered in the whole of England and Wales during the same quarter was 145,263. In addition to these registrations, the sample included 2,990 coroner's pink form B registrations and 1,010 certificates after inquest, giving a total of 20,752 deaths. This sample represents about one-seventh (14 per cent) of all deaths registered in the quarter.

TABLE E

Certification by Doctors (January—March 1967)

Source: The Registrar General for England and Wales

	Interval (in days) between death and time when last seen alive by the certifying doctor									
	0	1	2	3	4	5–7	8–13	14+	Not Stated	Total
Seen after death:										
Hospital	4,988	2,744	365	135	56	80	35	11	4	8,418
Elsewhere	1,924	1,947	633	370	226	394	326	249	59	6,128
Total	6,912	4,691	998	505	282	474	361	260	63	14,546
Not seen after death:										
Hospital	462	557	103	43	20	22	9	1	—	1,217
Elsewhere	307	328	83	33	23	32	20	6	3	835
Total	769	885	186	76	43	54	29	7	3	2,052
No statement:										
Hospital	21	8	—	1	—	—	—	—	—	30
Elsewhere	56	38	15	3	5	4	1	1	1	124
Total	77	46	15	4	5	4	1	1	1	154
Total:										
Hospital	5,471	3,309	468	179	76	102	44	12	4	9,665
Elsewhere	2,287	2,313	731	406	254	430	347	256	63	7,087
Total	7,758	5,622	1,199	585	330	532	391	268	67	16,752

Note: It is not possible to distinguish between a home address and elsewhere from the medical certificates.

5.10 The figures are based on the information contained in the medical certificate of the cause of death. Those in the first column indicate visits made on the day of death but before death occurred. It is noteworthy that of the total of 7,758 deaths in this column, the patient was apparently seen after as well as before death in 6,912 cases. The figures show that the great majority of deaths certified by doctors are certified after at least one recent clinical attendance. In 87 per cent of all cases the last attendance took place within 48 hours prior to the death, in 90 per cent within 3 days, and in 95 per cent within 7 days.

5.11 Before seeing these figures we had supposed that patients would have been attended more frequently in hospital than at home, and therefore that the likelihood of the patient being attended by the certifying practitioner within 7 days prior to the death would be much greater in the case of hospital deaths. In fact, there appears to be no great difference between the practice of general practitioners and hospital doctors. Table E shows that of all those who died in hospital, 97 per cent had been seen by the certifying doctor within the previous seven days and that the corresponding figures for those who died at home was 90 per cent. (It should be remembered of course, that the patient, at any rate in a hospital, is likely to have been attended within the same period and perhaps at a time closer to his death by another doctor

who did not give the certificate). A great many deaths at home are of elderly persons who have been ill for some time and it is common for general practitioners to make routine visits to elderly patients within their own homes at fortnightly or even monthly intervals, but the figures in Table E indicate that the last stage of their illness is usually sufficiently well recognised in advance for the general practitioner to make his last visit well within the seven day period before the death.

5.12 These figures serve to encourage us in our belief that it would be practicable, without causing appreciable hardship to doctors or to the relatives of the deceased, to impose quite a short time limit within which the certifying doctor must have attended the patient if he is to be qualified to give a certificate. We believe that a seven-day rule is feasible and we therefore recommend that a doctor should be permitted to certify the cause of death only if he has attended the deceased person at least once during the 7 days preceding death. If the " seven-day rule " is imposed directly on the doctor in this way, there will certainly be no need to attempt the more difficult task of providing a statutory definition of " attendance during the last illness ", which term can, in fact, be abandoned.

5.13 Some of our witnesses argued that a strict requirement that, in all cases, the certifying doctor should have visited the deceased person at least once within a prescribed period before death might cause hardship in a minority of cases, in which for whatever reason the doctor who fulfilled these conditions was not available. They pointed out that there has been a steady and continuing rise in the number of partnerships and group practices in recent years and suggested that where a doctor who has been treating a patient is, for some reason temporarily unavailable, his partner should be empowered to give a certificate in his place, provided that he has had access to the deceased person's case notes and has seen the body after death. In order that there should be no difficulty in distinguishing the partnerships to which a concession along these lines might be applied, it was suggested that it might be confined to partnerships registered under the National Health Service Acts.

5.14 In support of this proposed concession, the point was made also that it is already the practice in hospitals for a doctor to base his certificate of the cause of death to some extent on information (including written information) provided by other persons. This is a perfectly fair point to make but the analogy between the hospital doctor and a partner in general practice ought not to be pushed too far. Under the present law, a hospital doctor who gives a medical certificate of the cause of death must have attended the deceased person in his last illness. In other words, he must have been in some way responsible for the clinical treatment of the deceased person. Indeed, an important distinction can be drawn between hospitals (where it is not unusual for a patient to be attended by several doctors any of whom might be qualified to give a certificate) and general practice partnerships (where it is more likely that only one doctor will actually have attended the deceased person in the period immediately before death). A partner in general practice may therefore have no more evidence on which to base his diagnosis of the

cause of death than an examination of his colleague's records and a look at the body after death. Moreover, general practitioners' records are not always readily available and since, in some practices, a partner may be a stranger to many of his colleague's patients, it would be difficult to draw an equitable distinction between partners and, say, temporary relief doctors, who might be similarly qualified to certify insofar as they too might have had access to case notes.

5.15 We sympathise with the intention of those who have proposed an exception for the partner of the absent doctor and realise that the strict implementation of our proposal might occasionally give rise to hardship, but we do not think it would be right to depart from the principle that a certificate should only be given by a doctor who has personally attended the patient (whether in hospital or in general practice). To do so might nullify the effect of the extra restrictions which we are proposing.[1] Nevertheless, we hope that when a death is reported for further investigation simply because the doctor who has attended the deceased person is temporarily unobtainable, the " technical " character of the report will be taken into account before it is decided whether the fact and cause of death may be certified on the basis of information supplied by a doctor with access to the deceased person's medical history, or whether an autopsy is necessary.

(c) *Viewing the body*

5.16 So far in this chapter we have been concerned with the *qualification* of a doctor to give a certificate (i.e. the requirements which must be fulfilled before a doctor can be allowed to certify the fact and cause of death on his own authority); we turn now to consider the *obligations* of a doctor who fulfils these requirements. Several of our witnesses suggested that the most serious deficiency in the present arrangements for certifying death was the lack of any obligation upon a certifying medical practitioner to see, let alone to examine, a body after death. Most of them regarded this as, self-evidently, an unsatisfactory situation and, in their written evidence at least, they saw little need to justify their opinion that such an obligation should be imposed. Nevertheless, two separate strands of argument could be deduced. First, we were told that examination is necessary in order to facilitate the diagnosis of the cause of death and, secondly, it was claimed that the merit of an examination is that it may assist in the detection or deterrence of crime. Our witnesses were virtually unanimous in proposing that there should be an obligation on the certifying doctor to *examine* rather than simply to *see* the body after death; but not all of them told us what they meant by " examination ". There is a very real distinction between a sight of a body and an examination of it and the two have different objectives and values. The mere viewing of a body cannot be expected to achieve the same objective as a detailed examination of it. There is also a crucial difference in the practicality of a requirement to do the one or the other.

5.17 Certainly, if an examination of the body after death is to have anything like the usefulness which our witnesses have claimed for it, it must

[1] One way of mitigating any possible hardship without departing from this principle might be for a doctor going on leave or a holiday to inform his partner of any cases in which death is likely during his absence. A visit from the partner would then put him in a position to give a certificate.

be thorough.[1] This is true if the examination is intended primarily as an aid to the diagnosis of the medical cause of death, but it is even more important if the purpose is to detect a possible crime. As a deterrent to secret homicide a cursory examination is useless. If an examination falling short of a full autopsy by an expert pathologist is to stand any chance of success in bringing to light a deliberate attempt to conceal a crime, then it will need to take the form of a complete external examination of the whole body including, at the very least, a palpation of the skull.

5.18 The difficulties of implementing a universal requirement to conduct such an examination are considerable and obvious. When a doctor visits a family after the death of their relative, he is likely to be as much concerned with giving comfort to the bereaved as with an examination of the corpse. The need to make a thorough examination of the body before certifying death might well destroy the helpful relationship which so often exists between a doctor and bereaved relatives at this time. It would be no simple task for a doctor to conduct such an examination in a deceased person's own home particularly in the presence of rigor mortis. Quite apart from the possible effect on the relatives, who could scarcely be unaware that such an examination was being conducted and who in their likely emotional state might be expected to resent it, the carrying out of a complete external examination is an extremely demanding physical task. It is virtually impossible for anyone except an experienced mortuary attendant to undress a body single handed; but such an action is an essential prerequisite to a thorough external examination. It would be quite out of the question for a doctor to enlist the aid of relatives for this distasteful task. It follows that, as a matter of routine, a really thorough examination of the body would be impractical in a deceased person's own home.

5.19 Doubtless, the physical difficulties would not be so great in the case of hospital deaths where facilities for an examination provided by the personnel and resources of a mortuary might be expected to be readily available. But we see little point in an obligation to examine a corpse which applies only to hospital deaths. *Prima facie*, there should be the least need for an external examination (as distinct from an autopsy) for diagnostic purposes in a hospital; and the possibility of homicide in a hospital is remote indeed.

5.20 Despite the representations in favour of such a requirement, therefore, we have not felt able to recommend that a certifying doctor should make a full examination of the body after death. We are convinced that a full examination in every case would be both more difficult and less useful than has been allowed by those who have advocated it so fervently.

5.21 Nevertheless, we do not wish to perpetuate the existing situation in which a doctor need not even *see* the body before giving a certificate. Apart

[1] Although there is no record of the number of cases in which the body was or was not seen after death by the doctors completing the first " dummy " certificate in Dr. Hensman's study of the accuracy of certification to which we referred in Chapter 4 above, it seems reasonable to suppose that the body was in fact, seen in a number of cases in which the " dummy " certificate was shown to be inaccurate by the subsequent autopsy. In other words a " sight " of the body may have a very limited value as a means of diagnosing the medical cause of death.

from the risk that a doctor will fail to recognise some suspicious feature, there are in theory at least three other dangers in a law which allows a doctor to certify death without looking at the body. There is a possibility, first, that the person may not in fact be dead, secondly, that the dead person may not be the person that it is claimed he or she is, and thirdly that there may not even be a body.

5.22 An obligation upon a doctor to look at the body before certifying should go some way towards satisfying those persons, who, for whatever reason, have a fear that their bodies may be prematurely buried or cremated. It may also have a more practical value as a safeguard against the possibility of fraudulent claims for insurance or other purposes, e.g. claims made when the person concerned is not in fact dead. Such claims have been made in the past[1] although we are not aware that there is any suspicion that they are being made at all frequently now. If, in future, a doctor was obliged to see the body before certifying, it would be difficult for any such deception to be made without his deliberate connivance. Moreover, although we have argued (see paragraph 5.08 above) that examination of the body after death is not in itself of any very great diagnostic value, an inspection of the body which falls short of a full external examination may still provide some check on previous diagnosis and may also lead to the recognition of some totally new feature. It should certainly enable the doctor to detect a death which results from more obvious forms of violence or from a cause, like carbon monoxide poisoning, which is apparent from the external features of the corpse. These considerations lead us to conclude that there is a sufficiently strong case for introducing a statutory requirement of " inspection " of the body before certification. Accordingly, we recommend that, before he gives a certificate of the fact and cause of death, a doctor should be required to inspect the body of a deceased person. In circumstances in which the doctor has been expecting the death to occur and his first look at the body throws no doubt on his previous clinical diagnosis, his inspection of the body can be a comparatively brief one. At the other extreme, when death has occurred with unexpected suddenness and an inspection of the body does nothing to help him discover the cause of death, it will be the doctor's duty to report the death for further investigation.

5.23 It may be helpful if we now summarise the recommendations which have appeared so far in this chapter. We have recommended that before he gives a certificate of the fact and cause of death a medical practitioner must

(i) be a fully registered medical practitioner,

(ii) have attended the deceased person at least once during the seven days preceding death, and

(iii) have inspected the body after death.

5.24 A doctor who fulfils the first two of these requirements should be obliged to fulfil the third whether or not he gives a certificate of the fact and

[1] A few are cited by Havard, *op. cit.*, page 102; these are Scottish cases and the most recent example quoted relates to a conviction in 1933.

cause of death. One of the reasons why we have recommended that, before giving a certificate, a doctor should inspect the body of a deceased person is in order that he should personally satisfy himself that death has, in fact, occurred. It would seem illogical if a doctor were required to inspect the body before giving a certificate of the fact and cause of death but was not under a similar obligation to inspect the body before reporting the death for further enquiry. The same risk (i.e. that the allegedly dead person might still be alive) may be involved in either circumstance. In effect, therefore, we are recommending that there should be a new obligation on a fully registered medical practitioner, who is qualified by attendance to give a certificate to certify the fact of death even in circumstances in which he cannot certify the cause.

5.25 Having inspected the body, a doctor who fulfils the other two requirements set out in paragraph 23 above should be obliged *either* to give a certificate *or* to report the death to an appropriate authority for further investigation. It should be necessary for him to do one or the other in order to discharge the new obligation which we recommend should be placed upon him. The circumstances in which he should or should not give a certificate will be discussed in more detail in the next chapter.

CHAPTER 6

THE LIMITS OF THE DOCTOR'S ROLE IN THE CERTIFICATION OF THE CAUSE OF DEATH

6.01 In this chapter we consider first the circumstances in which a doctor who is " qualified " to give a certificate of the fact and cause of death and who has fulfilled his obligation to inspect the body after death should or should not give this certificate.

6.02 Under the present law, any doctor who is *qualified* to give a certificate, by reason of his attendance upon a deceased person during his last illness, is also *obliged* to give one, irrespective not only of the date of his last attendance but also of his knowledge of the cause of death. In the previous chapter, we have expressed our dissatisfaction with this situation and we have recommended that, for the doctor to be qualified to certify the cause of death there should be a new minimum requirement of recent clinical attendance. But so far we have said nothing about the extent of a doctor's knowledge of the cause of death.

6.03 As we have seen, in Chapter 4, perhaps the most serious criticism of the existing law is that it does not ensure that deaths are certified as accurately as they could be, or even as accurately as society has a right to expect. Most of our medical witnesses told us that they would like to see a situation in which many more deaths were certified after an autopsy. Some of them particularly stressed the importance of the autopsy as a protection against " secret homicide ". But there was general recognition that the primary importance of an autopsy lies in its value as an aid to the accurate determination of the medical cause of death. The findings of an autopsy, especially if they are looked at in conjunction with an informative clinical history of the deceased person provide the best basis for securing an accurate certification of the cause of death.

6.04 But certification based on autopsy is neither necessary nor practicable in all cases. It is not necessary because it often happens that a doctor who has been treating a patient during his last illness knows exactly what is the condition which has caused death; he may, indeed, have seen a report from a surgeon who has performed an operation on his patient some time before death which describes in detail the condition observed during the operation. An autopsy is not practicable in the case of every death because the resources, in terms both of suitable premises and suitable pathologists, are not available now and could not be made available in the foreseeable future. The problem is how to ensure that an autopsy is performed in respect of those deaths in which it is the most desirable pre-requisite to certification.

6.05 The logical first step in the creation of a legal framework which will achieve this end is to establish how far the doctor with closest knowledge of the

deceased and his death can be entrusted with sole responsibility for certifying the cause as well as the fact of death. We recognise that, in the absence of an autopsy, it is sometimes impossible for such a doctor to *know* the cause of a death in the absolute sense. But we think that it is entirely reasonable to ask him to adopt a somewhat lower standard of confidence in his judgment than absolute certainty, particularly since we have recommended (in Chapter 5) higher minimum qualifications as a pre-requisite to the doctor's power to certify the cause of death. The standard of confidence which we consider to be appropriate can be expressed thus: a doctor should be satisfied that he knows the medical cause of death and would be prepared to justify his conclusion before a group of his own colleagues of similar competence and experience. If a doctor's doubts about the cause of death are such that he feels that they can only be resolved by knowledge of the results of an autopsy, he should decline to give a certificate of the fact and cause of death and be *obliged* to report the death to the appropriate authority[1] which will have power to arrange for an autopsy to be carried out. Accordingly, we recommend that a doctor who is qualified to give a certificate of the fact and cause of death (see Chapter 5 above) and who has inspected the body after death should be obliged to report the death to the appropriate authority unless he is confident on reasonable grounds that he can certify the medical cause of death with accuracy and precision.

6.06 A criterion of this kind (with its corollary that, if it cannot be met, the doctor should not send a certificate to the registrar) is an essential first element in our future scheme for certification procedure. It may be asked, however, " why not give the doctor who is *almost* confident enough to certify the cause of death without autopsy, the right to double check his opinion by arranging for an autopsy on his own authority without needing first to report the death to a coroner or other appropriate authority? ". The proposition has a certain attraction and, indeed, plausibility. As Table D on pages 5–7 shows, coroners were responsible in 1969 for the certification of a large number of " natural " deaths, i.e. deaths from the most common fatal diseases. There can be no doubt that the great majority of these deaths were reported to coroners by doctors either because the doctors concerned knew that they did not meet the conditions of attendance which have to be met before a registrar can accept their certificate or because they did not know the cause of death and took a deliberate decision not to give a certificate. It may be presumed that, in virtually none of these cases was there any suspicion of foul play or expectation that the findings of an autopsy would give grounds for further enquiry into the circumstances of the death and it is arguable therefore that a legal right to require an autopsy to be performed, and perhaps also a duty to certify the cause of death as revealed by the autopsy, might be given to the doctor who had been most concerned with the treatment of the deceased person.

6.07 Despite the attractions of this argument, we are reluctant to recommend that potential certifying doctors should have the legal right to require

[1] Throughout Part I of this Report we shall use the expression " appropriate authority " as a term of art. We examine the nature and role of this authority in more detail in Chapter 9 below.

an autopsy by a pathologist to establish the cause of death in any case in which they think that an autopsy is necessary for this purpose, regardless of the views or wishes of the deceased person's relatives. There are several reasons for our reluctance. First, if there was an option to require an autopsy, there would be a natural temptation for doctors to exercise it rather than to trust to their unaided judgement; the basic criterion to which we attach importance would become blurred; and the pathology services would be given a burden that could and should be avoided. Secondly, there would be a risk in a number of cases (which might be few but, individually, could not be forecast in advance) that the pathologist's report would produce findings suggesting that further enquiry should be made into the circumstances leading to the death; in this situation, a doctor might find himself in a highly embarrassing position either with regard to the propriety of disclosing the findings to other persons affected by the death or with regard to the implications of the findings. Thirdly, the exercise of such an option would significantly increase the total sum of responsibility placed on the doctor in his certifying role. It may be that certifying doctors as a whole would welcome such a development but we believe that such a radical change in the responsibilities now exercised by certifying doctors would be likely to run up against the difficulty (which we have also seen to be a real one for certain coroners) that the volume of cases to be dealt with by individual doctors would be too small to provide the typical certifying doctor with the experience and expertise necessary for the efficient discharge of a right to call for a pathologist's report. Last, but not least, there are the feelings of the relatives and other persons closely associated with the deceased. An autopsy constitutes an interference with a dead body—the need for which is more widely accepted by the public as well as by doctors, than ever before—but it is still regarded by some people with a mixture of fear and repugnance. It may be more acceptable to those who feel this way if it is ordered by someone who may not be a doctor but who is certainly detached from the circumstances of the death.

6.08 Nothing which we have said in the previous paragraph should be taken as criticism of the practice that already exists in many hospitals where autopsies are already carried out with the consent of relatives. Some of these autopsies are performed to establish the cause of death; others are performed, even though the cause of death is not itself in doubt, because the doctors involved in the case feel that an investigation of the detailed nature of the pathological process and of the effects of treatment may reveal information which will enlarge the sum of medical knowledge for the general benefit. We hope that autopsies will continue to be performed, with the consent of relatives, for the second purpose, i.e. the advancement of medical knowledge. But, in future, hospital doctors should be obliged to report a death to the appropriate authority whenever the cause of death is in doubt. The responsibility for arranging an autopsy in these circumstances will fall on the authority and not on the hospital doctor—although it will usually be a pathologist on the staff of the hospital who will perform the autopsy on behalf of the appropriate authority.

6.09 There are also circumstances in which a doctor should be obliged to report the death to an appropriate authority even when he is confident that

he knows the cause as well as the fact of death. In practice doctors are already reporting deaths to the coroner when they are in this situation and an examination of the existing law, under which the causes of nearly one fifth of all deaths occurring in England and Wales every year are now certified by coroners rather than doctors will serve as a convenient starting point in our consideration of what obligations to report deaths for further investigation should be placed upon doctors.

The Existing Law

6.10 Under section 3 of the Coroners' Act 1887, a coroner has a duty to make enquiries whenever he is informed that there is lying within his jurisdiction the body of a person who there is reason to believe may have died a violent or unnatural death or a sudden death the cause of which is unknown or has died in prison or in any place or circumstances which, under another Act, require an inquest to be held. The Act does not place an obligation on any person to inform the coroner of deaths into which he has a duty to enquire and, strictly speaking, a doctor's obligation to do so is no higher than that of any other person.[1] Nevertheless, the doctor's moral obligation to make a report has become " a well founded custom with the passage of time. "[2] The provisions of the Act of 1887 provide one reason why doctors decline to certify the cause of certain deaths and instead report them to coroners. Another reason is the existence of a statutory obligation upon a registrar to report deaths to the coroner.

6.11 As we have pointed out (see paragraph 3.11 above), the registrar is already obliged to report to a coroner not only deaths where there is no medical certificate, or one whose value is doubtful because the certifier was not very closely involved with the deceased person's illness or has confessed doubt about the cause, but also those where the medical certificate indicates or other information suggests that the cause of death falls within a number of broadly drawn categories which cover *inter alia* any sort of accident, injury, poisoning or industrial disease. Doctors are aware of the registrar's obligation and, when they know that the cause of death which they have been called upon to certify falls within one of the above categories, it is usual for them to report the death to the coroner themselves. The fact that, in practice, doctors often report to coroners directly without waiting for the registrar to intervene helps to conceal a gap in the existing law; but it provides no excuse for failing to close it. In principle, it is more satisfactory that reports should be made by a person with first-hand rather than second-hand knowledge of the cause or circumstances of death. Moreover, a report by a doctor can save valuable time: in those cases in which a doctor neglects to report a death there may be a delay of up to 5 days before a report is made by the registrar[3]

[1] There is a common law obligation on every person about the deceased to give immediate notice to the coroner, or to the police of circumstances requiring the holding of an inquest; but there is no record of anyone having ever been prosecuted for failure to comply with this obligation.

[2] Jervis on Coroners (9th Ed.) page 60.

[3] Although a doctor who gives a medical certificate of the cause of death is required to send the certificate *forthwith* to the registrar, he is allowed to send the certificate by post (and delay can be caused in this way!); but it is the practice of many doctors to hand the certificate to the relative who will be the informant for registration purposes. An informant is allowed 5 days in which to register a death or to send the registrar evidence that a medical certificate has been completed.

and a 5-day delay could seriously prejudice the results of a post mortem examination. It is possible, too, that doctors might find themselves in a more comfortable relationship with relatives, who may occasionally be resentful that a death has been reported for further investigation, if there were a specific provision in the law requiring such a report to be made.

6.12 There is another reason why doctors report deaths to the coroner in the absence of any legal obligation upon them to do so. In some areas, doctors in hospitals report deaths to the coroner in response to local " rules " drawn up by individual coroners which purport to require them to report the deaths of patients who die within 24 hours (or sometimes 48 hours) of admission to hospital. At least one coroner has gone further than this by requiring that deaths from certain diseases, which he himself has specified, should be reported to him. We recognise that these " Rules " and lists have been drawn up with the worthiest of intentions but we do not favour their continued use. They are unsatisfactory in principle, since they have no legal force—in the sense that the fact that a coroner has issued a list does not place upon a doctor any greater obligation than his existing common law duty. Moreover, they can be vexatious in practice and, since they operate unevenly throughout the country, they may impair the value of comparative studies.

6.13 These different legal provisions and examples of administrative practice hardly deserve the title " system ". There is no clear obligation upon doctors, whose knowledge of the nature of disease and injury makes them the persons most fitted to identify " unusual " deaths, to report such deaths for further investigation. Even the deaths into which a coroner has a duty to enquire are nowhere set out in clear and unmistakable terms. It will be noted that the definition of these deaths contained in section 3 of the Act of 1887 does not correspond exactly with the definition of deaths which a registrar has a duty to report, which are set out in Regulation 51 of the Births, Deaths and Marriages Regulations 1968. The Regulations appear to extend, as well as to interpret, the rather exiguous terms of the Act, which we shall now look at in a little more detail.

6.14 The Act refers in particular to " a violent or unnatural death or a sudden death the cause of which is unknown ". All these terms are capable of different interpretations, but perhaps the concept of the " natural " death is the most difficult. In a philosophical sense, all deaths can be regarded as natural, since death is the natural end of all men. Even in medical terms, it is possible to regard all deaths as natural in the sense that they result from the failure of one or other of man's vital organs. There is no generally accepted legal or medical definition of either a " natural " or " unnatural " death and the fact that some deaths are regarded as being one rather than the other results as much from the judgment of the person making the distinction as from the application of any objective tests. In considering the question of what is or is not an unnatural death it may be useful to ask " what was the real or underlying cause of death, as distinct from the terminal cause? " or, putting the same question another way " was the terminal cause of death itself the direct consequence of some outside intervention or external circumstance? ". The answers will vary not only from doctor to doctor

but also according to the current state of medical or socio-medical knowledge. The development of industrial and technological processes is continually creating new and hitherto unrecognised hazards to life and health, which further extend the boundaries of " unnatural " death. For example, although death from cancer of the bladder is usually regarded as natural, it may be thought of as unnatural if the deceased person has been working in conditions which brought him into unusually close contact with certain aniline dyes which are now known to be causative agents of this disease. Even on the therapeutic side, methods of treatment alter with advances in medical knowledge and provision which would have seemed adequate and resourceful in one decade may be regarded as irrelevant, if not irresponsible, in another.

6.15 It is not possible to draw up an exhaustive list of all natural deaths, or even deaths from well-known diseases or conditions generally considered to be natural since, in individual cases, almost any one of these might be considered as an unnatural death. Whether or not a death is natural depends not only on the nature of the condition causing death, but also on the circumstances in which death occurs.

6.16 It is probable, indeed, that if, under the present law, a doctor thinks of reporting a death on the ground that it is unnatural, he does so because it is also, in his opinion, a violent death or a sudden death the cause of which is unknown. The concept of " violence " too is one which has no universally accepted interpretation. The fact that a death has been caused by violence is often readily ascertainable from the condition of a body or from the circumstances in which it is found, but this is not invariably so, since violence can sometimes be successfully concealed. It is generally accepted that a death involving an injury of some sort is a violent death but the converse argument—that a violent death must involve injury—is not so universally agreed. There are also differences of opinion, even between doctors, about whether deaths in connection with which an act of violence has certainly taken place (e.g. a fall or a surgical operation) should be regarded as violent deaths. There is a considerable overlap between the concepts of violent and unnatural death and it may be no accident that they are so closely linked together in the statute. Taken together in the phrase " violent or unnatural" death the words have a commonsense meaning.

6.17 " Sudden death the cause of which is unknown " is the category of death which accounts for the bulk of reports to coroners by doctors. The statutory definition contains two elements—suddenness and doubt—both of which depend for their recognition upon the judgment of the doctor concerned. Our witnesses told us that, in practice, doctors appear to interpret this definition quite flexibly and suggested that doctors do not feel that it is invariably necessary for both elements to be present before they report a death. There seems to be no doubt that doctors are now referring to coroners any death in which they have doubts about the cause, even though it may not have occurred suddenly or unexpectedly. We welcome this development which is in line with our earlier recommendation that doctors who are " qualified " to give a certificate of the fact and cause of death should do so only if they are satisfied that they know the cause. We suggest that in future, the " suddenness " or " unexpectedness " with which a death occurs should

be important simply as a factor in the doctors knowledge, or lack of knowledge of the cause of death.

PROPOSALS FOR THE FUTURE

Violent or Unnatural Causes

6.18 Public interest is greatest in those deaths which *prima facie* appear to have a " violent or unnatural " cause and our witnesses were unanimous in considering that the majority of deaths in this category should be investigated and certified by someone other than the deceased person's own doctor or, in his absence, another doctor called to deal with the death. They gave examples of the sort of death they had in mind—pre-eminently the deaths in respect of which coroners are now accustomed to hold inquests—but they and we have found great difficulty in finding a *generic* term which would cover the extremely wide variety of different circumstances which may make it necessary for a death to be reported for further investigation. We have reluctantly been forced back to the expression " violent or unnatural "—reluctantly because, as we have already explained in paragraphs 6.13–6.15 above, there are real difficulties in interpreting these words. Our impression, however, is that it is the separate use of these words which can be most troublesome and that the use of the two expressions in conjunction is by no means so frequently misunderstood or variously interpreted as either term when used by itself. We think that it may fairly be claimed that, despite strongly held differences of opinion about particular deaths, there is already a broad concensus of view within the medical profession of the sort of death which ought to be reported for further investigation on the ground that it is " violent or unnatural ". For this reason we recommend that a doctor who is qualified to give a certificate of the fact and cause of death whether or not he is also confident that he knows the medical cause of death should report to the " appropriate authority " any death which he has reason to believe may have a violent or unnatural cause. As a guide, any death falls within this wider category if it involves injury of some sort—however the injury is sustained. Appearance of injury is not, of course, an *essential* element; homicides, some suicides or accidental deaths may all be violent or unnatural deaths without external signs of injury.

The Public Interest

6.19 Does this general recommendation require further elaboration into a series of obligations expressed in specific terms addressed to different circumstances? It will be remembered that the existing law[1] does exemplify certain categories of violent and unnatural deaths. A registrar of deaths is obliged to report a death to the coroner in cases when he has reason to believe or when it appears to him that

(*a*) the death has been caused by abortion, or

(*b*) the death has occurred during an operation or before recovery from the effect of an anaesthetic, or

(*c*) the death was due to industrial disease or industrial poisoning.

[1] See paragraph 3.11 above.

We think that the present legislative arrangements whereby it is open to the Secretary of State for Health and Social Security to define specific categories of deaths and to require them to be " reportable " to coroners are an excellent means of adjusting and strengthening the main statutory framework for bringing to notice deaths in which there is thought to be a significant public interest of one kind or another. We propose that this feature should be maintained, but that it should be applicable to doctors as well as registrars.

6.20 We therefore recommend that 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 that a doctor should be obliged to report any death which he has reasonable cause to believe falls within one of these categories. In the main, we envisage that the Secretary of State will prescribe categories of death in respect of which there is for the time being a particular public interest, for example, the deaths of persons who are known to have taken a certain drug or to have been exposed to a suspected industrial disease or hazard. We recommend that the Secretary of State should have power to make a local order because we wish to facilitate the special investigation of local circumstances which may contribute to death. The principal object of such a local order, however, would be to facilitate the examination of causes of death developing over long periods of time which might have a connection with local industries or local conditions of some other kind. In making both national and local orders, it may be expected that the Secretary of State will take advice from other Ministers or other public authorities who may have an interest in the investigation of particular categories of death.

6.21 We consider that, before finally deciding to issue a certificate, a doctor should specifically apply his mind to the question whether he knows any other reason why the death should be further investigated in the public interest. He should consider, for example, whether it is a death which has, within his knowledge, given rise to rumours and gossip in the locality. The giving of a warning to the public against unsuspected hazards which could endanger other lives has been an important feature of the coroner's role as a public servant and we believe that it is in the public interest that a doctor should draw attention to any such danger which he may know or suspect to exist by reporting to the appropriate authority the death of any person who may have died as a result of some act or circumstance about which the public ought to be warned.

6.22 We recommend, therefore, that doctors who are qualified to give a certificate should have a residual obligation to report deaths which may require investigation in the public interest. Our intention is to ensure that deaths are reported which, although they do not fall precisely within the other categories which we have specifically mentioned, nevertheless have features calling for some other investigation.

6.23 Later in this Report[1] we look at this important problem of the reporting of deaths to an appropriate authority from the view point of persons

[1] In Chapter 12 below.

(*other than doctors*) who occupy a special place in the community. At that point we recommend that the deaths of persons who are deprived of their liberty by society (e.g. persons in police custody or prison service establishments or persons compulsorily detained under the Mental Health Act 1959) should invariably be reported to an appropriate authority; and that an obligation to report such deaths should be placed on defined individuals. To reinforce that safeguard, it is appropriate that we should recommend here that a doctor who is qualified to give a certificate of the fact and cause of death should himself report the death if he has any reason to suppose that it has not been reported by any other person having a statutory duty to do so.

Special categories of deaths of public interest

6.24 We do not think it is any longer necessary to maintain as separate categories of " reportable " deaths those deaths which have appeared to have resulted from abortion, neglect or suspicious circumstances: these will be adequately covered by our general recommendations (in paragraph 6.18) for the reporting of deaths believed to have violent or unnatural causes, or of deaths of which the cause is not sufficiently known. We consider now the deaths which may have connection with occupation or employment, which may have been caused or contributed to by the administration of drugs or poison or which may be associated with surgery or anaesthesia.

Employment

6.25 Employment is pre-eminent among environmental factors which are considered to be a cause of unnatural death; and the registrar has a duty to report to the coroner any death which appears to have been due to industrial accident or disease. An industrial accident is usually not difficult to recognise but " industrial disease " is not a clearly defined concept. As it is in fact interpreted for the purpose of reporting deaths to the coroner, it appears to be synonymous neither with disease contracted in the course of employment nor with disease caused by the employment. For a coroner to have jurisdiction, there must be something about the disease which distinguishes it as an occupational risk rather than a risk common to all persons. A number of industrial diseases have been prescribed under the National Insurance (Industrial Injuries) Act 1964; but not all of them can cause death and even the fact that death has been caused by a prescribed disease does not automatically make it one into which a coroner has a jurisdiction to enquire. Nevertheless, when a doctor is satisfied that death is due to a prescribed industrial disease it is almost certainly reported to a coroner—either by the doctor or by the registrar. Similarly, when a doctor is satisfied that the death was due to some occupational risk (but not to a prescribed industrial disease) he normally refers it to a coroner. If a doctor has not referred a death, the registrar does so if any of the information which he obtains from the informant at the time of registration, suggests in conjunction with the statement of cause given on the medical certificate, that the death is linked with the deceased person's occupation.

6.26 In reviewing this somewhat untidy situation and considering what we should suggest for the future, we tried to see why it had been thought

necessary in the past for a death which may have been due to some occupational factor to have its cause certified by a coroner rather than a medical practitioner. Two reasons suggest themselves. First, a coroner is likely to be in a much better position than a doctor to publicise a previously unsuspected relationship in a way which may serve as a warning to persons who might otherwise continue to be at risk. Second, it may have been thought that the establishment of such a relationship was often too complex a matter to be left to the unaided judgment of an individual practitioner. For our own part, we have serious doubts about whether the matter is also too complex to be left to the unaided judgment of a coroner—or indeed of any individual. The establishment of such a relationship might more sensibly be regarded as the province of an expert committee in occupational medicine. However, it would be outside our terms of reference for us to consider matters of that kind. Our task is to make sure that deaths in which occupation may have been a factor are or can be separately identified in the certification process.

6.27 The problem of identifying deaths in which occupation or employment may have been a significant factor must be looked at from the point of view both of the doctor who is "qualified" to give a certificate and is satisfied that he knows the medical cause of death and of the doctor who is also qualified to give a certificate but who is not satisfied—within the terms which we have suggested in paragraph 6.05 above—that he knows the cause of death. In accordance with the recommendation that the doctor in the second case will report the death to the appropriate authority. In any death which is reported under this provision, the possibility cannot be excluded that "employment" will be found by the appropriate authority to be a factor in the death—even if the doctor had no such thought in mind when he decided to refer it for further investigation. Indeed, the fact that the further investigation may be extensive, and that it may look for other causes of death beside the purely medical ones, increases the possibility that evidence will be revealed that employment was a factor in the death. The authority may also have investigated one or more similar deaths in the past and the totality of the information available to him may suggest a line of enquiry that would not have been apparent to a certifying doctor.

6.28 The recognition that employment was a factor in a death is a matter of considerable importance to relatives (who may have a claim against the employers) as well as to the public at large.[1] Considerations of equity suggest that, if employment is to be looked for as a factor in a death the cause of which has not been certified by a doctor, it should also be considered by a doctor called upon to certify a death even if he is certain that he knows the medical cause. In other words we propose that, even if he is satisfied that he knows the cause of death, a doctor should be specifically asked to consider whether employment might have been a factor. In this way, doctors may be encouraged to bring to light previously unsuspected occupational risks.

Drugs

6.29 The interests of the public (who may need to be warned against the effect of certain drugs) and the interests of medical knowledge and

[1] See Chapter 17 below.

research would both be advanced by a requirement that a doctor should report for further investigation any death which he has reasonable grounds for believing may have been caused or contributed to by any "drug". It is just as important to the community that death in which a well-known medicinal drug has played a part should be investigated as it is that there should be investigation into deaths which have been contributed to by the better known "drugs of misuse" (e.g. heroin). That is why our reference to drugs is deliberately left unqualified: it extends to the whole range of medical treatment and includes drugs which are normally regarded as beneficial. Our recommendation is to the effect that when a doctor has reasonable grounds for believing that a death may have been caused or contributed to by any medicine or drug he should report it to the "appropriate authority". We believe that it is in the public interest that such deaths should be reported to an authority which can if it wishes give publicity to what may have been a previously unsuspected danger. But we emphasise that it is not our intention that a report to the "appropriate authority" should be regarded as any kind of substitute for the report which doctors already make on a voluntary basis to the Committee on the Safety of Medicines (formerly the Dunlop Committee). In any case in which a report has not been made by a doctor the "appropriate authority" should itself consider whether to make a report.

Poison

6.30 A suspicion that a death may be due to or contributed to by poison, however administered, is already a ground for reference to a coroner by a registrar. In practice, therefore, it is also a ground for reference to a coroner by a doctor. It is clearly in the public interest that there should be a thorough enquiry into any death in which there is suspicion of poison whether accidentally or deliberately administered. We recommend that a doctor should be required specifically to consider the possibility of poisoning before deciding not to report a death for further investigation.

Surgery and anaesthesia

6.31 The registrar of deaths is required[1] to report to the coroner any death which "appears [to him] to have occurred during an operation or before recovery from an anaesthetic". Additionally, as we have seen,[2] coroners in some areas operate "local rules" under which hospitals are required to report all deaths within 24 or 48 hours of admission and sometimes also all deaths occurring within 24 hours of the first administration of an anaesthetic in preparation for a surgical operation. We found it very difficult to assess the practical effect of these arrangements. It seems possible that some deaths which occur during an operation or before recovery from an anaesthetic are not reported to the coroner, but we could not discover that the public interest had suffered because of this. It is quite clear that many deaths associated with an operation are due to the already observed and confirmed presence of gross advanced disease and the chances of a successful operation were from the outset recognised as slender both by doctors and by the patient or his relatives. It would be disadvantageous to extend the present requirements for reporting such deaths when the numbers in which

[1] Births, Deaths and Marriages Regulations 1968, Rule 51.
[2] See paragraph 6.12 above.

there is need for external enquiry are almost certainly very limited. We are in no doubt that the medical profession and the hospital and other authorities concerned are vigilant in making their own enquiries into deaths which may have been caused or exaggerated by mechanical failure, by divergence from normal operative procedures or by the unexpected effect of a particular technique or type of anaesthetic. The information thus gained may help to prevent other deaths from the same or similar causes. But surgery and anaesthesia are no longer as significant in this context as they used to be. Some other procedures and applications in treatment carry hazards to the patient of greater danger because of their novelty or technical complexity. The issues therefore before us have been whether to continue to single out surgery and anaesthesia for special reporting to the " appropriate authority "; whether, instead, to suggest that the present requirements should be ended; or whether to make proposals which would have the effect of involving the " appropriate authority " in enquiries into many more kinds of hospital deaths than those associated with surgery or anaesthesia.

6.32 As we have just indicated, one aspect of the public interest in deaths occurring during an operation or immediately after an operation is to gain knowledge from an expert enquiry into such tragedies in order to help avert others of the same kind. We also sense, however, that there is a more general public sensitivity towards deaths in this narrow category—just as there is towards deaths of persons in custody. We are quite satisfied that, save for this factor of public sensitivity, there are no sufficient grounds of scientific or other public interest which would justify the retention of the present requirement that all deaths occurring during an operation or before recovery from an anaesthetic should be reported. Nor can we find sufficient grounds for extending such a requirement to other categories of hospital deaths, for example, those occurring during or immediately following a particularly complicated therapeutic or diagnostic procedure. Techniques of diagnosis and treatment are changing too rapidly for hard and fast rules to be made. We are therefore persuaded that we should leave to the Secretary of State for Social Services the determination of those categories of hospital deaths which at some stage in the future, it may be appropriate to make reportable to " the appropriate authority ". On balance, however, we have concluded that, even though it may sometimes serve no substantial practical purpose, the present requirement for reporting deaths associated with surgery or anaesthesia should be retained for a further period until experience of its working may be reviewed in the new context produced by our other recommendations. We suggest that, when a doctor reports such a death to the appropriate authority, it would be useful if he were to indicate to the authority his opinion as to whether the real cause of death was natural disease or whether there is some real anaesthetic or surgical problem deserving expert investigation.

The obligations of a doctor who is " qualified " to give a certificate of the fact and cause of death

6.33 It will be convenient if we now draw together, for the purpose of making firm recommendations, the various conclusions which we have reached in the previous paragraphs. We recommend that a fully registered

medical practitioner who has attended a deceased person within seven days of his death and who has inspected the body after death should be obliged *either* to give a certificate *or* to report the death for further investigation; but that he should issue a certificate only if

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

(*b*) 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;

(*c*) 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;

(*d*) the cause or circumstances do not make the death one which the law requires should be reported to the appropriate authority;

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

6.34 In future it will not always be sufficient for a doctor to give a certificate which is simply as accurate as he can make it; he will be required to consider whether that standard of accuracy is good enough. We have recommended that, in future, a report to an appropriate authority should be mandatory unless the doctor is confident on reasonable grounds that he can accurately certify the medical cause of death and the death is not one which he has a specific obligation to report. Our recommendations should lead to a significant increase in the number of deaths reported for further investigation and the performance of many more post-mortem examinations. Since we are completely satisfied that certification when clinical diagnosis has been supplemented by a post-mortem examination is, in general, a more accurate procedure than certification without such an examination, the fact that the implementation of our recommendations would probably result in more post-mortem examinations being performed is likely to provide one basis for the general improvement in the accuracy of medical certification which it is our aim to promote. We discuss (in Part V) the resources, in terms of the numbers of suitable pathologists and adequate facilities, which will be necessary if these additional autopsies are to be carried out. The other basis for an improvement in the standards of medical certification of the causes of death should be a greater accuracy in those certificates which continue to be given by medical practitioners, since the operation of the duty to report should ensure that doctors will certify only those deaths of whose cause they are in no doubt. When these new obligations are placed on doctors, not only will medical science be able to make use of the benefits of more accurate certification, but society will be further protecting itself against the possibility that a suspicious death may not be investigated.

The doctor with an " interest " in a death

6.35 Before we leave the subject of the limits on a doctor's ability to give a certificate of the fact and cause of death we should consider the position of the doctor who is called upon to give a certificate in respect of a member

of his family and of the doctor who is aware that he has a pecuniary interest in a death. At present there is nothing in the law to prevent a doctor giving a medical certificate of the cause of death in respect of his own wife or in respect of someone who may have left him a considerable legacy. Doctors have been known to give certificates in both sets of circumstances and there have been examples (although not in recent years) of doctors who have murdered their relatives and who have then sought to conceal the fact by giving medical certificates of death from natural causes.[1]

6.36 Taking first the question of whether or not a doctor should be allowed to give a certificate in respect of a close relative, our view is that this should depend entirely on whether or not he or she has been in recent clinical attendance upon a deceased person during the last illness. We understand that the practice of doctors in treating or not treating their own close relatives varies: some do and some don't. This seems to us to be a matter of medical ethics on which we are not competent to express an opinion. We accept that a doctor in such a position may be uniquely well placed to commit a murder which may escape detection but we are inclined to think both that the risk that murder will in fact be committed is extremely small and that a doctor resolutely determined to kill a close relative would carry out that resolve whether or not the law allowed him to give a certificate which might be accepted by a registrar. We therefore do not recommend any change in the law to prevent doctors certifying the fact and cause of their relatives' deaths.

6.37 There is, perhaps, a better argument in favour of making it impossible for a doctor to give a certificate if he knows that he has a pecuniary interest in a death. We have already made it clear that it is no part of our concern to make it easier for doctors to give certificates of the fact and cause of death. Indeed, we have recommended that they should be obliged not to do so in certain circumstances. Under our proposals, doctors will have a new responsibility for the accuracy of the certificates which they give and in these circumstances it is arguable that we should not allow them to operate in circumstances in which any question of their own self-interest might be thought to be in possible conflict with the public interest. It is possible that the public might feel reassured if it were known that a doctor could not give a certificate in respect of any death from which he knew he would profit.[2]

6.38 Nevertheless, we are quite satisfied that there is no need for us to make a recommendation to this effect. In the first place a requirement that a doctor should not give a certificate if he knows that he is to benefit under

[1] Dr. Havard cites cases occurring in 1865 and 1887 in which a doctor was convicted of murdering his wife and another in 1947 when police enquiries ceased after the suicide of a doctor whose four wives had all predeceased him. Havard, *op. cit.*, pages 103–104.

[2] Some such thoughts may have been in the minds of those who were responsible for devising a procedure to regulate Cremation Regulations for since 1903 when the first Cremation Regulations were introduced there has been a question on the first cremation medical certificate requiring the doctor who had attended the deceased in his last illness to state whether or not he had such an interest in the death. But neither the certificate nor the Regulations indicate whether an affirmative answer to this question should be regarded as having any significance. The question did not appear on any of the certificates devised by the Cremation Society which formed the basis for the prescribed certificates and there is no reference to the question of pecuniary interest on the report of the Departmental Committee which produced the draft regulations (Cd. 1452).

a legacy would be quite impossible to enforce. Doctors who are beneficiaries will not always know this fact and those who do know may be able plausibly to claim ignorance, if they are challenged afterwards. We do not believe the remote possibility that a doctor would murder a patient for money is likely to be affected one way or the other by a requirement that a doctor knowing that he has a pecuniary interest in a death should disqualify himself from giving a certificate.

The Doctor who is not Qualified to give a Certificate

6.39 The general aim of all our recommendations is to ensure that the cause of every death is accurately established either by a certifying medical practitioner or by an independent authority. We believe that this situation can best be achieved by placing different obligations upon doctors in different circumstances. For this purpose, we have drawn a distinction between a doctor who is and a doctor who is not " technically qualified " to give a certificate of the fact and cause of death—that is between the doctor who does or who does not meet the requirements set out in the previous chapter.

6.40 We have dealt first with the obligation which we recommend should be imposed upon a doctor who is qualified to give such a certificate. We turn now to consider the doctor who is not qualified to give a certificate of the fact and cause of death. The doctor on whom we believe an obligation can and should be placed is the doctor who, although not qualified to give a certificate has some professional connection with the death. (If a doctor has no professional connection with the death, his duty to report a death to the appropriate authority should be no greater than that of the ordinary citizen.) A doctor with a " professional connection " with the death may be the regular medical attendant of the deceased person (or perhaps the partner of this doctor) who is not qualified to give a certificate because he has not seen his patient in the seven-day period before the death occurred: or he may be a doctor who has had no previous concern with the deceased person during his life but who finds himself called to look at a dead body. We recommend that any doctor who is not qualified to give a certificate of the fact and cause of death but who, in the course of his professional duties, is informed of the death of a person whom he has previously attended, or who attends in person on someone whom he finds to be dead, should be obliged to report the fact of death to an appropriate authority together with any information which may assist the enquiries to be conducted by that authority, including for example, any opinion which he (the doctor) may have about the probable cause of death. He should not, however, report a death to the appropriate authority without first seeing the body and establishing the fact of death.

6.41 We recognise that our recommendation may result in a number of deaths being reported to the appropriate authority by one doctor when another doctor might in fact be able (in the sense of being technically qualified as well as knowing the cause of death) to give a certificate. We considered, therefore, whether or not to recommend that, before reporting a death to the appropriate authority, a doctor should be obliged to make enquiry as to whether any other doctor could give a certificate; but we have concluded that it would not be practicable to impose such a requirement. The duty

to make such an enquiry should rest with the authority to whom the death is reported.

Procedure for Reporting Deaths

6.42 We recommend that a doctor should be obliged to report a death to the appropriate authority as soon as possible after he has decided that a report is necessary. In most cases it may be convenient for him to use the telephone in the first instance; but an oral report should be followed up as soon as possible by the issue of a certificate. We recommend that the certificate which the doctor sends to the appropriate authority should be a new certificate of the fact and cause of death (see Chapter 7 below). In future, this should be sent either to the registrar of deaths or to the appropriate authority. If he is reporting the death to the appropriate authority, the doctor should complete as much of the certificate as possible before sending it to the authority. He should always indicate on the certificate the reason why he has reported the death. The certificate will serve as a record of the fact that the doctor has inspected the body and is satisfied of the fact of death. But it will also have other advantages. It will provide proof that the doctor has carried out his statutory obligation to report the death and, if the appropriate authority decides that neither an inquest nor a post-mortem examination is necessary, the report will also provide him with a record of the doctor's opinion of the medical cause of death.

Other Persons

6.43 Our intention is that the doctor should in future be, as a matter of law as well as practice, the principal source of reported deaths. But we recognise that frequently someone other than a doctor will get to a body first and there will be other occasions on which, for some reason, a doctor fails to report a death. There are also some particular circumstances in which we consider that it is desirable that the death should not be certified by a doctor. Accordingly, we recommend in Part IV of this Report that certain other persons should be obliged to report deaths to an appropriate authority.

The Registrar of Deaths

6.44 As we have seen in Chapter 3, a registrar of deaths already has a duty to report certain deaths to the coroner. In his consideration of the facts and circumstances of any death which he is asked to register he is required specifically to ensure that the medical certification of the death is in order. In view of the obligations which we propose should be placed upon doctors giving certificates of the fact and cause of death there should in theory no longer be any need for a registrar to provide this kind of check. Nevertheless, there may, in practice, be occasions when the registrar is informed of a death in respect of which there is no certificate available or the medical cause of death is incorrectly certified and we consider that a registrar should continue to act as a "long-stop" in these cases. We recommend that, in relation to the certification of the medical cause of death, the registrar of death should basically retain his present functions and that in drawing up his instructions to registrars the Registrar General should have regard to the specific categories of death which we have mentioned.

CHAPTER 7

THE FORM OF THE MEDICAL CERTIFICATE OF THE FACT AND CAUSE OF DEATH

7.01 The present form of the medical certificate of the cause of death complies with an international model (with which any new certificate must also conform). It is prescribed by Regulations made under section 22 of the Births and Deaths Registration Act 1953. A copy of the certificate is appended to this chapter (at Figure 1). The certificate contains:

(*a*) the name and date of birth of the deceased and the date and place of death;

(*b*) a statement of when the certifying doctor last saw the deceased person alive and whether or not he, or another doctor, saw the body after death;

(*c*) an indication whether the cause of death as certified takes account of information from a post-mortem examination, whether information from such an examination will be available later or whether no post-mortem examination is intended;

(*d*) a statement of the cause of death showing

(i) the cause leading directly to death and any antecedent causes (with the interval between the onset of each of these causes and death) and

(ii) other significant conditions contributing to the death, but not related to the disease or condition causing it.

The back of the certificate provides spaces for the certifying doctor to indicate whether he has reported the death to the coroner and whether he expects to have available at a later date further information that might help in a more precise classification of the cause of death. These questions do not, however, form part of the prescribed form of the certificate and are for administrative use only.

7.02 In the two previous chapters we have dealt with circumstances in which a medical practitioner should either give a medical certificate of the fact and cause of death or report the death to an appropriate authority, and we have made proposals for improving the law relating to both these matters. But discontent with the existing law relating to the certification of death is not confined to criticism of the circumstances in which a medical certificate may or may not be completed. There is criticism also of the form of the certificate itself, which, it is argued, tends to produce information which is neither as accurate nor as comprehensive as the purposes of medical research require.

The need for accuracy

7.03 The provision of information for the advancement of medical science has been for many years a prime purpose of the procedure for certifying the

causes of death. Both therapeutic and preventive medicine have been advanced by the medical research made possible by knowledge gained from the information produced in certification process. This information, once it has been collected, is used in two ways. In the first place, it is used to compile mortality statistics which may serve a wide range of purposes. They make it possible, for example, to observe on a national or regional level the increase or decrease in mortality from a particular disease; to identify its association with a particular area or occupation or other set of circumstances; thus to detect environmental hazards and behaviour patterns; and to assess new methods of controlling disease by observing the good and bad effect of treatments and preventive measures in general use at different periods. These statistics also have an administrative value in that they provide the basic information required to enable rational decisions to be reached, e.g. in the provision and distribution of specific medical facilities and services. But the statistics must be accurate. Although to some extent errors may be self-compensating and general trends may still be detected despite some distortion of the figures, inaccuracies in the stated causes of death must clearly reduce the usefulness of general mortality statistics.

7.04 This is even more true of the second purpose served by information about causes of death, i.e. to enable the histories of selected groups to be studied in detail in order to identify any significant patterns. Where a comparatively small number of cases is examined, any inaccuracy in stated causes of death is, of course, much more likely to distort the conclusions reached. This is true whether the group of records being studied has been selected on the basis of a common cause of death (in which case some of the facts will relate to the wrong people) or the selection has been made on some other basis, such as occupation area (in which case the right people will be studied but some of the facts about them will be wrong).

7.05 Our witnesses have left us in no doubt as to their belief in the prime importance of accuracy in death certification for national medical research. It is also of great importance internationally. The obligation to produce national statistics in a common form clearly implies an obligation to produce accurate statistics. These are needed not only to ensure that international mortality statistics are compiled with the minimum of distortion, but also to provide a sound basis for research in such fields as actiology extending beyond national boundaries. For example, studies of groups migrating between different countries aimed at distinguishing hereditary and environmental features of causes of death found among the migrants will lose much of their value if there is not accurate certification in each country.

7.06 The recommendations in the two previous chapters should go far to ensure that a doctor will only certify the medical cause of death in circumstances where he is able to do so accurately; and that in all other cases reference to an appropriate authority will enable the cause of death to be determined with greater precision. Nevertheless, we feel that there is merit in the suggestion of several witnesses, including the BMA, that the certificate should be re-designed in such a way as to remind the certifying doctor of the need to consider whether he should report a death for further enquiry. We

accept that it is a legitimate criticism of the existing law relating to the certification of the cause of death that there is too great an emphasis on the requirement that a doctor who has attended a deceased person in his last illness should give a certificate and too little on the need for him to consider whether, instead of giving a certificate " to the best of his knowledge and belief ", he should report the death to the coroner in order to get the cause of death determined accurately. In the previous chapter we recommended that the present medical certificate of cause of death should be replaced by a dual purpose document which could be used either as a certificate of the fact and cause of death or as a form of report to an appropriate authority of a death calling for further enquiry. We now recommend that this new document should itself specify the circumstances in which each alternative would be proper so that the doctor is driven to ask himself, before completing the form, whether he is qualified to give a certificate or is required to report the death to an appropriate authority. We append to this chapter at Figure 2 a draft of the new certificate. This is no more than a rough idea of the form this new document might take. The draft assumes the acceptance of the general conclusions reached in previous chapters and the further recommendations on points of detail which follow.

The need for additional information

7.07 We accept that it is an important function of any procedure for certifying the cause of death to provide adequate statistical information for research purposes and we have already stressed the need for this information to be accurate. It has also been suggested that, in the interest of research, much more information should be collected and that the medical certificate of cause of death should be re-designed to facilitate this. In the following paragraphs, we shall consider various suggestions for improving the content of the certificate so as to make it more useful from the point of view of medical research.

Additional identification particulars

7.08 Several organisations, including the Medical Research Council, have drawn attention to the need for a more comprehensive identification of persons who have died, in order to facilitate research into the influence of heredity in various diseases, particularly chronic diseases which have developed over long periods or diseases of a genetically inherited type. If research into deaths of this type is to be effective, there must be a comprehensive " follow-up " of a patient's medical history and, for this purpose, accuracy of identification is essential at all stages. With this in mind it has been suggested that the medical certificate of the cause of death should contain either or both the National Health Service number and the National Insurance number. The NHS number has already served as the identifying factor in various studies which have been carried out on groups of workers. The same number can give access to medical records and, if an adequate system of record-linkage could be introduced, it would also enable access to records of hospital admissions to be obtained. The National Insurance number can provide a link between different employments, but, otherwise, its use is more limited than the NHS number, since half the population (i.e. those who have never been

in paid employment) have never been registered. The National Insurance number may also be changed in certain circumstances and ceases to be used after retirement. We accept that it is desirable for further identification particulars to appear on the certificate and should like to see the National Health Service number made use of in this way. One of the effects of our proposals in the two previous chapters should be that deaths which are certified by doctors outside hospitals (and not reported to the appropriate authority) are likely to be certified by the family doctor, since it is the family doctor who is most likely to meet the qualifications for certifying which we have proposed. Family doctors normally have a record of the NHS number of their patients and we are informed that the use of this number in hospitals is growing. We recommend, therefore, that a space should be provided on the medical certificate of the cause of death for the National Health Service number and that medical practitioners should be asked to provide this information whenever possible.

7.09 Other pieces of identifying information which it has been suggested should be included on the certificate are the date of birth and, in the case of a married woman, her maiden name. There is no need for us to recommend that there should be space for this information on the certificate; since 1 April 1968,[1] both of these particulars are now collected by the registrar from the informant when a death is registered.

Other additional information

(*a*) *Details of occupation*

7.10 Information about a deceased person's occupational history, including details of medical or occupational exposure to toxic substances, is vital to the research which seeks to identify the substances of occupations involving hitherto unsuspected hazards. We have therefore looked sympathetically at proposals put to us that information about occupational history should be recorded on the certificate of the fact and cause of death; but we have concluded, reluctantly, that recommendations to this effect would be impracticable. The relatives of the deceased person, on whom would certainly fall the main burden of supplying this information, may very well not know the precise details of a deceased person's occupation. A person may change his occupation many times in life and the significant period, from the point of view of research, may have occurred many years before his death. The certifying doctor will scarcely ever be in a position to supply the necessary information himself from his own knowledge of the deceased person and he will usually have no way of verifying the accuracy of any information which he receives.

7.11 Moreover, even the most accurate occupational history needs to be studied in relation to other factors if it is to be of real value to medical research. Ideally, information about a deceased person's occupation which is to be used for studies in general morbidity should be related not only to the cause of death but also to his earlier medical history. Reliable medical histories can be made available to research workers only if the information is

[1] See Regulation 48(1) and Form 9 of the Registration of Births, Deaths and Marriages Regulations 1968.

collected in a systematic way during the life of the patient and then made accessible by sophisticated systems of record-linkage. It is true that proposals for such systems have been put forward (e.g. by the Medical Research Council) and that, eventually, such systems may be established; but there are vast problems in collecting the information to be used in such systems and it would be foolish to be over-optimistic about the short-term prospects of valuable research being carried out along these lines.

7.12 For the moment, therefore, we are satisfied that there would be no point in asking doctors to obtain information about occupational history at the time when they give the certificate. Nor do we consider that there is any immediate prospect that reliable information of this kind could be made available as a result of the interrogation of the qualified informant by the registrar of deaths. On the other hand we do not discount the value of obtaining even limited information about a deceased person's occupation and we hope that the present simple statement of occupation (normally the last full-time occupation of the deceased) will continue to be recorded by the registrar.

(*b*) *Ethnic origins*

7.13 It has been suggested to us that research into the causation of disease, in particular the relative importance of inherited and environmental factors, could be assisted substantially by knowledge of the ethnic group of a deceased person and, in the case of an immigrant, by knowledge of the number of years spent in this country before death. It is known that the pattern and frequency of certain diseases, notably cancer and heart disease, can differ widely as between, for example, Europeans and Africans. We recognise that the provision of space on the certificate for details of ethnic origins might produce some information of value to medical research—precisely how valuable this might be we are not ourselves competent to determine. But, however valuable might be the information thus obtained, we believe that the difficulties of collecting and analysing this information are likely to be so formidable that it would be inappropriate to recommend that material for the attempt should be provided. We therefore make no recommendation about the inclusion of a reference to ethnic origins on the medical certificate of the fact and cause of death.

(*c*) *Terminal clinical state*

7.14 We have looked carefully at a suggestion that the certificate should contain, in addition to the antecedent and underlying pathological cause of death, information about the terminal clinical state. The British Medical Association suggested that the certificate might contain a paragraph on the following lines:—

MODE OF DEATH

To the best of my knowledge, this was following:—

(*a*) syncope;
(*b*) coma;
(*c*) convulsions;
(*d*) exhaustion;
(*e*) haemorrhage.

If death was observed, please state whether by:—

(*a*) medical practitioner;

(*b*) state registered nurse;

(*c*) relative;

(*d*) some other person."

7.15 We doubt whether this information, once obtained, would be of any practical use either as a check on the accuracy of certification or, as the BMA themselves suggested, as a safeguard against the concealment of a suspicious death. The terms used to describe the terminal clinical state are incomplete, imprecise and capable of interpretation in various ways. Moreover, since we understand that it is unusual for the certifying practitioner, whether he is a hospital doctor or a general practitioner, to have been present at the actual moment of death, he is likely to have to rely in most cases on the evidence of some other person for his description of the terminal clinical state.

7.16 If the information produced in response to the inclusion on the certificate of questions on the lines proposed is to have any value, it must be subjected to expert scrutiny. But we are advised that even a very experienced doctor will scarcely ever be able to express an opinion on whether the description of the terminal clinical state given by a certifying doctor in the terms suggested by the British Medical Association either confirms or throws doubts on the assignment of the cause of death and we are quite satisfied that such a check on the content of the certificate could certainly not be carried out by registrars of death. The provision of this additional information on all certificates would be of value from the point of view of a check on accuracy only if all certificates passed through the hands of a skilled medical examiner, who would also have the power to require a further examination of the body. The practicability of setting up such a system of scrutiny of certificates is something which we considered in the context of our examination of the arrangements for the disposal of dead bodies, when we concluded that it would be neither practicable nor desirable.

7.17 In these circumstances, and since we are advised that information relating to the terminal clinical state is of little value for the purpose of mortality statistics, we do not recommend that information about terminal clinical state should be included on the certificate.

(*d*) *Multiple causes*

7.18 The existing form of the certificate assumes that the certifying doctor will be able, in every case, to determine the disease or condition directly leading to death and this assumption is also implicit in various international agreements which deal with the certification of death. But there is no doubt that, sometimes, the assignment of death by the certifying doctor to one cause rather than another can involve selection on the basis of a very difficult assessment of probabilities, since any one of a number of causes may equally be held responsible for death. The rise in the mean age of death which has been a characteristic of our society has increased the frequency of instances

where death appears to be the result of a multiplicity of causes. The arbitrary nature of some of the assignments to a single cause of death is now well recognised and there is a growing body of opinion, both in this country and abroad, which is in favour of assigning multiple causes to a death.

7.19 Unfortunately, it would not be a simple matter to introduce a certificate which would require information to be provided about multiple causes of death. There might need to be a change in attitudes to diagnosis and some doctors might find it difficult to adjust to the new responsibility. It would also be difficult to assemble and tabulate this information even if it could be obtained. The introduction of sophisticated computer systems will solve the problems of statistical analysis, but there would remain large problems of interpretation.

7.20 We were informed that pilot schemes in which, for a sample of deaths, information about multiple causes is collected and studied have already been conducted and that the possibility of including multiple causes on a certificate of the cause of death has been discussed both in the Registrar General's Office and within the World Health Organisation. We welcome these developments and we hope that they will be pursued. We look forward to the day when it may prove possible to amend the new certificate of the fact and cause of death in order to allow the inclusion of multiple causes.

(*e*) *Other major morbid conditions*

7.21 It was suggested that the certificate should contain details of other major morbid conditions which are present in the deceased person but which have *not* contributed to his death. One of the consequences of the general tendency of the population to live longer is that people die with many more morbid conditions present than was once the case. These conditions may have developed over long periods but they may have made no contribution to death. The autopsy on a person who has died violently in a road accident, for example, may reveal the presence of a cancer which might, in time, have proved fatal but has not, in fact, contributed to the death. The identification of conditons which are present in a deceased person, even though they may have no apparent connection with the death, can be of considerable importance to medical research. Statistical information about the incidence of disease is at present limited. Although doctors know quite a lot about diseases which cause death, there is a comparative dearth of information about those diseases which are apparently non-fatal. In consequence, both the incidence and the importance of various diseases may be underestimated, e.g. diseases which are considered to be fatal only in rare cases may assume greater significance if their presence is noted on a number of certificates ascribing death to the same cause. There is now a growing interest in the causes of death of people who suffer from particular diseases; it is hoped that research along these lines may reveal hitherto unsuspected relationships between diseases or hidden dangers in the methods of treating an apparently non-fatal disease. We have concluded that it would be desirable and practicable for this information to be collected and we therefore recommend that the medical certificate of the fact and cause of death should be modified

so as to allow for the recording of major morbid conditions which have not caused or contributed to death.

(*f*) *Surgical operations*

7.22 The present law requires a certifying doctor or coroner to include on his certificate information about previous operations in those cases where the condition for which the operation was performed was also the underlying cause of the death, but it was suggested to us that it would be useful if the certificate could contain details of any operation performed shortly before death, whether or not the operation is believed to have contributed to death. We were informed by the Registrar General that a recent piece of research into a possible relationship between the use of the contraceptive pill and death from thrombosis in women of child-bearing age has suggested that a number of deaths selected for study were not, in fact, simple cases of thrombosis, as stated on the medical certificate of cause of death; they occurred shortly after an operation which was performed to deal with a condition now suspected to have been the underlying cause of death. The absence of any mention of the preceding operation on these certificates could have led to mistaken conclusions. This example illustrates the possibility that failure to mention an operation may result in failure to assign a death to the correct underlying cause (i.e. the disease or condition for which the operation was performed). We accept that it is desirable in the interests of accurate certification and soundly based medical research that space should be found on the new certificate for the inclusion of information relating to recent surgical operations and to the condition for which the operations were performed and we recommend accordingly.

7.23 We have not, however, found it easy to recommend what should be the period of time before death within which any operation performed on a deceased person should be mentioned on the certificate. Clearly, it would be impracticable to require doctors to mention any operation performed on a deceased person at any time before his death—although this would be the ideal solution if the interests of medical research were considered to be paramount. What we are seeking to achieve is a mention in the certificate of an operation which may have a greater significance in relation to the cause of death than is at first realised by whoever is giving the certificate of the fact and cause of death. For this purpose we are inclined to think that a period of about three months would be the most suitable, but we do not make a firm recommendation on this point.

(*g*) *Accidents*

7.24 A case for including space on the certificate for details of recent serious accidents involving the deceased person can be made out on much the same grounds as that for the inclusion of details of surgical operations or of major morbid conditions present in the body but not contributing to death. All this information is likely to be valuable to those who are researching into hitherto unsuspected relationships between different diseases or between a particular disease and a particular traumatic experience. Here again it is not easy to recommend the period of time before death in which an

accident has occurred if it is to be mentioned on the certificate and we suggest a period of twelve months with considerable diffidence.

7.25 In the preceding paragraphs we have accepted that there is a case (in the interests of medical research) for including some additional information on the medical certificate of the fact and cause of death. We now therefore recommend that the certificate should be designed so as to include information about

(*a*) other morbid conditions which have not caused or contributed to death;
(*b*) surgical operations performed within 3 months of death; and
(*c*) accidents occurring within 12 months of death.

None of this information is required for the purpose of international commitments, and since it is not directly concerned with the cause of death, we recommend that it should be included in a separate part of the new certificate. The information should not be included in the public register or appear on the certificates issued by the registrar to the public; but it should be available to the Registrar General for statistical or other research purposes.

Figure 1

MED A 6

516451

BIRTHS AND DEATHS REGISTRATION ACT 1953
(Form prescribed by the Registration of Births, Deaths and Marriages Regulations 1968)

Registrar to enter No. of Death Entry

MEDICAL CERTIFICATE OF CAUSE OF DEATH

For use only by a Registered Medical Practitioner WHO HAS BEEN IN ATTENDANCE during the deceased's last illness, and to be delivered by him forthwith to the Registrar of Births and Deaths

Name of deceased.....

Date of death as stated to me.....day of.....19..... Age as stated to me.....

Place of death .....

Last seen alive by me .....day of.....19.....

* { 1 The certified cause of death takes account of information obtained from post-mortem. / 2 Information from post-mortem may be available later.* / 3 Post-mortem not being held. } { a Seen after death by me. / b Seen after death by another medical practitioner but not by me. / c Not seen after death by a medical practitioner. }

CAUSE OF DEATH

		These particulars not to be entered in death register: Approximate interval between onset and death
I	I	
Disease or condition directly leading to death†	(a) ..... due to (or as a consequence of)	
Antecedent causes. Morbid conditions, if any, giving rise to the above cause stating the underlying condition last.	(b) ..... due to (or as a consequence of)	
	(c)	
II	II	
Other significant conditions, contributing to the death, but not related to the disease or condition causing it.	.....	

I hereby certify that I was in medical attendance during the above named deceased's last illness, and that the particulars and cause of death above written are true to the best of my knowledge and belief.

Signature ..... *Qualifications as registered by Medical Council* .....

Residence ..... *Date* .....

* Please ring appropriate digit and letter.
† This does not mean the mode of dying, such as heart failure, asphyxia, asthenia, etc.; it means the disease, injury, or complication which caused death.

FIGURE 2

BIRTHS AND DEATHS REGISTRATION ACT 197
(Form prescribed by the Registration of Births, Deaths & Marriages (Amendment) Regulations 197)

Serial Number

Registrar to enter no. of Death Entry

MEDICAL CERTIFICATE OF THE FACT AND CAUSE OF DEATH

For use only by a FULLY REGISTERED medical practitioner

PARTICULARS OF DECEASED

Full names ..... N.H.S. Number.....

Date of death..... Date of birth (or year if date unknown) .....

Place of death .....

CAUSE OF DEATH

		These particulars not to be entered in death register: Approximate interval between onset and death
I	I	
Disease or condition leading to death	(a) ..... due to (or as a consequence of)	.....
Antecedent causes. Morbid conditions, if any, giving rise to the above cause	(b) ..... due to (or as a consequence of)	.....
(The underlying condition to be recorded last)	(c)	.....
II	II	
Other significant conditions contributing to the death but not related to the disease or condition causing it	.....	.....

CERTIFICATION
Either A or B to be completed

A

To the REGISTRAR of Births and Deaths

I CERTIFY that I have inspected the body of the above-named after death;

that I last attended the deceased for the condition which caused death ..... days before death; and

that I am confident that the cause of death was that recorded above; and

that I know of no reason why this death should be reported to the coroner (see list in certificate B).

B

To the CORONER

I CERTIFY that I have inspected the body of the above-named after death. I am reporting this death because

☐ I did not attend the deceased for the condition which caused death within 7 days before death; or

☐ the death might have been due to or contributed to by her/his employment followed at some time by the deceased, drugs, medicine or poison or a violent or unnatural cause;

☐ I have reason to believe that the death occurred during an operation or under or prior to complete recovery from an anaesthetic or arising out of an incident during an anaesthetic;

☐ the cause or circumstances make the death one which the law requires should be reported;

☐ the death might need to be investigated in the public interest;

☐ I cannot confidently identify the cause of death.

Signed ..... Date.....

Medical Quals. ..... Address .....

SUPPLEMENTARY INFORMATION—to be completed where relevant

Please record any available details of:

Morbid conditions present but NOT contributing to death .....

Surgical operations performed within 3 months of death .....

Accidents suffered by deceased within 12 months of death .....

CHAPTER 8

THE CERTIFICATION OF PERINATAL DEATH

8.01 The use of the term " perinatal death " as a description of still-births and deaths in very early infancy was recommended by the World Health Organisation over ten years ago and has now found general international acceptance—although, for statistical purposes, the length of the perinatal period is differently defined in different countries. In England and Wales, perinatal mortality includes intra-uterine deaths after the 28th week of pregnancy and deaths during the first week of life. According to the Chief Medical Officer at the Department of Health and Social Security, the rate of perinatal deaths calculated per 1,000 total births is " a valuable indicator of the quality of care provided for the mother and the newborn. "[1] In his Report for the year 1968, Sir George Godber pointed out that, although the infant mortality rate in England and Wales fell by almost one half in the twenty year period from 1948 to 1968 (from 34 to 18 per thousand live births) " first-day " deaths still constituted 34·6 per cent of that total.[2] He commented that " the results of our efforts are by no means good enough ". In his oral evidence, Sir George emphasised that despite a continuing favourable trend, the number of still-births and deaths in early infancy continues to present a significant public health problem. In the short term, this situation can best be improved by increasing the availability of good antenatal care, expert attention during delivery and efficient postnatal facilities. But in the longer-term, an improvement can also come from soundly based research into the causes of perinatal death.

8.02 The value of any piece of research depends to a great extent on the quality of the material on which the research is based, and since material for epidemiological research into the causes of perinatal death is mainly derived from the information produced by the certification process, a desire to see whether the quality of this information can be improved might in itself be considered reason enough for an examination of the procedure under which perinatal deaths are investigated and certified. In fact, however, there are other reasons why such an examination is desirable. The law relating to the certification, registration and disposal of still-births has been criticised[3] on the ground that it contains weaknesses and anomalies which could have the effect of allowing the deaths of live-born children, possibly in suspicious circumstances, to be passed off as still-births. The legal definition of a still-birth, the terms of the obligation upon persons to register a still-birth and of the registrar's obligation to notify the coroner of any alleged still-birth which he has reason to believe might have been born alive, have all been called into question.

[1] " On the State of the Public Health ", Annual Report of the Chief Medical Officer of the Ministry of Health for the year 1966, Chapter VI page 96.
[2] Annual Report for 1968, paragraph 5.92.
[3] See, for example, paragraphs 27–31 in the BMA Report " Deaths in the Community ", 1964.

The legal categories of birth

8.03 When a woman produces a human foetus there are three legally recognised descriptions which may be applied to it. It may be:

(1) a live birth
(2) a still-birth
(3) a miscarriage

The first and most important consideration is to decide whether or not it is a live birth. If it is not a live-birth it must be determined whether it is a still-birth or a miscarriage. In deciding whether or not there has been a live birth there is a dual test involving a point in time (the point at which the child has been completely expelled from its mother) and a test for life (breathing or other signs of life). The law does not specify what these other signs of life may be. Once it has been decided that a child has not been born alive the second question (whether it is a still-birth or a miscarriage) is determined solely by reference to the period of the child's gestation. A dead foetus ejected during the first 28 weeks of pregnancy is a miscarriage. A dead child ejected after the 28th week is a still-birth. The law relating to certification, registration and disposal is concerned only with live and still-births. The Births and Deaths Registration Acts do not define a live-birth: the meaning of that term has to be deduced from the definition of a still-birth.

Definition of " still-birth "

8.04 A still-born child is defined in the Births and Deaths Registration Act 1953 as one which has issued after the 28th week of pregnancy and which does not, after complete expulsion, breathe or show any other signs of life.[1] A number of our witnesses told us that they regarded the present situation as unsatisfactory. They criticised the arbitrary nature of the definition of a still-birth

(1) in its reference to a period of 28 weeks' gestation and
(2) in its insistence on the need for complete expulsion from the mother.

The " 28 week rule " for gestation

8.05 As we have seen, the importance of the 28 week rule is that it provides the point in time which distinguishes a still-birth from a miscarriage. If a foetus has been in the womb for 28 weeks before ejection the fact that there has been a delivery must be registered and the entry in the register must relate to a live-birth or a still-birth. The period of 28 weeks' gestation provides the point in time after which there is a requirement to show that a dead foetus was dead at birth. The law is not concerned with a dead foetus ejected before the expiration of this period, for there is no obligation to register a miscarriage; nor is there any regulation of the method of disposal. One or two of our witnesses pointed out that, in theory, it might be possible for a child born alive, but which subsequently dies or is killed, to be passed off as a miscarriage by someone who would claim, if challenged, that the child was not born alive and that registration as a still-birth was not required because the pregnancy had been less than 28 weeks in duration. We were given no examples of any such occurrence and we have been unable

[1] Birth and Deaths Registration Act 1953, section 41.

to discover any for ourselves. Our conclusion is that although deception of this nature is theoretically possible, it is extremely unlikely.

8.06 The period of 28 weeks' gestation is normally calculated by reference to the date of the woman's last menstrual period. It is well known that this basis for calculation is not always reliable and it is true also that a foetus may, in fact, be viable before the expiration of a 28 week period so calculated. In the light of both these facts, it was suggested to us that a period of 24 weeks' gestation might provide a better dividing line between a miscarriage and a still-birth. If the period of gestation was reduced to 24 weeks, it would follow that any foetus ejected within this period could not be a still-birth. It would be a miscarriage unless it were, in fact, a living child. At the end of the period an ejected foetus would be either a still-birth or a live born child.

Would a 24 week period be preferable?

8.07 We are inclined to think that a 24 week period would be a more realistic one from the point of view of the viability of a child born after that time; but the question which we have asked ourselves is whether the advantages of introducing this new concept into a definition of a still-birth are sufficiently strong to balance the disadvantages that such a change would certainly bring. The argument in favour of a 24 week rule is that it would increase the protection afforded to the foetus: by reducing the period of gestation in the still-birth definition the risk is reduced that a live-birth might be disguised as a non-registrable miscarriage. But there remains the problem of detecting and identifying the alleged miscarriage which was in reality a live-birth. This problem could still arise both because of errors in calculations and because a child might show clear signs of life, however briefly, even if it were born before the end of the 24 week period. The disadvantages in changing the definition would not be confined to the additional trouble and inconvenience to the persons on whom would fall the task of securing the certification of a still-birth, its registration and subsequent disposal. The reduction of the period of gestation would have the effect of increasing the number of recorded still-births and this would certainly be to the detriment of all the work now being done with still-birth statistics—which are of a kind where trends are more important than actual numbers. The argument in favour of a 24 week rule was not strongly pressed and after due consideration we have concluded that there is insufficient justification for such a radical change in the law.

" Complete expulsion "

8.08 The existing definition of a still-birth specified, as the necessary reference point in time for determining whether a child is alive or dead, the instant at which expulsion is complete. This part of the definition was criticised by the BMA in their Report, " Deaths in the Community ",[1] in the following terms:

> " The law requires a new born child to have been completely extruded from its mother (although the umbilical cord need not have been severed), in addition to having shown signs of life, and to have breathed,

[1] *Op. cit.*, paragraph 27.

before it can be regarded as having been ' born alive '. A child which has not been born alive cannot, of course, die. It follows that if a child is destroyed while so much as a foot remains in the maternal passages, it cannot be homicide, even though a child may have shown signs of life and have breathed. "

We did not receive any information to show recorded cases of a child being destroyed whilst any part of it was still in the maternal passage or any suggestion for specific modification of the phrase " after complete expulsion. "

8.09 Some of our witnesses thought that the words referring to complete expulsion could simply be deleted from the definition and suggested that the determination of whether any dead foetus had been live- or still-born could depend upon the allegedly scientifically verifiable fact of whether or not it had breathed before dying. It was suggested that the use of this test would represent a move away from an arbitrary definition based on an irrelevance (complete expulsion) towards a recognition that what is important in determining whether or not a child was born live is the question of whether or not it ever had a capacity for independent existence. The argument is superficially attractive, but we believe it to be unsound.

8.10 There are two concepts involved in deciding whether or not a child was or was not alive at birth: viz. a point in time and a test for signs of life. It is necessary first to decide the point in time in relation to the birth process at which the test for signs of life is relevant and secondly what that test should be. The proponents of the argument that the only test which needs to be applied is a determination of whether or not a child has breathed air apparently believe that this one issue can replace the two to which we have already referred. To make breathing the test would dispense with the reference point in time (which becomes the point in the birth process at which breathing took place). But to rely solely on the test of whether or not a child has breathed air is to imply that other signs of life are unimportant and we are not satisfied that we would be justified in accepting that a child completely expelled from its mother and with a heart-beat but which did not breathe should necessarily and invariably be regarded as still-born. It might even be dangerous to do so. If this were the law it would be possible for an unscrupulous person to make sure (either by taking action or even perhaps by neglecting to take action) to ensure that a child otherwise likely to survive the birth process did not reach the point at which it was ready to take breath. There would be no reference point at which his action could be judged. If we retain, as we believe we should, a reference in the definition of a still-birth to other signs of life besides breathing, it follows that we must retain also a point in time. Without a point in time in the definition any child issued after 28 weeks' gestation which had shown signs of life at any stage would be regarded in law as having been live-born. Every foetus which lives in the uterus longer than about 18 weeks will have shown recognisable signs of life in the uterus and a definition along these lines would mean that still-births as a category would completely disappear. In their place, we should have

miscarriages and live births only.[1] We doubt whether the opponents of the expression " after it is completely expelled " intended that their proposed amendment should have this effect. They may have had in mind a new reference point such as " the time at which the birth process starts ". Such a reference point would be most difficult to define, and almost any definition would be difficult to apply in practice. There would be problems of determining when the birth process had begun and in deciding whether, at that point, the child was dead or not. Such imprecision would be most undesirable on a matter that could have serious legal implications.

8.11 Moreover, such a new reference point, even if acceptable for legal and other non-statutory purposes, would reduce the number of still-births and increase the number of live births followed by very early deaths and so (like the proposal to reduce the period of gestation from 28 to 24 weeks, which would produce an apparent increase in the number of still-births) it would ruin the continuity of statistics which were first collected in 1926. After careful consideration of the risks asserted to lie behind the existing definition of a still birth and of the difficulties of finding a better definition, we have concluded that no change is called for on present evidence of actual or potential malpractice.

8.12 We have concluded also that it would be quite wrong to recommend any blurring of the distinction between a still-birth and a death in very early infancy. Although the medical causes of both events may be, and often are, very similar, we believe that public opinion would not tolerate a law which made no distinction between the death of a living child and the failure of an unborn foetus.

Certification and Registration Procedure

8.13 Registration of still-births has been compulsory since 1926.[2] Under the present law,[3] the informant is required to provide either (a) a certificate signed by a qualified medical practitioner or midwife who was present at the birth or who has examined the body or (b) a declaration that no such certificate can be obtained, e.g. in the absence of any qualified person. Since 1960, there has been a legal obligation upon a doctor or midwife who has attended the birth or examined the child afterwards to give a certificate stating to the best of knowledge and belief the cause of death and the estimated duration of pregnancy. Both certificate and the declaration must confirm that the child was not born alive. The registrar is required[4] to report to the coroner any case where he has reason to believe that the child may have been born alive; the coroner decides what action should be taken in the same way as he does when a death is referred to him.

8.14 For registration purposes a still-birth is treated as a birth rather than a death. It follows that a " qualified informant " is allowed 42 days in which

[1] The possibility that a foetus which had never shown any recognisable signs of life might be expelled after an established period of pregnancy of more than 28 weeks seems extremely remote.
[2] Section 7(2) of the Births and Deaths Registration Act 1926.
[3] Section 11 of the Births and Deaths Registration Act 1953.
[4] Regulation 43, Registration of Births, Deaths and Marriages Regulations 1968.

to register the still-birth and, in theory, this lengthy interval of time might be expected to lessen the usefulness of a reference to the coroner by a registrar. But we understand that in practice it is rare for anything like six weeks to elapse before registration, if only because of the difficulties likely to arise in connection with disposal if the still-birth has not been registered. Bearing in mind the close involvement of doctor or midwife in the overwhelming majority of cases (see Table F), it seems unlikely that the extended period often leads to belated reference to the coroner. We appreciate that the more restricted list of "qualified informants" for still-birth registration (which again follows that for birth rather than death registration) may make it difficult in some cases to arrange attendance on the registrar within a week of the event. Nevertheless, since in our view there is much to be said in favour of treating still-births and deaths occurring in early infancy in much the same way, we recommend that the time allowed for registering a still-birth should in future, be the same as the time allowed for registering a death.[1]

8.15 The vast majority of still-births are certified either by a doctor or by a midwife who was present at the birth or who afterwards examined the body—see table F below.

TABLE F

Number and percentage distribution of stillbirths by method of certification, 1964 to 1968. England and Wales.

(Source: the Registrar General for England and Wales)

Year	Doctor		Declaration* or Not known		Coroner		Midwife		
	No.	%	No.	%	No.	%	No.	%	Total
1964	12,744	94·5	29	0·2	172	1·2	601	4·1	14,546
1965	13,010	94·0	13	0·1	172	1·2	646	4·7	13,841
1966	12,543	94·7	23	0·2	144	1·1	533	4·0	13,243
1967	11,852	94·6	19	0·2	133	1·1	524	4·2	12,528
1968	11,123	93·9	18	0·2	142	1·2	565	4·8	11,848

* Declaration by the informant in the prescribed form to the effect that no registered medical practitioner or certified midwife was present at the birth or examined the body, or that his or her certificate cannot be obtained and that the child was not born alive.

8.16 We have been informed that a doctor or a certified midwife is nearly always in attendance at a birth so that the occasions on which a still-birth certificate is given solely on the basis of an examination of the body by a doctor or midwife not present at the birth are very rare indeed. We have already expressed the view (see Chapter 5 above) that it is wrong in principle for doctors to certify as to the fact of something of which they have no personal knowledge and we suggest that the same principle should apply to the certification of still-births. Whatever the form of certificate used (whether a still-birth certificate or the new certificate of perinatal death which we discuss in paragraphs 21–25 below) the certificate should not be given by a doctor or midwife who was not present at the birth.

[1] See paragraph 3.09.

8.17 In line with our earlier recommendation as regards the obligation of a doctor to give a medical certificate of the fact and cause of death,[1] doctors or midwives who have attended at the birth should be obliged either to give a certificate[2] or to report the still birth to the appropriate authority, but they should be able to give a certificate only if

(*a*) they are confident on reasonable grounds that they can certify the fact and the medical cause of the still-birth with accuracy and precision;

(*b*) 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; and

(*c*) they know of no reason why, in the public interest, any further enquiry should be made into the still-birth.

8.18 In every case where neither a doctor nor a midwife is present at the birth an alleged still-birth should be reported to the appropriate authority. 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. It should no longer be possible for a still-birth to be registered on the basis of a declaration by an informant that the child was not born alive.

8.19 The registrar of births and deaths should be obliged to report a still-birth, or alleged still-birth, to the appropriate authority 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 appropriate authority by the certifying doctor or midwife; and

(iii) when it is suggested to him by any person that a certified still-birth may have been a live-born child.

Recommendations at (ii) and (iii) above are, in substance, a re-statement of the existing law under which registrars report deaths to coroners.

8.20 Taken together, the recommendations in the last three paragraphs should be sufficient to ensure that, in future, the medical causes of every still-birth are certified either by an appropriate authority or by a doctor or midwife who is present at the moment of still-birth. It remains to consider the nature and content of the certificate and the investigation that ought to be carried out before such a certificate is issued.

Investigation and recording of causes of Infant Death

8.21 The form of the certificate of still-birth is prescribed in the Births, Deaths and Marriages Regulations 1968 and a specimen is reproduced as

[1] See Chapter 6 above.
[2] We discuss the nature and content of this certificate in paragraphs 21–25 below.

Figure 3. The certificate is modelled upon the ordinary medical certificate of the cause of death, which is, of course, used in the certification of the death of any child who survives the birth process, however marginally. Neither the certificate of still-birth nor the medical certificate of the cause of death is, in our view and that of a number of our witnesses, as effective as it might be in shedding light on the causes of infant death. It is true that the registrar is empowered to collect certain relevant information at the time a still-birth is registered, but he has no similar power in relation to infant deaths.

8.22 Several of our witnesses drew attention to these deficiencies and pointed out that the causes of " death " of still-born children and of infants are very often the same. In the context of perinatal mortality studies, the exact time of death in relation to the process of birth is not significant and it will become less so as improved obstetric technique leads to an increase in the number of infants surviving for a short time after birth. It was suggested that more could be learned about the causes of infant mortality if standard information about still-births and deaths in early infancy could be obtained and the most favoured method of obtaining this information was the introduction of a new certificate of perinatal death. It was pointed out that such a certificate could contain obstetric information about the mother as well as clinical information about the child, and might also include information about duration of pregnancy, birth weight, parents' ages and previous live and still-born infants born to the mother—factors of particular importance in the investigation of perinatal mortality. This sort of information is already obtained by the registrar of deaths under the provisions of the Population Statistics Acts in respect of still-births, but not in respect of early infant deaths.

8.23 The other obvious way of obtaining standard information in the case of deaths in early infancy is by a system of record linkage, i.e. a link between the birth certificate and the certificate of the fact and cause of death. But this would be a cumbersome process and unless the form of these two certificates was drastically altered they would not in themselves provide all the information sought by those anxious to conduct research in this field. There are other reasons, too, why we are disposed to make a recommendation in favour of the suggestion put to us for a new certificate. In the first place, we appreciate the logic of the argument in favour of the introduction of such a certificate: standard information can best be provided on a standard form. Secondly, we are aware that a perinatal death certificate has already been adopted in a number of countries, notably Sweden and Czechoslovakia, whose rates of infant mortality compare favourably with our own.[1] It is arguable that we shall not be able to match these lower rates until we show more curiosity about causes; the best stimulus to more detailed enquiries into the causes of perinatal death may be the introduction of a new certificate.

8.24 The main difficulty in the way of introducing such a certificate is likely to lie in ensuring that the person who gives it is someone with personal knowledge of what he certifies. The doctor who is present at the death of an infant, especially in hospital, may not always know the details of the

[1] See, in particular, Table VI, 1 in the Annual Report of the Chief Medical Officer Ministry of Health, for the year 1966.

Figure 3

MEDICAL CERTIFICATE OF STILL-BIRTH SB 288321

(Births and Deaths Registration Act 1953, S.11 (1), as amended by the Population (Statistics) Act 1960)
(Form prescribed by the Registration of Births, Deaths and Marriages Regulations 1968)

To be given only in respect of a child which has issued forth from its mother after the 28th week of pregnancy and which did not at any time after being completely expelled from its mother breathe or show any other signs of life.

Registered at
Entry No.

*I was present at the still-birth of a *male / *female child born

*I have examined the body of a *male / *female child which I am informed and believe was born

on the ..... day of ..... 19..... to .....
(NAME OF MOTHER)

at .....
(PLACE OF BIRTH)

I hereby certify that (i) the child was not born alive, and
(ii) to the best of my knowledge and belief the cause of death and the estimated duration of pregnancy of the mother were as stated below.

CAUSE OF DEATH	Estimated duration of pregnancy
I	I
DIRECT CAUSE State fœtal or maternal condition directly causing death. (a)	..... weeks
ANTECEDENT CAUSES State fœtal and/or maternal conditions, if any, giving rise to the above cause, stating the underlying cause last. due to (b) ..... due to (c)	Weight of fœtus (if known)
II	II
OTHER SIGNIFICANT CONDITIONS of fœtus or mother which may have contributed to but, in so far as is known, were not related to direct cause of death.	..... lbs. ..... oz.

† { 1 The certified cause of death has been confirmed by post-mortem. 2 Post-mortem information may be available later. 3 Post-mortem not being held.

Signature ..... Date .....

Qualification as registered by General Medical Council, or Registered No. as Certified Midwife. .....

Residence .....

* Strike out the words which do not apply.
† Ring appropriate digit.

THIS IS NOT AN AUTHORITY FOR BURIAL OR CREMATION

4DC

obstetric history. The likelihood that this will be the case (i.e. that it will be a paediatric doctor rather than an obstetric doctor who gives the certificate) will increase with every day that the child lives; but this is an argument for restricting the length of the perinatal period for certification purposes rather than for abandoning the idea of a perinatal certificate. No real difficulty should arise if the internationally accepted period of one week after the birth is adopted for this purpose. This would also be the most convenient period for the purpose of perinatal mortality statistics, which are already compiled on this basis. If a seven day period is chosen, it is likely that the doctor responsible for issuing the certificate of perinatal death will either himself know all the facts relating to the mother and to the delivery which the certificate will require or else he will be able to obtain them easily. In one or two countries[1] a longer perinatal period has been adopted, but we understand that for the most part the factors in a cause of death which are associated with delivery do not extend beyond three or four days and that it is in this period that the major mysteries as regards the cause of death most often arise. Accordingly we do not feel able to recommend the adoption of a perinatal period extending more than seven days after birth.

8.25 For the future, we recommend that there should be a uniform procedure for investigating and certifying all perinatal deaths. The present still-birth certificate should be abolished (although still-births should continue to be separately identified) and the medical certificate of the cause of death should not be used for deaths which occur within seven days of birth. Both these certificates should be replaced by a certificate of perinatal death, which should be completed in the case of still-births and the deaths of children within seven days of birth. In the case of the child dead at birth (the still-birth), the obligation to give the certificate should fall (as we proposed in paragraph 17 above) on any doctor or midwife present at the birth and, in the case of a child born alive who dies within seven days of delivery, a similar obligation should be placed upon the doctor who attended the child before death. In every case, the doctor should be a fully registered medical practitioner and in both cases it should be necessary for him to have inspected the body. In other words we are recommending that the qualification of a doctor to give a certificate of perinatal death should be in terms similar to those which we have proposed in Chapter 5, in respect of a doctor giving a certificate of the fact and cause of death.

8.26 As regards the investigation of perinatal death, it is important that, whether the investigation is carried out by the doctor who gives the certificate or by the appropriate authority, it should relate to conditions in both the mother and the child. The form of the certificate of perinatal death should help to ensure that this is so. Even when an autopsy has been performed on the instance of the appropriate authority, it is necessary to look also to maternal factors to establish the cause of death. The death of an infant may be directly attributable to some condition in the mother (including the umbilical cord or placenta) or it may be due to the manner in which the mother's confinement was, or was not, supervised. A finding in the baby of a condition

[1] In Australia, for example, the period adopted in all the states is 28 days.

FIGURE 4

BIRTHS AND DEATHS REGISTRATION ACT 197
(Form prescribed by the Registration of Births Deaths & Marriages (Amendment) Regulations 197)

Serial number

Still/live-born

MEDICAL CERTIFICATE OF THE FACT AND CAUSE OF PERINATAL DEATH

To be completed:
(a) in respect of a still-born child of at least 28 weeks gestation—by a fully registered medical practitioner or a certified midwife
(b) in respect of a live-born child dying within the first seven days of life—by a fully registered medical practitioner

Registrar to enter no. of death entry

PARTICULARS RELATING TO MOTHER AND CHILD

Full name of mother .....

Name of child, if given ..... Sex .....

Date of death, if live-born .....day of .....19.....

Age at death .....days (complete periods of 24 hours) ..... hours

Place of death or still-birth .....

CAUSE OF DEATH

		Mother	Foetus or child
Disease or condition of foetus, child or mother directly leading to death	(a)	.....	.....
		due to (or as a consequence of)	
Antecedent causes. Morbid conditions, if any, of foetus, child or mother giving rise to the above cause	(b)	.....	.....
		due to (or as a consequence of)	
(The underlying condition to be recorded last)	(c)	.....	.....
II		II	
Other significant conditions of foetus, child or mother, including abnormalities of pregnancy or labour, which may have contributed to but, in so far as is known, were not related to the disease or condition causing it		.....	.....
		.....	.....

Date of birth .....day of .....19...

Place of birth .....

Weight at birth (if known) .....kg.

Number of mother's previous children:
born alive (including any who have since died).....
still-born .....

(1) Date of beginning of mother's last normal menstruation (if known) .....

(2) If reply to (1) uncertain, estimated duration of pregnancy ..... weeks
If not known, enter N.K.

CERTIFICATION

Either A or B to be completed

A

To the REGISTRAR of Births and Deaths

I certify that I have inspected the above-mentioned death/still-birth;

that I attended { at the still-birth* / the deceased child prior to death;* }

that I am confident that the cause of death was that recorded above;

that I know of no reason why this death should be reported to the coroner (see list in certificate B).

B

To the CORONER

I certify that I have inspected the above-mentioned death/still-birth. I am reporting this death*/ still-birth* because

†☐ neither a doctor nor a midwife were present at the birth;

‡☐ I did not attend the deceased child prior to death;

☐ the death might have been due to or contributed to by the employment followed at some time by the mother, drugs, medicine or poison or a violent or unnatural cause;

☐ I have no reason to believe that the death occurred during an operation (on the mother§) or under or prior to complete recovery from an anaesthetic or arising out of any incident during an anaesthetic;

☐ the cause or circumstances make the death one which the law requires should be reported;

☐ the death might need to be investigated in the public interest;

☐ I cannot confidently identify the cause of death.

* Delete whichever is inapplicable.
† To be completed only in the case of a still-birth.
‡ To be completed only in the case of a live-birth.
§ In the case of a still-birth.

Signed .....Date .....

Medical qualifications
Registered number as certified midwife } .....

Address .....

such as " asphyxia " may be a consequence of several different abnormalities in the mother.

8.27 When a perinatal death is reported to the appropriate authority in order that an autopsy may be performed to establish the cause of death, the examination should only rarely stop when the gross autopsy is complete. Although in the case of many deaths of adults an accurate cause of death may be revealed at this stage, the opposite is likely to be true with a death in the perinatal period, where many different conditions can look the same to the naked eye. We are advised that, except in the case of gross developmental errors, extensive specialist investigations will usually be needed.

8.28 Ideally, an autopsy on a child which has died in the perinatal period should be performed in a mortuary attached to a recognised hospital for children or hospital for women and it should be performed by a pathologist recognised as an expert in paediatric pathology. On grounds of practicality, we do not make specific recommendations to this effect, but we hope that the continuing development of pathology services (about which we have something to say in Part V or our Report) will soon enable the ideal to be translated into a reality.

PART II

THE APPROPRIATE AUTHORITY

CHAPTER 9

SYSTEMS IN OTHER COUNTRIES

Introduction

9.01 In Part I of this Report, we recommended that doctors should be obliged to refer to what we have described as the " appropriate authority "

(*a*) deaths which they are not " qualified " to certify (within the terms set out in Chapter 5);

(*b*) deaths about whose medical cause they have reasonable doubt; and

(*c*) deaths occurring in other specified circumstances.

By " appropriate authority " we have meant persons or agencies having independent responsibilities and powers

(i) to establish the medical cause of death when, for whatever reason, the cause of death has not been certified by a medical practitioner; and

(ii) to make enquiries into the circumstances in which some deaths occur, irrespective of whether or not the medical cause of death is already known.

Expressed in this way, the functions may be viewed as distinct and separate, but, as we quickly came to realise, they are, and ought to be, complementary and mutually supporting.

9.02 If the medical cause of every death is to be accurately ascertained and certified it is obvious that, for those cases in which a doctor will be unable to give a certificate, some adjunct to the normal procedure for certification will be necessary. There are bound to be many people who will not be under the care of a doctor when they die. There are bound to be cases where a doctor is not able to give a certificate either because his attendance of the deceased person does not satisfy the new requirements which we have recommended in Chapter 5 or because he is uncertain about the correct diagnosis of the cause of death. The task of an appropriate authority in such circumstances will sometimes be simple and straightforward, for example, when a death is reported to the authority because the doctor who has been treating the deceased person is " technically " disqualified (e.g. by lack of attendance within 7 days of death) from giving a certificate, but is nevertheless fully capable of making an accurate diagnosis of the cause of death. In other cases, it will be necessary for the authority to arrange for an autopsy to be carried out in order to establish the cause of death. Accordingly, the appropriate authority, however it is constituted, must have available sufficient medical resources to allow it to establish the cause of death accurately in difficult or medically complex cases.

9.03 There are also circumstances in which the public interest demands that some enquiry should be made into the circumstances in which a death has occurred (the second function of the appropriate authority). There will be occasions, for example, when a doctor called upon to give a certificate of the fact and cause of death will be unable to do so because he will have decided that the death is in one or more of the categories which, under our proposals, he will be obliged to refer for further investigation into the circumstances in which it occurred. We have marked out this group of deaths from the rest because it is in these that the public interest is essentially involved in the exact determination of the circumstances surrounding the death. Unfortunately as we have observed before in Chapter 6, this group of deaths does not present itself as distinctively defined or, for administrative purposes, readily separable from the generality of all deaths. Indeed, in England and Wales, the procedure under which the medical cause of death is certified by doctors is an integral part of the arrangements for identifying those deaths which call for further circumstantial investigation; and the autopsies arranged by coroners in order to elucidate the medical causes of death which cannot be immediately diagnosed by an attending doctor are similarly an indispensable means of identifying those deaths, in which for one reason or another, there is a substantial public interest.

9.04 Because of this high degree of inter-relationship between the two functions of an appropriate authority, they must be properly co-ordinated. In England and Wales, co-ordination of a rather unusual kind has been effected by the evolution of responsibility for both functions within the single office of coroner; this is much more an accident of history than the result of any deliberate intent.

9.05 It seemed to us essential that, before we made any detailed examination of the need for a reform of the office of coroner, we should try to weigh the advantages implicit in giving to a single " appropriate authority " the responsibilities defined in paragraph 1 above. The Departmental Committee of 1936 (the Wright Committee), which concluded that the office of coroner should be retained, was criticised for not making sufficient study of procedures in force in other countries. We doubt whether this criticism was well founded. It is always difficult for outsiders to make comparative judgments on matters as complex as the operation of the legal and administrative systems of other countries. These are usually more flexible and less administratively tidy than they appear. Their merits are by no means generally agreed by those more closely connected with them and it is difficult for outsiders to appreciate their finer points. Notwithstanding these reservations, however, we felt that a comparative study might illuminate more clearly the strengths and weaknesses of the system in England and Wales and that, at the very least, it would allow us to see in better perspective the force of the argument put to us that the English coroner is an anachronism—shown to be unnecessary by the experience of other countries which manage to do without one. Accordingly, in the following paragraphs we give some account of procedures in some other developed countries and assess their relevance and applicability to the improvement of the existing arrangements in England and Wales.

A. The Procedure in Scotland

The Role of the Doctor in the Certification of Death

9.06 Until 1966, Scottish law required that the medical certificate of the cause of death should be provided by " the medical person who shall have been in attendance during the last illness and until the death of any person ". Literal interpretation of this provision would have meant that there would have been many occasions on which no doctor would have been able to give a certificate, e.g. when someone died suddenly after a long period of apparent good health. It could also have led to difficulties when a number of doctors were in group practice or where death occurred in a large hospital. In practice, however, this provision was not interpreted literally. Instead, when a death occurred in the circumstances described, a certificate was usually issued, amended to show that the certifying doctor had not been " in attendance " but had seen the body after death.

9.07 In order to make statutory provision for this procedure, the opportunity was taken in the Registration of Births, Deaths and Marriages (Scotland) Act 1965 to change the law so that a certificate may now be given under section 24 of that Act either by the doctor in attendance during the deceased's last illness or, if there was no such doctor, by any other doctor able to do so. Doctors no longer have to certify (or delete the certification) that "I attended AB . . . " and can state merely that " AB died on . . . ". This has proved to be a convenience for doctors where, for example, a person dies at a time when his usual medical attendant is not available. We were informed that, in these circumstances, the certificate is issued in most cases by the doctor on duty who has access to the deceased person's medical records and who, on the basis of this information and a sight of the body, can give an accurate certificate.

The Role of the Registrar

9.08 Before 1966, registrars of births, deaths and marriages were required to send to an official known as the procurator fiscal[1] particulars of sudden, violent, suspicious and accidental deaths, and deaths which were due to unknown causes. The latter included uncertified deaths. Since 1st January 1966, in accordance with instructions given by the Registrar General under section 7 (5) and section 28 of the Registration of Births, Deaths and Marriages (Scotland) Act 1965, the registrar has been obliged to report to the procurator fiscal any death which falls into any one of 19 categories. This list is reproduced as an Annex to this chapter.

Disposal of bodies

9.09 The law relating to the disposal of bodies in Scotland is less strict than it is in England. Almost certainly geography has a lot to do with this. In Scotland there are many inhabited areas and islands where there is no resident doctor and at certain times of the year access to these areas can be difficult if not impossible. We were informed that to delay disposal of the body until it could be seen by a doctor would be in many cases impracticable. In

[1] See paragraphs 12–26.

spite of this there is a very low percentage (3·1 per cent in 1969) of cases in Scotland in which the body is not seen before a certificate of cause of death is issued.

9.10 While a body may be interred without registration it is unusual for this to be done and there are stringent statutory rules which must be followed to ensure that such cases come to light. When a registrar registers a death he issues to the informant, under section 27 of the 1965 Registration Act, a certificate that the death has been registered. This certificate must be handed to " the person having charge of the place of interment or cremation previous to the interment or cremation taking place ". If a body is buried without such a certificate being delivered the person having charge of the place of interment is obliged to notify the registrar.

9.11 Cremation, on the other hand, cannot precede registration. The Cremation (Scotland) Regulations are broadly similar to those in operation in England and Wales: and the prescribed cremation certificates as well as a certificate of registration of death (or its English or Northern Ireland equivalent) must be produced before a cremation can be allowed to proceed. Cremation in Scotland is confined to the urban areas, so that problems in respect of death occurring in remote areas where there is no resident doctor do not apply.

The role of the procurator fiscal

9.12 Procurators fiscal are appointed by and subject to the directions of the Lord Advocate, who is responsible in Scotland for the prosecution of criminal offences other than minor offences prosecuted in Police or Justice of the Peace courts. There is a procurator fiscal for each Sheriff Court district, charged with responsibility for prosecution of criminal offences in that area. Nearly all procurators fiscal are full-time officers, but in a few areas where there is a widespread community and small population local solicitors hold part-time appointments. In view of the nature of his duties it is scarcely surprising that it is a requirement that the procurator fiscal should be legally qualified. He need not, however, possess any medical qualifications and normally looks for his medical knowledge to his specialist advisers, pre-eminently police surgeons, many of whom are doctors with considerable experience and standing in their profession. In Edinburgh, the police surgeon is the head of the University department of Forensic Medicine.

9.13 The main responsibilities of the procurator fiscal are to prepare prosecutions in the sheriff court, to conduct those prosecutions and to prepare those cases which are to be prosecuted in the High Court. But it is also his duty to investigate any sudden, violent, suspicious or accidental death, or death from an unknown cause, which is reported to him. The basic object of this investigation is to establish whether or not there has been any criminality or possible negligence involved in a death. He is not obliged to establish the precise cause of death in a medical sense once the possibility of criminal proceedings has been ruled out.

9.14 It is a particular feature of the enquiries conducted by the fiscal himself that they are conducted in private. Potential witnesses are interviewed

informally; they are not accompanied by legal representatives, neither are they on oath. They are not required to sign any statements which may be taken in the course of an interview and, although notes are sometimes taken, these are not admissible in any subsequent proceedings, nor can they be put to witnesses in the course of any public inquiry.

9.15 Responsibility for ensuring that there is opportunity for further enquiry into both the medical and circumstantial causes of some deaths falls mainly on the registrar of deaths (see paragraph 8 above). Procurators fiscal also receive reports from the police, who inform their local fiscal whenever they learn of a death which appears to be one in respect of which the procurator fiscal is required to conduct an investigation. Attending doctors also report deaths to the procurator fiscal and consult with him as to whether the circumstances justify them in giving medical certificates of the cause of death or whether the procurator fiscal is to investigate by way of independent medical inquiry and police enquiry into the circumstances.

9.16 When a death has been reported to him, the procurator fiscal must decide whether further inquiry is necessary. If the notification has come from the police, (e.g. if the death was clearly the result of violence of some kind) the fiscal will be supplied with any statement taken in the course of the police investigation. The fiscal's investigation into a death in populous urban areas is carried out on his behalf by police officers who are plain clothes members of the local CID, seconded for duty as " sudden death officers ". In rural, less-populated, districts the fiscal is assisted by a local police officer. In addition to interviewing and taking statements from witnesses, " sudden death officers " acting for a procurator fiscal also sometimes examine medical records. On the basis of all the information available to him, which almost invariably includes an indication of the view of relatives, the procurator fiscal decides whether an autopsy is necessary.

9.17 It is common for the local police surgeon to make an external examination of the body at an early stage and if, after making such an examination, considering the history of the case from preliminary police enquiry, and discussing the death with the doctor originally called upon to certify the death, the surgeon decides that death was due to natural causes, he will himself issue a certificate. It also sometimes happens that the fiscal asks another doctor who has not previously seen the deceased to examine the body with a view to giving a certificate of the cause of death. If a certificate can be obtained in this way the fiscal will probably decide that no further enquiry is necessary. If, on the other hand, the fiscal considers that an autopsy should be carried out he applies for the sheriff's authority for this. His petition to the sheriff indicates why he considers that an autopsy is necessary. The sheriff's authority is rarely refused when a petition has been presented by a procurator fiscal.

9.18 The object of the fiscal's enquiry is not to establish the cause of death as such, but only to satisfy himself that it resulted from natural causes. However, if a desire for an autopsy is expressed by the doctors who have treated the deceased to establish the precise cause of death, it is usual for a

fiscal to indicate that he has no objection subject to the consent of the relatives being obtained. He does not consider it part of his duty to arrange for a compulsory autopsy to be performed solely to establish the precise cause of death in a medical sense.

9.19 Where an autopsy is carried out for the purposes of an investigation by the procurator fiscal it is usually performed in a local authority public mortuary, but hospital mortuaries may also be used, particularly if the death occurred in hospital. They are performed by police surgeons as well as by hospital pathologists. Specialist pathologists are employed for specialist work. The fiscal is free to choose the practitioner whom he orders to conduct the examination.

9.20 If the death is one within a category set out below, he must report the result of his investigation to the Crown Office. In other cases the fiscal concludes his inquiries whenever he is satisfied that a death was due to natural causes or accident and the circumstances are free from suspicion. As we have already noted, it often happens that a fiscal declares himself satisfied on this point without first seeing the results of an autopsy. Deaths which must be reported to the Crown Office are those:

(i) where there are any suspicious circumstances;

(ii) where death was caused by an accident arising out of the use of a vehicle;

(iii) where the circumstances point to suicide;

(iv) where the death was caused by an accident, poison or disease, notice of which is required to be given to any Government Department or to any Inspector or other officer of a Government Department under or in pursuance of any Act;

(v) where the death occurred in circumstances continuance of which or possible recurrence of which is prejudicial to the health and safety of the public;

(vi) where the death occurred in industrial employment;

(vii) where the death occurred in any prison or police cell or where the deceased was in custody at the time of death;

(viii) where death occurred under an anaesthetic, or in unusual circumstances or if there are features which suggest negligence;

(ix) where death was due to gas poisoning;

(x) where death was directly or indirectly connected with the actions of a third party whether or not criminal responsibility rests on any person; and

(xi) where any desire has been expressed that a public inquiry should be held into the circumstances of the death or where the procurator fiscal is of the opinion that a public inquiry should be held under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1906.

When the procurator fiscal submits a report of his investigations to the Crown Office, it is considered by one of the Advocates-Depute.[1] If the Advocate-Depute decides that the evidence before him is insufficient or inconclusive, he may order further enquiries to be made. If he is satisfied that he has sufficient information, he may decide that no further action is necessary, or he may institute or instruct criminal proceedings or he may order a public inquiry to be held. In the case of a death from an accident during industrial employment, the procurator fiscal himself arranges a public inquiry under the Fatal Accidents Inquiries (Scotland) Act 1895 without reference to the Crown Office. He makes his report after this public inquiry has been held.

The Fatal Accidents Inquiries (Scotland) Act 1895

9.21 If the death is one to which the 1895 Act applies the sheriff must hold a public inquiry. The Act applies to the death of any person engaged in industrial employment which is due to an accident occurring during the course of such employment. The procedure is that the procurator fiscal presents to the sheriff a petition craving that an inquiry be held into the death in question. The sheriff then appoints a date for the inquiry, which is held in public after being advertised in the Press.

9.22 The inquiry is conducted either by the sheriff or by the sheriff substitute. It is held with a jury of seven and is conducted as nearly as possible in accordance with the ordinary procedure in a trial by jury before the Sheriff Court. The procurator fiscal adduces the evidence before the sheriff, having summoned witnesses, who can be compelled to attend and who give their evidence on oath. A witness cannot be compelled to give evidence which may incriminate himself. Interested parties (e.g. relatives of the deceased, any trades union or friendly society of which the deceased was a member, his employer or an Inspector of Factories) are entitled to be present at the proceedings (or may be represented if they so desire), may adduce evidence of witnesses tendered by them and may address the court when all the evidence has been taken. The verdict at such an enquiry must be in a prescribed form " setting forth, so far as such particulars have been proved, when and where the accident and the death or deaths to which the enquiry relates took place, the cause or causes of such accident or death or deaths, the persons, if any, to whose fault or negligence the accident is attributable, the precautions, if any, by which it might have been avoided, any defects in the system or mode of working which contributed to the accident, and any other facts disclosed by the evidence which, in the opinion of the jury are relevant to the inquiry ". This verdict may not be given in evidence or form the basis of any subsequent proceedings whether civil or criminal.

The Fatal Accidents and Sudden Deaths Inquiries (Scotland) Act 1906

9.23 Under the 1906 Act, the Lord Advocate has power to order a sheriff to hold a public inquiry in any case where he considers it expedient to do so in the public interest. Inquiries are held under this Act in a wide variety of circumstances, for example when serious allegations of negligence are made

[1] The Crown Office comprises the Lord Advocate, the Solicitor General for Scotland, five Advocates-Depute (known collectively as Crown Counsel) and an administrative staff under the Crown Agent.

against persons who are unlikely to be charged with criminal offence or when it appears that there is a strong desire nationally or locally for an inquiry to be held. A notable recent example of an inquiry held under this Act, although one which was scarcely typical of the majority of such inquiries, was the inquiry into the tragedy at the Ibrox Park football stadium. The Lord Advocate's power to order an inquiry under this Act is discretionary and could be used in almost any circumstances. In contrast to the situation in England, where the law makes inquests on such deaths mandatory, it is unusual for public inquiries to be held into suicides, road fatalities or other non-industrial accidents. The criterion for deciding whether or not a public inquiry should be held is whether or not it will serve a useful purpose. The Lord Advocate is not precluded from directing that a public inquiry be held by the absence of a request either by the procurator fiscal or some other person that an inquiry should be held.

9.24 A public inquiry under this Act is conducted in a similar fashion to an inquiry under the Act of 1895. As is the case following an inquiry under the 1895 Act, a report as to the evidence or the actual notes of evidence given at such an inquiry is sent by the procurator fiscal to the Crown Office together with the jury's verdict and any rider or recommendation attached to it. It is a duty of the procurator fiscal to communicate a rider or recommendation to a party affected by it and to report to the Crown Office on the steps that have been taken to carry it out.

9.25 It is not unusual for the relatives of the deceased to express the desire for a public inquiry to be held. All such requests are communicated to Crown Counsel, who give careful consideration to them. However, in relation to the number of reports to procurators fiscal, the number of public inquiries is small. The Procurator Fiscal of Edinburgh has been good enough to let us have some statistics relating to deaths reported to him in the first ten months of 1970. Out of 981 deaths reported to him in this period, 12 (or 2·1 per cent) resulted in public inquiries. 14 of these were directed by the Lord Advocate under the 1906 Act and 6 of the 14 were road fatalities. On the other hand, arising out of deaths reported in the same period criminal proceedings under the Road Traffic Acts followed in 11 cases which were not the subject of public inquiries, and other criminal proceedings (murder or culpable homicide) followed in 3 cases.

9.26 The fiscal also told us that in the same period 240 autopsies were carried out on warrants issued by the Sheriff on application by him. He added that there were also many instances among the deaths reported to him where autopsies were performed privately with the consent of the relatives and after consultation with him. Once the possibility of crime has been ruled out, the procurator fiscal only rarely continues with his investigation in order to establish the medical cause of death with accuracy and precision. Nevertheless, if his investigation has disclosed a more precise medical cause of death than the cause which has been registered, he transmits his information to the Registrar General so that the latter can amend his records.

9.27 The Scottish system of special enquiry into the causes of death places strong emphasis on one function of our " appropriate authority "—the

investigation of possible criminality, while attaching comparatively little importance to the other function of establishing the precise medical cause of death. It is true of course that a registrar of deaths may refer a death to a fiscal for purely medical reasons—he must refer every "uncertified death"; but the practice in Scotland does not begin to approach the situation in England, where there is already a tendency for coroners to have reported to them any death the medical causes of which cannot be diagnosed by the general practitioner or hospital doctor concerned without a post-mortem examination.

9.28 There is a fundamental difference of emphasis between English and Scottish procedures, which arises directly from differences in law and legal systems. The law relating to the registration of deaths in Scotland allows a death to be registered on the basis of information about the medical cause supplied by a doctor who need have had no previous connection with the deceased person and who may therefore lack the knowledge that can be provided only by recent clinical attendance. The result is that cases coming to the notice of the procurator fiscal are much smaller in number than the total number of cases in which, suspicious circumstances apart, the true medical cause of death is not known with certainty or precision. Moreover, even when he is exercising what to him is the subsidiary function of establishing the medical cause of death, the procurator fiscal makes much more sparing use of post-mortem examinations than the coroner in England and Wales. The deciding factor in the procurator fiscal's decision whether or not to ask for an autopsy is whether or not there is any suspicion of criminality surrounding the death. We were informed that the slightest suspicion of criminality would suffice to induce him to arrange for such an examination, but that in the absence of that suspicion he would not order an autopsy at public expense against the known wishes of the next of kin simply in order to establish the medical cause of death more accurately. There is still a body of opinion unfavourable to autopsies in Scotland and the fiscal respects such opinion as far as he can. The fact that the autopsy rate in Scotland (i.e. the number of autopsies carried out as a percentage of all deaths) is significantly lower than in England and Wales may be seen from the table below.

TABLE G

Source: The Registrar General for England and Wales; the Registrar General for Scotland

	Total No. of deaths 1969	Autopsy performed			Autopsies as % of total deaths
		under authority of coroner/p.f.	Otherwise	Total	
Scotland	63,821	2,674	7,588	10,262	16·1
England and Wales	579,378	116,104	42,920	159,024	27·4

9.29 In theory it could be argued that the Scottish system achieves a satisfactory balance: compensating for any superficiality in the procedure for certifying the medical cause of death by the attention which it brings to bear on possible criminality. We do not think, however, that taken overall the Scottish procedure could provide a more satisfactory way of achieving

the standards already attained in England and Wales if it were adopted in these two countries. Still less do we believe that it could achieve actual improvement either in the accuracy of certification of medical causes of death or in the rate of detection of other factors affecting deaths in which there is a strong public interest. Indeed the Scottish system does not entirely accord with a basic principle which we established early in our enquiries—that it is only when the medical cause of death is established with accuracy and precision (by autopsy, if necessary) that the possibility of crime can be completely ruled out.

9.30 This is not to say that we have concluded that the Scottish system has nothing to teach us. The close association of the procurator fiscal with the Crown Office and the fact that the decision whether or not a public enquiry should be held into any death is taken centrally are features of the Scottish system which can do much to ensure consistency in procedure and the avoidance of unnecessary public enquiries. We were attracted too by the privacy with which the procurator fiscal was able to conduct preliminary enquiries of relatives and others concerned with a death. We return to these matters in our later consideration of proposed changes in the office of the coroner and in his activities.

ANNEX TO CHAPTER 9, A

TYPES OF DEATH TO BE REPORTED TO PROCURATOR FISCAL BY REGISTRAR OF DEATHS

(1) Any uncertified death.
(2) Any death which was caused by an accident arising out of the use of a vehicle, or which was caused by an aircraft or rail accident.
(3) Any death arising out of industrial employment, by accident, industrial disease or industrial poisoning.
(4) Any death due to poisoning (coal gas, barbiturate, etc.).
(5) Any death where the circumstances would seem to indicate suicide.
(6) Any death where there are indications that it occurred under an anaesthetic.
(7) Any death resulting from an accident in the home, hospital, institution or any public place.
(8) Any death following an abortion.
(9) Any death apparently caused by neglect (e.g. malnutrition).
(10) Any death occurring in prison or a police cell where deceased was in custody at the time of death.
(11) Any death of a new-born child whose body is found.
(12) Any death (occurring not in a house) where deceased's residence is unknown.
(13) Death by drowning.
(14) Death of a child from suffocation (including overlaying).
(15) Where the death occurred as the result of smallpox or typhoid.
(16) Any death as a result of a fire or explosion.
(17) Any sudden death.
(18) Any other death due to violent, suspicious or unexplained cause.
(19) Deaths of foster children.

B. The Medical Examiner System

9.31 We made enquiries about systems used in the United States, partly because we were aware that the office of coroner had been introduced there by the early colonists, partly because the Wright Committee made express mention of a developing use of an official called a " medical examiner ".[1]

9.32 About 1,851,000 deaths occur in the United States each year. The proportion of these which are subjected to medico-legal investigation of any kind varies from state to state and, indeed, between counties within the same state. Each state has complete freedom to adopt whatever system it chooses. There are a number of states which continue, in whole or in part, to operate a coroner's system. In some states, it is possible to find coroners and medical examiners who have adjacent jurisdictions.

9.33 Although the office of coroner was brought to the United States by English colonists it is no longer recognisable in many areas there as the coroner's office of today or its 17th-century predecessor in England and Wales. We need not record the stages of its diverse evolution under American conditions. What is chiefly characteristic of all but a few American coronerships is that the appointment is political; no particular skills are required of the elected nominee (it may frequently happen that the coroner has scarcely any knowledge of either medicine or the law)[2]; and the powers and duties of coroners vary from state to state (in some areas they have the power to order an autopsy only in those cases where there is a very clear suspicion of suicide or homicide). Not surprisingly the value of the office of coroner in the United States has been strongly questioned. In 1928,[3] for example, a report of the American National Research Council exposed many of the weaknesses of the coroners' system as it then existed in many states. There has been a marked trend since then to replace that system by the office of medical examiner.

The medical examiner system in New York

9.34 The information we collected showed that the precise features of the medical examiner system vary somewhat from state to state. We decided therefore to concentrate our study on the system as it exists in New York City because this is recognised as being a particularly good example of the medical examiner system. We are grateful to the Commissioner of the New York City Police and the City's Chief Medical Examiner for the help which they gave us with our enquiries.

9.35 The medical examiner system was introduced into New York City in 1915, following a critical investigation[4] of the coroner's office there. The coroner's offices in the five counties comprising the City were abolished and

[1] Cmd. 5070, chapter III, paragraph 57.
[2] Notable exceptions are the states of Ohio and Louisiana where the coroner, although still elected by popular vote, must be medically qualified. In San Francisco, although there is no legal requirement that the coroner should be medically qualified, it is the invariable practice for a physician to be appointed.
[3] Schultz, O. T. and Morgan, E. M: The Coroner and the Medical Examiner, *Bull. Nat. Res. Council*, No. 64; Washington D.C., July 1928.
[4] Wallstein, L. M., Report on Special Examination of the Accounts and Methods of the Office of Coroner in the City of New York, January 1915.

replaced by a single medical examiner's office, under a chief medical officer. Under New York City legislation a candidate for appointment as chief medical examiner must hold a position in the Civil Service and be a doctor of medicine and skilled pathologist. The appointment is made by the mayor, who also has the power to dismiss the examiner—subject to making known in advance to the Civil Service Commission his reasons for doing so and allowing the chief medical examiner an opportunity to give a public answer to whatever criticisms are levelled against him. The chief medical examiner has the power to appoint and remove subordinate officers, whose numbers are governed by the City Budget. They include deputy chief medical examiners, associate, assistant and junior medical examiners, all of whom are full-time salaried officials with the same basic qualifications as the chief medical examiner. There are also medical investigators (who must be licensed physicians), scientific experts and other officers and employees.

9.36 Although the appointment of the chief medical examiner is made by the mayor (who is elected on a political platform) it is not itself a political appointment, and we understand that its duration is not likely to be affected by the successive election of mayors of different political persuasions. The chief medical examiner is protected because the reasons for any intention to dismiss him have to be made known to a body which is independent of politics. As a result, his office is free from political pressures, and, assuming that he is competent in his job, he is likely to hold his appointment for a considerable period and become highly proficient at his task.

9.37 The chief medical examiner has a duty to inquire into the medical aspects of deaths resulting from criminal violence, by casualty, by suicide, suddenly when in apparent health, when unattended by a physician, in prison or in any suspicious or unusual manner, or where an application is made to cremate.[1] He is required to keep complete records of his inquiries into every death which his office investigates. If his inquiries lead him to suspect criminality or to consider that further investigation is necessary, he is required[2] immediately to notify the appropriate district attorney, who is the official responsible for initiating prosecutions. When he notifies the district attorney he must supply the latter with copies of all the relevant information he has recorded. Copies of records not sent to the district attorney can be made available, upon payment of a prescribed fee, to any properly interested party. The medical examiner's records, though not the statements which he may take from witnesses, are admissible in the American courts. In fact, the provision of expert and objective evidence for use by either party in court proceedings is a recognised function of the medical examiner system. But the examiner has no judicial function and cannot summon a jury or hold a public inquiry or inquest.

9.38 The chief medical examiner receives reports of deaths within his jurisdiction from the police, the Health Department, the attending doctor or any citizen who may be aware of the circumstances surrounding a reportable

[1] New York City Charter, Chapter 60, section 1720, paragraph 6.
[2] *Ibid*, paragraph 7.

death. Citizens of New York have a duty[1] to report such deaths not only to the chief medical examiner but also to the police. Medical practitioners also have a duty to report deaths to the examiner's office, but their compliance is uneven and some simply report all deaths to the City Health Department. Doctors are required to send the Department a certificate of death and a confidential medical report containing an opinion as to the cause of death; both documents are in a form prescribed under the Articles of the City's Health Code. On the basis of the information in these documents it is possible for the Health Department to check whether or not a body may be disposed of without first having to be examined by a medical examiner. Specially trained clerks within the Health Department make a check which is designed to ensure that the chief medical examiner is notified of all deaths within his jurisdiction.

9.39 As soon as a death is reported to the chief medical examiner he or one of his staff of medical examiners or medical investigators must go to the scene of death and take charge of and examine the body. It is then his duty to make a full investigation of the circumstances of the death and to take notes of all the relevant details. If he considers that any objects at the scene may assist in the determination of the cause of death, he is empowered to take charge of these and, if they are portable, to deliver them to the police department. It is the responsibility of the investigating official to decide, after considering the circumstances and examining the body, whether a certificate of death can be issued at the scene or whether the body should be examined by autopsy and the death investigated further. If an autopsy is deemed to be necessary, it must be performed by a medical examiner and will include necessary histological, toxicological, serological and microbiological examinations. When the death is a homicide, the autopsy must be witnessed by at least one other medical examiner.

9.40 The decision whether or not to order an autopsy in any case rests with the chief medical examiner, but he may be sued by relatives or other interested persons who dispute his decision. Even when it may seem self-evident to a medical examiner that an autopsy should be performed it sometimes happens that bereaved relatives, who oppose it, threaten civil action; the possibility of such a suit has been described as an occupational hazard. Because the chief medical examiner is not protected from the consequences of his decisions to conduct autopsies he may come under pressure to attempt a diagnosis of a cause of death without autopsy. The difficulties of trying to establish without autopsy the cause of a death which is sufficiently out of the ordinary to be referred for medico-legal investigation have already been emphasised in this Report and need no further elaboration here.

9.41 We have already noted (paragraph 37 above) that the chief medical examiner is required to report to the district attorney any death which may appear as a result of his inquiries to have been due to criminal action or about which there are suspicious circumstances. We are informed that the working relationship between the Police Department and the Office of the Chief Medical Examiner is extremely good. Although the law does not specifically

[1] New York City Administrative Code, Chapter 39, paragraph 878-1.0.

provide for this, there are also, in practice, strong links between the chief medical examiner and other authorities in the city. For example, information derived from medical examiners' investigations which indicates possible hazards to public health, is promptly reported to the appropriate agencies for remedial action. There is excellent liaison, too, with the academic world; the Chief Medical Examiner in New York City is also Professor in the Department of Forensic Medicine of the New York University School of Medicine. This relationship means that in practice the medical examiner's office can have the assistance of the Department in cases of special difficulty.[1]

Appraisal

9.42 The medical examiner, like the procurator fiscal, is concerned with both the functions of the " appropriate authority " outlined in the first few paragraphs in this Part of our Report. But, like the procurator fiscal, his enquiry into deaths from which potentially criminal causes can be rapidly excluded is thereafter too perfunctory to provide for us an acceptable model of accurate certification of the medical cause of every death. It has never been possible, even in New York, to produce statistics about causes of death in the form in which such records can be produced in England. In many cases, the medical examiner is doing no more than providing evidence of the fact of death of certain individuals which cannot be provided in any other way. Unlike the coroner, his jurisdiction stops well short of adequate enquiry into the circumstances of those deaths which are singled out for special investigation for other than purely medical reasons. Given the predominantly medical bias in a medical examiner's training it is not surprising that the medical examiner's investigation of the circumstances surrounding a death is sometimes not regarded as sufficiently thorough to remove public doubts and suspicions.[2] When an English coroner accepts jurisdiction over a death, he is obliged to certify the cause of death as well as to provide (in inquest cases) the information required for registration purposes. It would be impossible without a fundamental revision of law in fields other than death certification to translate the American medical examiner system to these shores. Such a revolutionary change is not in our view necessary. The virtues of a medical examiner system can be achieved in English conditions by evolutionary change from the existing position.

C. European practice

9.43 With the help of the International Criminal Police Organisation (INTERPOL)—for whose co-operation we are most grateful—we were able to collect and examine information about the procedures in various countries for investigating cases of sudden or violent death and deaths the cause of which is unknown. The information described the current law and practice in Austria, Belgium, Denmark, France, Greece, Italy, Norway, Portugal, Spain, Sweden, Switzerland and West Germany.

The systems in operation in the countries of Western Europe are all different, but they have a number of common features which we identify in the next few paragraphs.

9.44 In all European countries there is a law which provides for the investigation of those deaths about which there is proof or suspicion of criminality. In general, it is the duty of any citizen who is aware of the occurrence or circumstances of a reportable death to notify the police, with whom rests the *initial* responsibility for an investigation. In no country is there any provision for a public inquiry as distinct from court proceedings.

9.45 The conduct of an initial investigation varies considerably, but it is usual for a specially appointed doctor and/or a policeman to examine the body externally and to inquire into the circumstances of the death. The object of the examination and the inquiry is invariably to discover whether a death is natural or unnatural. In most countries, an unnatural death is defined as a death in which criminality is known or thought to have been a contributing factor—a purely accidental death, e.g. from injuries as a result of a fall, which is regarded as an unnatural death in England, is not always so regarded on the continent. If the doctor is able to conclude as a result of his external examination of the body that death was due to natural causes, the investigation usually goes no further. But if, as a result either of the doctor's examination or the initial enquiries conducted by the police, it becomes evident that a crime has been committed, the Public Prosecutor, or his equivalent, must be notified. It is then his responsibility to decide what further action, if any, is required, and to institute criminal proceedings if necessary.

9.46 Once a death has been reported to a public prosecutor the responsibility for deciding the cause of death falls on him unless criminal proceedings are, in fact, instituted—in which case responsibility for determining the cause of death rests with the criminal court hearing the case. The public prosecutor conducts his inquiries in private and does not publish his findings.

Medical examinations

9.47 In several countries there are official panels of doctors who invariably conduct the initial external examination of the body. These doctors have titles like " legal doctor " or " medical examiner ". Their main function is to assist the police by attempting to determine, by external medical examination, whether criminality could have contributed to a death. In some countries (for example, Austria) all deaths are subject to a medical examination or official inspection before disposal of the body can be allowed. It frequently happens that a body is seen after death by more than one doctor, e.g. by an attending physician and subsequently by a medical examiner, and this " double check " may well prove useful on occasions in detecting a possible crime. In Denmark, examinations can, in exceptional circumstances, be performed by

[1] A good working relationship with other agencies is also a feature of the medical examiner system in other states. In Massachusetts, there is a semi-official central medical-legal laboratory which was established by combining the facilities of the Department of Legal Medicine at Harvard Medical School with those of the State Police Laboratory. Forensic pathologists from the medical school respond to requests from the medical examiners passed on to them by the State Police. In addition, one member of the Department of Legal Medicine is a senior medical examiner in the Boston Metropolitan Area and two other members are associate medical examiners. In Virginia, the Chief Medical Examiner has his office in the State Medical College and is professor there of legal medicine and forensic pathology.

[2] In this respect we noted the strong criticism expressed in America of the decision taken by a member of the medical examiner's staff in Boston, Massachussetts, not to perform an autopsy before certifying the cause of death of Miss Mary Jo Kopechne, whose body was recovered from a submerged car which had been driven by Senator Edward Kennedy.

a specially appointed layman. In cases of natural death there appears to be no legal requirement that the precise medical cause of death should be established before a death is registered and disposal carried out.

Autopsies

9.48 It is usual for the Public Prosecutor to be informed if an examining doctor considers that an autopsy is needed to prove or disprove criminality and for the autopsy to be carried out on his authority. If an autopsy is conducted to provide additional evidence for a criminal trial, the authority for it is sometimes given by the presiding judge or examining magistrate. In some countries the magistrate is present when the autopsy is performed.

9.49 The qualifications of doctors performing autopsies appear to vary considerably from country to country, but some have a strict requirement that the autopsy must be performed by a doctor specially trained in forensic work. In Spain, there is a National Force of Forensic Doctors, whose members conduct autopsies when called upon to do so by the authorities. These forensic doctors may seek the assistance of Anatomic Forensic Institutes and Medical Forensic Clinics. Spain was the only country which claimed to have sufficient numbers of forensic doctors for the investigation of deaths where criminality was indicated.

9.50 The number of medico-legal autopsies held as a proportion of all reported deaths varies considerably in the different countries. It was, however, abundantly clear from our enquiries that universal autopsy was the exception rather than the rule in European medico-legal procedures. There appear to be two reasons for this: first, the attitude of the general public in much of Continental Europe does not seem to accept the necessity for an autopsy with the same understanding as is usually shown in England and Wales, and second, the legal framework in which investigations are conducted. The emphasis in the law on the continent is always more on the need to detect a possible crime in connection with a death rather than on the need to establish an accurate cause of death in medical terms. Consequently, the decision as to whether or not a death is " natural " is often taken after a doctor has merely examined the body externally rather than after an autopsy. The reply to the INTERPOL enquiry from the Dutch police admitted that wrong conclusions had been drawn after such examinations and that it was not uncommon for bodies to be exhumed afterwards in order that full autopsies could be performed.

Evaluation

9.51 At least three features of the procedures in force in those countries about which we have information are common to almost all of them and may, we think, be regarded as typical. These are:

(1) the reliance placed on an initial external examination of the body by a specially appointed doctor;

(2) the reliance on the police as the agents of enquiry in the investigation of the circumstances of death;

(3) the avoidance of a specially created " appropriate authority " responsible for either the accurate certification of the medical cause of death (where this is not known to an attending doctor) or the determination of the circumstantial causes of deaths in which there is a substantial public interest.

We have serious reservations about these features.

9.52 The doctor who examines externally the body of someone whose death has been reported for medico-legal investigation has as his objective the detection of signs of possible criminality. But unless he looks at the information obtained during that examination together with information about the recent clinical history (if any) of the deceased and the results of an autopsy, his chances of detecting crime are considerably reduced. Without such aids, he is even more likely to fail if his object is to establish the cause of death correctly in a medical sense. In our view, this should be the objective of every medico-legal investigation into a death, for, when this objective is achieved, society obtains the dual benefit of more accurate statistical information about causes of death and a greater certainty that a death to which some other person or extraneous circumstances has contributed will be identified. Against this criterion, none of the European systems which we have reviewed offer any advantage over that which already operates in England and Wales and which, however uneven in its effectiveness, maintains a measure of co-ordination of function not matched by any system elsewhere as far as we could judge.

D. General conclusion

9.53 So far as we are aware, nowhere outside England and Wales is the first function of the coroner (i.e. certifying the cause of death in a medical sense) performed with the degree of thoroughness that can normally be expected here. In the systems which we examined the function of certifying the cause of those deaths reported for further investigation which did not become the subject of criminal proceedings was performed by the authority to whom the death was first reported or by whom it was initially investigated, i.e. variously by the police, a public prosecutor or a medical examiner. If the inquiries resulted in criminal proceedings or a public inquiry the death was certified in accordance with the findings of the court of inquiry without reference to the authority which had been concerned with the death at the earlier stage. There was thus no exact parallel with the position of the English coroner, who is responsible in law for the certification of every death over which he accepts jurisdiction even if it is also a death in connection with which there are criminal proceedings.

9.54 We believe that there are considerable advantages in a procedure under which all reported deaths are initially reported to the same authority: any attempt to place deaths in categories before they have been initially investigated (e.g. by referring some of them to the police and some to a medical authority of some kind or another) is likely to giverise to mistakes or anomalies. It is true that a certain proportion of all deaths reported under the procedure which we outlined in Part I of our Report will be reported for purely medical reasons and that the medical character of the report will be known from the beginning; but it may happen, as has on occasions happened in the past, that the result of an autopsy conducted for medical reasons will produce information suggesting that some enquiry is called for into the circumstances in which

the death occurred. This is one reason why it is so important that an autopsy should be held whenever a death is reported to an appropriate authority for anything but the most technical of reasons. Co-ordination between the "medical" and "circumstantial" investigation of a death is often most important and this is most likely to be achieved if one person or authority is responsible for both kinds of investigation.

9.55 This does not necessarily mean that the single authority should be equally involved in both kinds of enquiry or that he should necessarily take a personal part in either. Unless he were a qualified, experienced pathologist he would be imperfectly equipped to conduct the medical enquiries (e.g. the autopsy) that would be necessary to establish the medical cause of death; unless he were a trained lawyer with some experience of public proceedings he would be imperfectly equipped to conduct any public enquiry into a death. It would be possible for the official to whom the death was reported to take personal responsibility for only one of these specialist functions (or even neither of them) and still remain in charge of the whole enquiry and responsible for providing a certificate based on its results. What is important is not that one official should be actively concerned with the detail of both kinds of investigation. Rather it is that one man should be responsible for both and that he should be accepted by the general public as being impartial in any dispute and completely free from pressures of any kind. It is difficult to find an official who completely meets this criterion even among the experts who have been suggested by some of the critics of the English coroner system as being better fitted to carry out a coroner's investigations.

9.56 Although it can be argued that factory accidents may best be investigated by factory inspectors, road accidents by the police (and perhaps, later, the Road Research Laboratory) and sudden deaths from unknown causes by pathologists, these persons may not be completely detached from the circumstances of death. An accident in a factory may raise questions about the efficiency of the factory inspectorate; the police have responsibilities for traffic control; and a pathologist may find himself called upon to investigate the negligence of a colleague. The best interests of the public are served by inquiries into sudden deaths, or deaths from causes which remain doubtful, that are conducted under the auspices of someone who is independent of the medical profession, of the police, and of "government" in its widest sense. The English coroner system is all of these things and, whatever changes need to be made in organisation and responsibility of the system, we are in no doubt that the coroner's office, as the present embodiment of the "appropriate authority", should retain its present integration of function and independence of character. In Part III of this Report, we critically examine the coroner system in England and Wales and suggest what changes are necessary for its more effective functioning.

PART III

THE CORONER'S PRESENT AND FUTURE RESPONSIBILITIES

CHAPTER 10

THE DEVELOPMENT OF THE OFFICE OF CORONER

10.01 This chapter follows the development of the office of coroner from its origins to the present day. Our account of the history of the office is taken from several sources and is neither intended nor claimed to be authoritative. Its purpose is simply to give some idea of why the office was first introduced and how the coroner came to be concerned with the duties for which he is now responsible.

10.02 The office of coroner is one of the oldest known to English law. There is evidence of the existence of a coroner (at least in name) as early as the reign of King Alfred (871–910); but the institution of the office is usually dated from the publication of the Articles of Eyre[1] in 1194. The most important reason for the creation of the new office was the need for an official whose primary duty it would be to protect the financial interest of the Crown in criminal proceedings.

10.03 Article 20 of the Articles of Eyre 1194 provided for the election by every county of three knights and one clerk as "keepers of the pleas of the Crown"—*custos placitorum coronas*. The coroner had to be resident in the county or (later) the borough for which he was elected. His other qualification was his wealth. The fact that he was required to be a knight with considerable financial resources was probably seen as a form of insurance against the possibility of misbehaviour—in the event of which his lands or possessions could be confiscated. The county coroner took his oath of office before the sheriff and his tenure was for life and during good behaviour. He would, however, lose his post automatically if he was elected to the office of sheriff or verderer.[2] The office of coroner was unpaid.

10.04 Originally, there were three coroners elected in each county, but throughout the thirteenth century numbers varied between two and four. The first borough coroners were authorised by Royal Charters in 1200. In the towns, too, numbers varied. In some towns only one was elected, but in others there were as many as four. The procedure for election varied but the electors were always the knights and freeholders of the shire or, in the towns, the burgesses. Soon after the first grants to boroughs, by charter, of the right to their own coroner, similar rights were given to or asserted by various "liberties" or "franchises" (i.e. areas within a county in which, for some purposes, the writ of a local landowner replaced that of the King). By 1300,

[1] An "eyre" was a periodical circuit of justices.
[2] A judicial officer who had charge of the King's forests.

there were at least 265 coroners in England and Wales, of whom well over 50 were franchise coroners.

10.05 Throughout the medieval period, the coroner was concerned primarily with the furtherance of the King's financial interests: judicial functions were of secondary and, sometimes, only incidental importance—and interest in medical causes of death was virtually non-existent. During this period, the whole of the judicial system was motivated primarily by the prospect of securing revenue for the Crown and, sometimes, for the judges. Criminals paid heavily for their crimes, not only through loss of life or privileges but also financially. Moreover, proven criminals were not alone in suffering financial burdens at the hands of the medieval judiciary. The preservation of law and order was the responsibility of the whole population. Consequently, the fact that a crime had been committed implied that the men of the neighbourhood had failed in their duty. The judicial authorities were therefore concerned not only with bringing criminals to justice but also with disciplining erring townships. Punishment meted out to towns and neighbourhoods adjudged guilty failing in their duty took the form of heavy fines called " amercements ".

10.06 The precise duties of the medieval coroner as Keeper of the King's Pleas at the time when the office was created have never been authoritatively established. The Articles of 1194 and the earliest borough charters stated simply that coroners were to " keep " (i.e. to record) pleas and other matters pertaining to the Crown.

Not until the second half of the thirteenth century, when Bracton wrote his treatise *De Legibus Angliae*, was there any attempt at a comprehensive definition of the coroner's duties. From Bracton and from the other writers who followed him it is possible to identify among a number of separate duties[1] the holding of inquests on dead bodies.

10.07 As the Keeper of the King's Pleas, the coroner had no authority to act as a judge by trying pleas. Nevertheless, it appears that the coroner did often try criminal pleas, for in 1215 it was deemed necessary to include a provision in Magna Carta to the effect that " no sheriff, constable, coroner or other of our bailiffs, shall hold pleas of our Crown ". Despite Magna Carta, coroners continued to act as judges in criminal cases, and often conducted jury trials in ordinary civil pleas, sometimes in association with a sheriff.

Inquests on dead bodies

10.08 Most coroners' inquests were held on homicides and deaths by misadventure, but, from the earliest times, a coroner was also expected to make enquiries when death was sudden or unexpected, when a body was found in the open and the cause of death was unknown and when a death occurred in prison. Anyone who found the body of a person whose death was thought to be sudden or unnatural was obliged to raise the " hue and cry " and to notify the coroner. In many areas the procedure was for the person who discovered the body—" the first finder "—to inform the " four nearest neighbours ", who would notify the bailiff of the hundred, whose duty it then was

[1] Other duties mentioned by these writers included hearing confessions and receiving abjurations of the realm from felons in sanctuary, hearing appeals and appeals of approvers at the county court, keeping records of exactions and outlawries held in the county court, and attending inquisitions held by the sheriff.

to summon the coroner. Before holding an inquest, the coroner had to view the body and he therefore attended the scene of death immediately he was summoned. Speed was important if the coroner was to have any chance of apprehending a suspect and it could also help to ensure the preservation of the Crown's financial rights, which might be lost if the body was buried or removed. Great importance was attached to the coroner's view of the body and it was the responsibility of the neighbourhood or township in which it was found to see that it was not interfered with before the coroner's arrival. Failure to summon the coroner or intentional removal or burial of a body might lead to the amercement of the community at the Eyre.

10.09 Inquests were always held with juries, which were usually summoned by the bailiff of the hundred acting on the instructions of the coroner. Originally, the jury consisted of representatives of four or more neighbouring townships, but, in the last quarter of the thirteenth century, they were usually joined by twelve freemen representing the hundred. Because they were familiar with the area in which the body was found and often with the circumstances surrounding death, jurors also acted as witnesses at the coroner's proceedings. It was usual for the jurors to go to the scene and to view the body with the coroner. The purpose of the view was to see if there was any evidence of wounding and to decide whether the death had occurred where the body was discovered or elsewhere.

10.10 In cases of homicide and death by misadventure, the coroner had to receive "presentments of Englishry " (or, in Wales, " Welshry "). Under this procedure, kinsmen of the deceased had to come forward and present themselves to the coroner and prove their relationship to him. Failure to prove this relationship would mean that the hundred in which the body was discovered would incur the *murdrum* fine. The existence of this fine meant that the place of death assumed crucial importance and it was by no means unusual for bodies to be moved from one hundred to another in an effort to escape the legal consequences of a death. The original object of this procedure was probably to protect the Norman conquerors in an unfriendly environment. It remained up to and throughout the thirteenth century purely for financial reasons. In only a very few instances would it have been impossible to establish Englishry, but there are many examples of the fine being imposed. The number of fines actually increased in the second half of the thirteenth century, even though, in 1259, it was abolished in cases of death by misadventure.[1] The reason for this must have been that it was cheaper for the kinsmen to contribute to the *murdrum* fine (as members of the hundred) rather than to incur the financial cost of an appearance (or non-appearance) at the inquest, the county court and the Eyre. To the hundred, the *murdrum* fine was just another tax.

10.11 It was also the coroner's duty to ensure the arrest of anyone indicted at the inquest of homicide, or of aiding or abetting homicide. The usual practice was for him to send a warrant either to the sheriff or the bailiff of the hundred, whose responsibility it then was to make the arrest. At the

[1] Provisions of Westminster, c. 25, confirmed by the Statute of Marlborough (52 Henry III), c. 25.

inquest, the coroner also inquired where the criminals had gone or who had received them. One purpose of these inquiries was to obtain the names of more persons or townships which might be amerced at the Eyre.

10.12 But the coroner was not only concerned with the criminal. He also had to attach (i.e. bind over to appear at the county court and the Eyre) a great number of people, from all of whom sureties were required. Those who were regularly "attached" in this way included the persons who were present at the death, the finders of the body and the four nearest neighbours and anyone who might have been aware of the circumstances surrounding the death or who might have been guilty of neglecting his responsibilities in respect of maintaining law and order. The process of attachment was yet another fertile source of revenue for the Crown because, if it was decided at the Eyre that the attached had, in any way, failed in their duty or if they did not appear at either the county court or the Eyre, they would be amerced. In the case of non-appearance, the sureties were also amerced.

10.13 Every coroner's jury also found itself with the duty of having to "appraise" (or value) something—usually the land and chattels of homicides or suicides and those who fled after a sudden or unnatural death. Responsibility for safeguarding such items as were appraised at inquests passed to the township in which they were found and nothing was actually forfeited until the justices at the Eyre decided whether or not they were to be forfeited to the Crown. The jury also appraised the weapon which caused the death in cases of homicide and suicide and the animal or object which caused the death in cases of misadventure. The "thing" which caused the death in a case of misadventure was called a deodand and valuable possessions like cattle and horses were frequently forfeited to the Crown as deodands. Deodands were occasionally given by the Crown to the deceased person's dependants as a form of compensation for their loss.

10.14 After an inquest, a coroner was required to make a record of his proceedings, to include, where appropriate, details of amercements, lands, chattels and deodands and the names of all persons whom he had attached. All this information was inscribed on his roll, which was presented to the justices at the Eyre. Both the coroner and his jury sometimes took part in the proceedings before the justices.

10.15 Because of his preoccupation with what was considered (not without justification) to be financial extortion, the coroner was not a popular official. Townships and hundreds were well aware of the inconvenience and financial hardship that could follow the discovery of a possible homicide or misadventure in their area and it seems likely that successful attempts were often made to conceal dead bodies in order to avoid notifying the coroner—even though those effecting the concealment may frequently have been innocent of causing death. Although the surviving records indicate that inquests on dead bodies were frequently held throughout the thirteenth century in all parts of England, there must have been many deaths which escaped the coroner's attention.

10.16 By the end of the thirteenth century, the coroner had emerged as an important official, second only to the sheriff in the hierarchy of county offices.

But during the 14th and 15th centuries, a number of changes were made in the country's legal system which seriously affected the position of the office. The general eyre, which had never been popular, fell gradually into disuse and had virtually disappeared by 1300. The end of the eyre made an important contribution to the decline in the status of the office of coroner. The link between the coroner and the central law courts which had been an important reason for creating the office was severed. The use of the general eyre to collect forfeitures to the King held by the coroner had never been a profitable exercise, but once it ceased it was never adequately replaced. Moreover the decline of the eyre coincided with the rise to prominence of two new local officials, the escheator and the keeper of the peace, each of whom began to assume some of the duties which had once been performed by the coroner.

10.17 The function of the escheator, who first appeared in the early 13th century, was originally to enquire into the lands of noblemen who had died without heirs, and effect their return to the King. He also kept records of the duties he performed and had to render regular accounts to the Exchequer. The office became a most important element in the King's financial and administrative system and its holder came to be concerned with appraising and taking possession of lands, chattels and deodands belonging to outlaws, abjurors, suicides or the victims of homicides—duties for which the coroner had once been solely responsible. The coroner sometimes made appraisals with the escheator, and sometimes separately, but it was the escheator's record which was the more important, because it was he who had to account to the Exchequer.

10.18 The original role of the keeper of the peace was to assist in the maintenance of order. However, his peace-keeping duties were soon extended and he was given power to arrest and make enquiries into felonies. He then became known as the justice of the peace and, as such, had power to "hold" as well as "keep" crown pleas. This was one reason why the justice became more important than the coroner, for the latter never officially enjoyed the privilege of holding pleas. The justice received sureties from persons bound over to keep the peace and enquired into escapes of men who were imprisoned for felony—again duties which were previously often exercised by the coroner. He encroached more and more upon the coroner's jurisdiction, sometimes acting with him, and at other times in his place. By the end of the 15th century, the justices had reached a position where they had control over coroners and jurisdiction over their misdeeds.

10.19 By 1500, almost the sole remaining function of any importance performed by the coroner was the holding of inquests into violent death, but even these no longer held the same importance as in the 13th century. Whilst the escheator and the justice of the peace had been busily taking over the coroner's duties, another serious blow was dealt to his status with the abolition of the *murdrum* fine in 1340. With it was lost a further incentive to holding inquests. And with his standing so far diminished, it became increasingly difficult to persuade the coroner to carry out his duties conscientiously.

10.20 Despite the efforts of the justices of the peace, crime continued to flourish in medieval England and a great number of murderers in particular

must have gone unpunished. It may have been concern at the number of homicides which led Parliament in 1487 to pass an Act[1] which served both as an inducement to the coroner to carry out his duties diligently and as a deterrent against his not doing so. He was to receive a fee of 13s. 4d. for every inquest held " upon the view of the body slain ", but if he failed to do so, he would be fined a sum of 100s. The fee was to be paid out of the chattels of the convicted felon, or out of the amercement imposed on the township if the felon had been allowed to escape. In 1509[2] a further Act was passed to deal with the coroner's fees. This made it clear that the coroner was not to claim a fee for holding inquests on misadventures—which he obviously had been doing—and was an indication that importance was no longer attached to the investigation of sudden deaths unless there was evidence of felonious violence. It is true that the same Act also required him to view the body of any person " slain, drowned or otherwise dead by misadventure ", but the wording of the statute suggests that the purpose of the view was to allow the body to be afterwards buried, not that it should form the basis of any judicial inquiry.

10.21 It was not until 1751[3] that action was taken to improve the status of the office of coroner, which had in the meantime continued to exist in a moribund state. It was acknowledged that the remuneration provided by the Act of 1487 was inadequate reward for the general tasks expected of a coroner and the Act of 1751 increased this by providing that he should receive a fee of 20s. and travelling expenses of 9d. per mile—in respect of all inquests " duly held ". The new fees were to be paid out of the county rate, by order of the Justices of the Peace, and they were to be in addition to the fee of 13s. 4d. prescribed in the Act of 1487. The Act of 1751 was probably a genuine attempt to restore some dignity and purpose to the office. The increased fee was an encouragement to the coroner to perform all his duties with diligence and integrity and another provision in the Act sought to regulate the coroner's conduct by providing that a coroner could be removed from office by a court which convicted him of " extortion, or wilful neglect of his duty, or misdemeanour in his office ".

10.22 But instead of providing a basis for a reformed coroners' service, the Act caused a series of disputes between the coroners and the judicial authorities which were to continue for more than 100 years. The arguments arose because of differences of opinion as to what constituted a " duly held " inquest. The reasons for the different interpretations of a coroner's duties in relation to dead bodies can be attributed, at least in part, to the lack of any clarification of his duties in the years immediately after the office of coroner was instituted, which led to confusion and misreporting by early historians. The eighteenth and nineteenth century justices on the whole took the view that the coroner was never intended to enquire into sudden deaths unless there was manifest evidence of violence, whilst the coroners contended that their jurisdiction was to include all sudden and unexplained deaths. The justices were able to give practical effect to their view of the law by refusing to pay the coroners' fees for inquests which they considered were not " duly held ".

[1] 3 Henry VII, c. 2.
[2] 1 Henry VIII, c. 7.
[3] 25 George II, c. 29.

10.23 But if some of the justices were hostile to the idea of the coroner investigating any but the most obviously violent deaths, support for a very different view of his functions and responsibilities came from those who were anxious to achieve an improvement in the existing machinery for collecting and recording accurate statistical information about mortality in this country. Two Acts of Parliament passed in 1836 provide evidence of this concern. The first was the Births and Deaths Registration Act (already referred to in Chapter 2), which provided for the registration of every death occurring in England and Wales and which placed certain specific duties on coroners as well as on other persons in some way connected with a death. The occupier of a house in which a death occurred was obliged to notify the registrar of the district within 5 days of the death and a coroner was obliged to notify the registrar of bodies " found exposed " which were reported to him, stating the place where the body was found. The registrar was also to be informed within 8 days of a death of any registrable particulars concerning the death, either by a person present at the death or by a coroner after an inquest, depending upon the circumstances of the death. Burial of a body was permitted upon receipt of a registrar's certificate or a coroner's order for burial—given after an inquest had been opened. Burial prior to the issue of either document was lawful provided the registrar was notified of the fact within 7 days of the burial taking place by the person carrying it out. Failure to give such notification was an offence liable to a £10 fine.

10.24 The second piece of legislation in 1836 was an Act to provide for the Attendance and Remuneration of Medical Witnesses at Coroner's Inquests.[1] The Act gave the coroner a specific power to order a medical practitioner to attend an inquest and to perform an autopsy, if he was not satisfied that the cause of death had been established. The inquest jury was empowered to require the coroner to secure the attendance of any other medical practitioner if a majority of them were dissatisfied with the evidence as to the cause of death submitted by the original medical witness. This second medical witness could also be ordered to perform an autopsy, even if one had already been carried out. The fees of the medical witnesses were to be paid from the funds collected for the relief of the poor. The effect of the Registration Act passed in 1836 was to cause many more cases of sudden death to be reported to coroners and because of the other Act passed in that year the accuracy of the medical information supplied to registrars was also improved.

10.25 In 1837 an Act[2] was passed to provide that coroners should be entitled by law to claim all reasonable expenses for inquests, and not simply fees for medical witnesses. The expenses were to be met from the County Rate or, in the towns, from the Borough Fund. This meant that the justices and the Town Councils were again given the power to examine the coroners on oath as to their accounts, while the coroner was obliged to settle the expenses of all witnesses at the end of the inquest. In the knowledge that the sum which he had already paid out might ultimately be held to be inadmissible, the coroner was in some areas positively discouraged from holding an inquest

[1] 6 and 7 William IV, c. 89.
[2] 1 Victoria, c. 68.

except when there was obvious evidence of felonious violence. In those areas in which the justices took a " strict " line on the legality of coroners' inquests they were able, in effect, to dictate the circumstances in which the police (who had become a chief source of notifications) should report deaths to the coroner. This attitude was attacked regularly in Reports issued by the Registrar General in the middle years of the last century. The Registrar General pointed out that the situation in some areas was such that murders could go undetected and he stressed the importance of medical evidence at coroner's inquests on sudden deaths. The Registrar General's crusade for the county coroner's independence of the justices gained some valuable support with the founding in 1846 of the Coroner's Society of England and Wales.

10.26 However, it was not until 1860, when the County Coroners Act was passed to provide that county coroners should be paid by salary rather than by fee, that county coroners achieved a degree of independence. Even then the justices still retained a measure of control in that they had to agree a salary with the coroner; but the coroner was given a right to appeal to the Home Secretary if agreement could not be reached between himself and the justices. The justices also retained their control over the coroner's expenses in relation to holding inquests.

10.27 Almost as important as the passing of the 1860 Act was the Report of a parliamentary select committee on coroners[1] in the same year. It recommended that the coroner's jurisdiction to hold the inquest should embrace every case of violent or unnatural death, sudden death where the cause was unknown and any death where, though the death was apparently natural, reasonable suspicion of criminality existed. After 1860 the numbers of inquests rose sharply, but it was not until 27 years later that the recommendations of the select committee were implemented in the Coroners Act of 1887.

10.28 The 1887 Act was a watershed in the development of the office of coroner. In consolidating the law relating to coroners, which remains the statutory basis of the law today, the Act confirmed that the emphasis was no longer to be on protecting the financial interests of the Realm, but rather on providing a service for the investigation of both the cause of and the circumstances surrounding deaths, for the eventual benefit of the community as a whole.[2] The coroner's interest in medical causes of death grew gradually as a result of the ever increasing demand of the registration system, which, as it developed, required more precise information on mortality, and in answer to increasing public concern at the possibility that murder might be concealed.

[1] House of Commons Reports from Committees, 1860, 16th Volume.

[2] Over the years, a number of Acts had been passed which effectively reduced the coroner's functions as protector of the king's finances. The *murdrum* fine was abolished in 1340. Forfeiture of a suspected felon's goods was abolished in 1483 by " An Act for bailing of Persons suspected of felony ". The practice of appraising or forfeiting deodands and chattels adjudged to have caused deaths was considered to be unreasonable and inconvenient and was abolished by an Act of 1846. The forfeiture of the goods and chattels of suicides and convicted felons survived until 1870, when it was abolished by an Act of Parliament. Outlawry in civil proceedings was abolished in 1879, but in criminal proceedings, not until 1938.

10.29 The 1887 Act repealed many of the old statutes referring to the coroner and abolished some of his original duties.[1] But the 1887 Act did not completely deprive the coroner of his financial interests, for it was still his duty to enquire into treasure trove. Moreover the coroner retained his duty of acting in the place of the sheriff on occasions, for example, when the sheriff was a party to legal proceedings and therefore unable to act in his official capacity. But the Act made it perfectly clear that the coroner's chief function was to be the holding of inquests on dead bodies. In accordance with the recommendations of the 1860 select committee, the Act provided that:

> " where a coroner is informed that the dead body of a person is lying within his jurisdiction, and there is reasonable cause to suspect that such person has died either a violent or an unnatural death, or has died in prison, or in such place or under such circumstances as to require an inquest in pursuance of any Act, the coroner, whether the cause of death arose in his jurisdiction or not, shall, as soon as practicable, issue his warrant for summoning not less than twelve nor more than twenty-three good and lawful men to appear before him at a specified time and place, there to inquire as jurors touching the death of such person as aforesaid. "

10.30 A year later the Local Government Act of 1888 broke the only remaining links between the coroners and the justices by transferring to the counties the justices' powers to agree with the coroners the amount of their salaries and to control the payment of coroners' fees, allowances and disbursements. The Act also abolished the election of coroners by the freeholders of the county and instead provided that coroners should be appointed by the county or borough council to a county or district within a county.

10.31 The coroner had at last gained sufficient powers and authority to enable him to perform his duties efficiently, but there was no liability upon anyone to notify him of death which fell within his jurisdiction. The days when fines were levied upon people or communities for failing to raise the hue and cry had long since passed and the coroner had to rely upon people notifying him on a voluntary basis. The registrars of deaths from time to time informed him of deaths where suspicious facts had emerged during the registration process, and, as we have seen in Chapter 2, their obligation to report deaths to the coroner was clarified in the instructions issued by the Registrar General in 1885.

10.32 By 1901, coroners were being notified of about 60,000 deaths a year—a figure representing about 10 per cent of all deaths in England and Wales at that time. But in almost a third of these cases, no inquests were held. As the coroner had no authority to order an autopsy unless he also held an inquest, these deaths were registered without further medical investigation. Figures published by the Registrar General in the previous year[2] show that in about 7,500 of the cases in which coroners declined to hold an inquest the deaths were eventually registered as " uncertified ".

[1] Section 44 of the Act: " A coroner shall not take pleas of the Crown nor hold inquests of royal fish nor wreck nor of felonies except felonies on inquisitions of death; and he shall not inquire of the goods of such as by the inquest are found guilty of murder or manslaughter, nor cause them to be valued and delivered to the township ".

[2] Registrar General, 62nd Annual Report, 1900.

10.33. As we have seen in Chapter 2, the registration of uncertified deaths was the subject of several committees and petitions to Parliament throughout the first decade of the 20th century. The Select Committee on Coroners, which reported in 1910, saw the value of a coroner's enquiry which stopped short of the holding of an inquest. The Committee recommended that " in every case in which a medical certificate is not given the death ought to be reported to the coroner. It does not follow that the coroner would hold an inquest, but he ought to be informed of every uncertified death, for the purpose of making enquiry ". They also recommended that a coroner " should, without holding an inquest, have power to order and pay for a post-mortem in cases of sudden death where the cause is unknown and there is no reason to suspect that the death is unnatural or violent ". The practice of coroners in reporting to the registrar that they did not intend to hold inquests was welcomed by the Registrar General. By 1911—and possibly earlier—the General Register Office was issuing coroners with forms which contained a space for them to indicate their intention not to hold inquests. The availability of these forms is probably one reason for the increase in the numbers of deaths reported which were disposed of in this way (see Appendix 2).

10.34 During the early years of this century the coroner maintained a strong interest in the criminal aspects of sudden deaths and as late as 1910, the select committee had encouraged the use of the inquest as a means of obtaining information about crimes. But, by now, the police were fully competent to accept the principal responsibility for investigating and prosecuting homicides. This situation was given statutory recognition in the Coroners (Amendment) Act of 1926.

10.35 The Act reduced the coroner's interest in the detection of crime, but, at the same time, it extended his concern with the accuracy of the certification of the medical cause of death. Several important reforms introduced by the Act had been recommended by the 1910 select committee. Among these were the procedure whereby the coroner was empowered to order an autopsy without having to proceed to an inquest in cases where death was due to natural causes; the abolition of franchise coronerships; and the payment of borough coroners by salary instead of by fees in the same way as county coroners. Other important features of the Act included an obligation on a coroner to adjourn his inquest in cases where someone had been charged with the murder, manslaughter or infanticide of the deceased; a provision that county and borough coroners might appoint assistant deputy coroners; a new requirement that future holders of the office should have medical or legal qualifications, with not less than 5 years standing within their profession; a provision allowing a coroner to sit without a jury in cases of suicides and most kinds of non-traffic accidents; the introduction of a superannuation scheme for county and borough coroners after not less than 5 years' service; and a provision giving the Lord Chancellor power to make comprehensive rules of practice concerning the procedure in coroners' courts and concerning autopsy examinations.

10.36 The 1926 legislation did not lead immediately to a reduction in the numbers of inquests held. The explanation for this was an increase in the

numbers of deaths reported to coroners, which was in itself no doubt partly due to the tightening up of the registration procedures consequent upon the Births and Deaths Registration Act of the same year. During the next ten years, the numbers of deaths reported rose by about 10,000 and, whilst the number of inquests remained fairly constant, the numbers of deaths which the coroner disposed of after autopsy without proceeding to an inquest rose to a number almost equal to the increase in reported deaths. After the second World War, however, the effect of the new procedure was more apparent. By 1969, nearly 70 per cent of all deaths reported to coroners were disposed of in this way. The numbers of inquests held has fallen dramatically. In fact, there are now considerably fewer inquests held than in 1901, when the number of cases reported to the coroner was only half that of today. The effects of the 1926 Act on inquests are illustrated in more detail in Appendix 2.

10.37 In 1935, following widespread criticism of the manner in which some recent inquests had been conducted, a Departmental Committee under the chairmanship of Lord Wright was appointed to inquire into the law and practice relating to coroners. The Committee's report, published in 1936, showed a marked change of emphasis from that of its predecessor in 1910. The 1910 Committee had been very much concerned to enhance the utility of the inquest as a means of obtaining information about crimes. The chief concern of the Wright Committee appears to have been to lessen the damage to persons' reputations occasioned by the rigour of some coroners' enquiries. To this end, the Committee recommended:

(i) that the number of coroners should be reduced;

(ii) that only barristers or solicitors should be appointed;

(iii) that the duty of the coroner's jury to determine whether any person was guilty of murder, manslaughter or infanticide, and the duty of the coroner to commit a person thus named for trial, should be abolished;

(iv) that coroners should be required to adjourn their inquest if requested to do so by a chief officer of police on the grounds that he was considering whether to proceed for an indictable offence in respect of the death; and

(v) that in cases of suicide, the verdict of *felo de se* should be abolished, Press reports should be restricted, and no enquiry should be made into that state of mind of the deceased except in order to throw light on the question whether he took his own life.

The Committee also recommended the establishment of a statutory Rules Committee to draw up rules to govern coroners' procedure, subject to the approval of the Lord Chancellor and the Home Secretary, and of a Disciplinary Committee to consider complaints about coroners.

10.38 There has been no major legislation on the subject of coroners since 1926, and consequently those of the Wright Committee's recommendations which required to be enacted in legislation have not been put into effect. In fact, not until 1950 was any action at all taken in respect of the Committee's recommendations. In that year a Rules Committee, under the chairmanship of Sir Austin Jones, sat to compile a set of draft Rules. The Committee was an advisory and not, as the Wright Committee had

recommended, a statutory body. The Rules were finally made in 1953 under the powers granted to the Lord Chancellor by the 1926 Act. They represented the first attempt by Government to establish some uniformity of practice in coroners' courts practice and paid particular attention to proceedings in court. In 1952, a circular letter from the Home Office drew the attention of those local authorities having the power to appoint coroners to the recommendation of the Wright Committee that administrative action should be taken to reduce the number of small coronerships.

10.39 Nearly 800 years after its introduction, the office of coroner still exists and is again under scrutiny. In the succeeding chapters we examine the practicality and desirability of the various suggestions for changes in the nature of the office and of the coroner's powers, duties and activities which have been put to us. We do so against the background of a description of the existing situation.

CHRONOLOGICAL LIST OF ACTS AND EVENTS AFFECTING THE OFFICE OF CORONER

1194	Articles of Eyre (Institution of Office)
about 1300	End of the Eyre (by disuse)
1487, 1509	Acts authorising fees for coroners
1751	An Act to authorise increased fees for coroners and to regulate coroners' conduct
1836	The Births and Deaths Registration Act (deaths to be notified to the registrar)
1836	An Act to provide for the Attendance and Remuneration of medical witnesses at Inquests
1837	An Act authorising coroners to claim all reasonable expenses for inquests
1860	The County Coroners Act (county coroners to be paid a salary)
1887	An Act to consolidate the law relating to coroners (the statutory basis of the law today)
	Local Government Act 1888 (provided that coroners should be appointed by County or Borough Councils)
1910	Report of Select Committee on Coroners
1926	Coroners (Amendment) Act
1936	Report of Departmental Committee (under the Chairmanship of Lord Wright)
1953	Coroners Rules

CHAPTER 11

THE OFFICE OF CORONER TODAY

11.01 In the previous chapter, we have traced the evolution of the office of coroner from its earliest days as an important element in a primitive system of tax collection, through a period in which the coroner was primarily an investigator of all kinds of violent or suspicious death, to the present day, in which he carries out a wide variety of functions, some of which could never have been envisaged in 1187. What is a coroner? " A coroner is an independent judicial officer who is solely responsible, subject to the requirements of the law, for the conduct of his duties. " This sentence has been for many years an essential ingredient of almost every official statement made on the subject of coroners. It forms a convenient starting point for a discussion of the nature of the coroner's office today.

11.02 (*a*) *The coroner is " independent "*. A coroner is independent of both local and central government. He is appointed for life and paid by a local authority which thereafter has no control over any of his actions whether administrative or judicial. No Minister has the right to give him directions, call him to account, or review his decisions.

(*b*) *He is a " judicial officer "*. A coroner is a judicial officer because he has the power, and in some cases the duty, to preside over court proceedings—called inquests. It is the function of an inquest, as it is of several other legal proceedings, to record a legal conclusion in the form of a verdict. When in court, a coroner has some of the powers of a judge or magistrate, e.g. he may commit someone for contempt of court and his statements in court are privileged.

(*c*) " *Solely responsible* ". A coroner is solely responsible for his own proceedings in the obvious sense that he sits by himself; but he also takes his own decisions and cannot be directed by any authority, except the High Court.

(*d*) " *Subject to the requirements of the law* ". The coroner has wide powers, but his freedom of action is limited by the law. The Coroners' Acts 1887 and 1926 are, in the main, enabling and permissive in character; procedure (more particularly inquest procedure) is governed by the Coroners Rules 1953. The Rules contain some mandatory requirements (e.g. that every inquest must be held in public) and some restrictions of scope (e.g. that the proceedings and evidence at an inquest should be directed solely to ascertaining certain defined matters or that no verdict should be expressed in such a way as to appear to determine any question of civil liability). The Rules also contain protection for individuals (e.g. a provision that no witness should be obliged to give an answer tending to incriminate himself and an entitlement for any " properly interested person " to examine any witness at an inquest).

(*e*) *The " conduct of his duties "*. The coroner's duties are contained in the law which we have mentioned in the previous paragraph. The effect of the

Coroners' Acts 1887 and 1926 is that a coroner has a duty to hold an inquest in certain defined circumstances and that in other circumstances he has a discretion whether or not to proceed in this way (see Chapter 13). Once a case has been put upon enquiry, a coroner's principal duty is to establish the cause of death and he has a wide range of discretionary powers to help him do this.

The balance of his responsibilities

11.03 It is not difficult to see why the foregoing description of a coroner has from time to time provoked rather than answered questions about the office. There have been those who have felt that the coroner should be open to rebuke or censure by some central authority, that his discretion is too wide and his powers too absolute for a local official. What is often lost sight of in comment of this kind is the changed character and emphasis of the greater part of the coroner's work in recent years.

11.04 Some idea of the changes which have taken place in the development of coroners' work over the last 70 years or so can be obtained from Appendices 2 and 4, which contain statistics of coroners' work since 1901. It will be noted that the total number of deaths reported to coroners has more than doubled in this 70 year period, but the number of inquests held has fallen by nearly one-third. The tendency for this first figure to rise and for the second to fall, regardless of minor fluctuations in the total number of deaths in each year, is firmly established and is well illustrated in Table H below, which summarises the figures for the last 10 years.

TABLE H

Deaths Reported to Coroners 1960–1969
Showing numbers of post-mortem examinations and inquests
(Source: Coroners' returns to the Home Office)

Year	No. of registered deaths	No. of deaths reported to coroners	No inquest		Inquest		Total No. of p.m.s
			with p.m.	without p.m.	with p.m.	without p.m.	
1960	526,268	101,079	57,841	16,933	21,496	4,809	79,337
1961	551,752	101,667	62,329	13,162	22,229	3,947	84,558
1962	557,836	106,786	66,589	13,314	23,417	3,466	90,006
1963	572,868	113,001	72,443	13,245	24,179	3,134	96,622
1964	534,737	109,844	70,826	11,924	24,639	2,455	95,465
1965	549,379	116,267	76,604	12,639	24,914	2,110	101,518
1966	563,624	117,438	77,826	12,754	24,893	1,965	102,719
1967	542,519	117,935	79,364	12,964	23,918	1,689	103,282
1968	576,754	124,420	85,870	13,927	23,407	1,216	109,277
1969	579,378	131,639	92,003	14,506	24,101	1,029	116,104

11.05 These figures taken together with those in Table I [*page 122*] (which sets out the principal causes of death certified by coroners in 1968 and 1969) are sufficient to establish beyond doubt that the main function of the coroner is now to establish the medical cause of death in a wide variety of situations, few of which have anything to do with crime or suspicious circumstances. The holding of inquests on the bodies of persons who have died violent or unnatural deaths remains, of course, a valuable feature of coroners' work,

TABLE I

Causes of Deaths, as Certified by Coroners, 1968 and 1969

Source: The Registrar General for England and Wales

Cause	1968	1969
Enteritis and other diarrhoeal diseases	301	320
Tuberculosis of respiratory system	389	318
Other tuberculosis, including late effects	116	164
Meningococcal infection	50	54
Syphilis and its sequelae	66	77
All other infective and parasitic diseases	236	215
Malignant neoplasms	5,503	5,859
Benign neoplasms and neoplasms of unspecified nature	284	271
Diabetes mellitus	385	445
Avitaminoses and other nutritional deficiency	33	27
Anaemias	133	126
Meningitis	110	112
Active rheumatic fever	9	13
Chronic rheumatic heart disease	1,656	1,951
Hypertensive disease	2,528	2,636
Ischaemic heart disease	40,791	42,943
Other forms of heart disease	2,669	2,704
Cerebrovascular disease	6,029	6,259
Influenza	328	620
Pneumonia	5,330	5,607
Bronchitis, emphysema and asthma	5,015	5,511
Peptic ulcer	1,258	1,350
Appendicitis	125	121
Intestinal obstruction and hernia	802	847
Cirrhosis of liver	382	439
Nephritis and nephrosis	200	177
Hyperplasia of prostate	211	192
Abortion	46	33
Other complications of pregnancy, childbirth and the puerperium. Delivery without mention of complication	108	87
Congenital anomalies	948	1,046
Birth injury, difficult labour and other anoxic and hypoxic conditions	190	194
Other causes of perinatal mortality	57	66
Symptoms and ill-defined conditions	145	137
All other diseases	11,148	12,170
Motor vehicle accidents	6,339	6,616
All other accidents	10,551	10,924
Suicide and self-inflicted injuries	4,583	4,325
All other external causes	1,534	1,696

but in terms simply of work-load it is over-shadowed by the less dramatic but perhaps to-day more important task of certifying the medical cause of death. The balance of the coroner's functions has changed gradually, almost imperceptibly, over the years, but recognition that it has changed is crucial to any consideration of how the coroner should work in future. It is interesting, and perhaps not unprofitable, to speculate on how this present situation has come about.

11.06 As we have seen (in Chapter 10), the general duty to hold an inquest, imposed by the Act of 1887, was confined to violent or unnatural deaths or *sudden* deaths the cause of which was unknown. It seems likely that "sudden death" was at first thought to have a flavour of violence, for unnatural death and sudden deaths where the cause of death was not known were probably originally investigated in order to establish whether or not they were

violent or unnatural. Although there has been no change in the law defining those deaths which are properly the subject of a coroner's enquiries, a situation has gradually come about in which almost all deaths of which the causes are not known, or which are in serious doubt, have come to be regarded as deaths which should be reported to a coroner. The tendency for this situation to emerge was probably much strengthened by the fact that, even before 1926, coroners did not hold inquests on every death reported to them. A substantial proportion was disposed of after preliminary enquiries without an inquest—a method of disposal which was known even before the end of the 19th century as the "Pink Form" procedure. In some at least of these cases a post-mortem examination was held before the coroner signified that he had no further interest in the death, although, in the absence of any express authority for a coroner to arrange for such autopsies to be performed, it is not known how they were financed. The 1926 Act put this procedure on a regular footing by providing that a coroner could conclude his enquiries into a death which appeared to be a sudden death the cause of which was unkown if, after a post-mortem examination, he was satisfied that the death was not violent or unnatural. One result of the 1926 legislation was a considerable increase in the numbers of deaths reported to coroners; and it seems not unreasonable to conclude that the grant to coroners of a power to certify the cause of death after a formal enquiry which in no way touched on the circumstances of the death or the possibility of violence, but instead established the medical cause of death with greater certainty, may have led to the situation in which it was thought reasonable for a coroner to enquire into any death in which there was doubt about the cause.

11.07 Another significant factor in the rise in the number of deaths reported to coroners may have been the simultaneous growth of pathological facilities in England and Wales. It seems *prima facie* quite likely that the increased availability of facilities for establishing the medical cause of death with reasonable certainty has drawn attention to doubts about the causes of some deaths which would previously have been certified without an autopsy. We do not suggest that there has been any general use of coroners simply as an agency for the performance of more autopsies—although this may have happened from time to time in particular places. What cannot be denied, however, is that the coroners system has provided a comparatively simple procedure for arranging an autopsy and that it has provided a fee for the performance of that examination. The coincidence of these factors and the growth in pathological facilities may therefore have been at least partly responsible for the rise in the number of deaths reported to coroners and for the predominantly medical nature of the enquiries which followed. Whatever the reasons for the transformation, the coroner is no longer simply the "judicial officer" of the definition quoted in paragraph 11.01.

Public opinion and coroners

11.08 As the desire to establish accurate causes of death grows and the number of deaths reported to coroners annually goes on rising steadily, more and more people find themselves coming into contact with the coroner's procedures. We concluded that it might help our enquiries and our appraisal if we could ascertain the views and experience of a representative sample of the

public at large. We believed that the public could make a real contribution to our report, not only by answering particular questions but also by posing problems which might not otherwise be evident to us. It seemed to us that the best way of discovering the views of a substantial number of members of the public was to commission some special research. Two separate surveys were carried out on our behalf. The first (by National Opinion Polls Limited) took a random sample of persons above the age of 16 in England and Wales and asked a number of questions designed to elicit knowledge of, and general attitudes towards, coroners. The respondents in the second enquiry (carried out by Sales Research Services Limited) were all persons who had had direct experience of coroners' investigations following the death of a relative or friend.

Survey by National Opinion Polls Limited

11.09 Nearly all the 1825 respondents in the NOP enquiry had heard of the coroner and most knew that he was concerned with an investigation to establish the cause of death. Respondents were asked to describe the circumstances in which deaths might be reported to a coroner and their replies indicated a widely held belief that he was concerned mainly with violent or suspicious deaths. The connotations of violent or suspicious death which evidently attach to the coroner in the public mind were also apparent in the replies to a question asking respondents to suggest what the functions of a coroner *ought* to be. Three-quarters of the respondents with knowledge of the coroner suggested that one of his functions should be to discover whether anyone was responsible for the death.

11.10 Comments about the way in which the coroner was thought to conduct his enquiries were usually quite favourable, particularly from those who had been personally involved in such enquiries. 75 per cent of those with direct knowledge of coroners thought that coroners had a good understanding of people and were sympathetic; and 89 per cent of this same group were agreed that coroners were fair minded and had a good sense of justice. As part of the survey several test statements in which coroners were described in unfavourable terms were mentioned to all respondents; those which found most support were those alleging unnecessary critical comments by coroners and suggesting that they intruded too much into private grief. These criticisms were each mentioned by about one-quarter of all respondents.

11.11 The more remote was the respondent's source of information about the coroner, the less favourable was the impression gained of him. Of those who had heard about the coroner from friends or relations, 75 per cent had formed a favourable impression, whilst of those who had read newspaper reports about coroners, 67 per cent were similarly impressed.

11.12 The survey showed a general disposition to accept the necessity for and value of autopsy. About 80 per cent of all respondents said that they knew what happened at a post-mortem examination. Ninety-four per cent said that they would not object to a post-mortem examination being carried out on a close relative if the cause of death was unknown. A further 3 per cent

had no opinion to give. Only 67 respondents (or 4 per cent) said that they would object under these circumstances and of these about one-fifth offered no reason for their objection. The main reasons which were offered were emotional ones, for example, that dead bodies should not be subjected to the procedures involved in autopsy. The respondents showed slightly less readiness to accept the necessity for a post-mortem examination if the reason for it was to assist medical research rather than to establish the cause of death, but even so, 80 per cent said that they would not object. The survey also indicated that there was more objection to an autopsy on the body of a child than to one of an elderly person.

11.13 A large majority (82 per cent) of all respondents said that they were satisfied the coroner did his job well and only 8 per cent of these were unable to give reasons to support their statements. Only 35 out of the total of 1825 respondents expressed the view that the coroner did not do his job well. The reasons offered for this opinion were diverse, but the greatest support (8 respondents) was for an assertion that coroners were " not qualified enough ". One hundred and forty two respondents suggested improvements in the coroners service, the majority relating to coroners' qualifications, selection for office and general powers. They did not add to the suggestions which we had already obtained from the evidence of our witnesses.

Survey by Sales Research Services Limited

11.14 All of the 564 respondents in the SRS enquiry had some direct recent experience of a death that had been reported to a coroner. In 290 cases, coroners had held an inquest and the remaining 274 deaths had been certified after an autopsy only. Respondents were divided into 3 groups, drawn respectively from Greater London, conurbations outside London and county districts. All were asked to recall their experiences in relation to the procedures which followed the death of a near relative or friend. In doing so, they inevitably drew attention to the practices of individual coroners and their officers.

11.15 The results of the survey indicated that relatives who were involved with coroners' enquiries were usually satisfied with the manner in which these enquiries had been conducted and with the consideration which they received during the course of these enquiries. The majority of persons interviewed accepted that the coroner's enquiries were necessary. Although sometimes distressed by the procedures, they accepted also the need for an identification of the body, an autopsy and an inquest. Several said that they were glad that there had been an enquiry and were grateful for the information which it provided for them. Understandably, most people were concerned that the enquiry should be over as quickly as possible, but there seemed to be a general feeling that the coroner had completed his proceedings with the minimum of delay. Very little objection was expressed to press publicity; indeed a few respondents said that they were glad of it. Both coroners and their officers were often said to have " gone beyond their official duty in being kind and helpful ". This comment was particularly prevalent in the Greater London area, where in nearly half of all cases advice was given about making funeral arrangements. In a number of instances, the coroner's officers actually

made the funeral arrangements on behalf of the relatives. This form of assistance was also given fairly often in the county districts, but to a markedly lesser extent in the conurbations outside London.

11.16 The main criticisms of coroners' procedure which emerged from this survey can be summarised as follows:

(i) delays in funeral arrangements as a consequence of a coroner's enquiries;
(ii) distress caused by the need to identify a body;
(iii) the fact of the autopsy;
(iv) inadequacy in the physical arrangements for the inquest (e.g. accommodation);
(v) doubts about the conduct or the outcome of the enquiry;
(vi) delays in the completion of the enquiry or in learning of the cause of death.

(i) *Delays in funeral arrangements*

11.17 The survey showed that funerals had usually taken place within 7 days of death (75 per cent of all inquest cases and 92 per cent of all post-mortem cases fell into this category). Long delays were more frequent in Greater London than elsewhere. Complaints about delays as a result of the coroners' enquiries were made by about one-third of all respondents—the majority of these relating to delays caused by inquests. But less than one half of those who claimed that funerals had been delayed said that they had been in any way upset by this fact. Only 50 respondents were said to be very upset; but in one half of these cases the funeral was held within 4–7 days of death. It appeared that people had widely differing views on what constituted a delay; the majority of the people who stated that the funeral was *not* delayed had arranged for the funeral to be held between 4 and 7 days after death, i.e. the same period which was considered by others to have caused great distress. We have discussed future arrangements for the issue of disposal certificates by coroners in Chapter 28.

(ii) *Distress caused by identification procedures*

11.18 The survey revealed that coroners' practice in asking persons to identify bodies varied considerably in different parts of the country. In Greater London, for example, less than half of all identifications for inquest purposes were performed by relatives or close friends of the deceased, but the proportion of identifications carried out by these persons rose to about 75 per cent as an average for the rest of the country. Where an inquest was to be held, the body had been identified about twice as often by a man as by a woman. On the other hand, in autopsy cases identifications were performed almost equally by men and women. The majority of identifications took place in hospital mortuaries, but if inquest cases are taken as a separate category the most frequent place for identification was a public mortuary, often attached to the coroner's court.

11.19 Although less than half of all respondents had any very strong feelings on this matter, about a quarter of the respondents in inquest cases said

that they would rather not have to identify a body of a close relative. About a half of this number objected strongly in autopsy cases. We took particular note of the fact that, of all those persons who had identified bodies, two-thirds were upset by having to do so. However, very few respondents thought that anything could be done to ease their distress and most of them attached some importantce to identification of a body by a close relative. There was little support for the view that identification was an unimportant or unnecessary procedure. We have more to say about the procedure for identifying bodies in Chapter 15 below.

(iii) *The autopsy*

11.20 On average less than one quarter of all respondents were upset by the fact of the autopsy—a few were unaware that one had been carried out. The autopsy seemed to cause most distress if the deceased had been fairly young or if the death had been caused by an accident. The proportion of all respondents claiming to have been distressed by the autopsy was never very high—27 per cent of all respondents in the county districts and rather less in London and other conurbations. The great majority of all respondents who were aware that an autopsy had taken place considered that it was right that there should have been one.

11.21 Most people were informed by the coroner's officer that an autopsy would have to be performed, but of those who claimed that they were not told (19 per cent of respondents in inquest cases and 12 per cent in autopsy cases), only a tiny minority were upset that it was carried out without their knowledge or, in some cases, without their consent. The manner in which people were informed about the autopsy seems to have mattered a good deal to some of the respondents. The fuller or more sympathetic the explanation the less distress was caused. About half of all respondents thought that there should be a right for relatives to refuse consent to a post-mortem if the cause of death was known, or if a doctor had been in attendance before death, or if death had been expected.

11.22 As with the NOP random survey, we were a little surprised to find such a widespread acceptance of the need for autopsies, but we noted that acceptance was more grudging when bereaved relatives were particularly upset. We noted also that the coroner (or his officer) could do much to ease this distress for relatives by the manner in which he explained the need for autopsies.

(iv) *Inadequacy in inquest arrangements*

11.23 The survey showed that nearly all inquests were attended by relatives of the deceased and that there was comparatively little dissatisfaction with the period of notice given of the timing of the inquests.

11.24 In the majority of cases in Greater London and in the conurbations, the inquest was held in the coroner's court or office. In the county districts, however, slightly more than half took place in other places. Police stations appear to have been the most popular alternative venue, but others included magistrates' courts, town halls and hospital rooms.

11.25 More than half of all respondents complained about having to wait before the inquest began and nearly 40 per cent said that they had waited for over 15 minutes. The worst area in this respect was Greater London, where 44 per cent of all respondents waited 15 minutes or more.

11.26 About half of all persons kept waiting were accommodated in waiting or witness rooms and this proportion was as high as two-thirds in Greater London. Otherwise people had to wait in the court room itself, in corridors, outside buildings or, very rarely, in a room with a dead body. Respondents expressed a strong preference for proper waiting rooms.

11.27 One-third of all respondents who had to await their turn listened to other cases which preceded theirs. Although a few thought this an interesting experience and others claimed to have been unconcerned by it, most would have preferred not to have been present and some were very upset by the experience.

11.28 Over two-thirds of all persons who attended inquests said that others had been present while their own cases were being heard. More than one-third of these were distressed or annoyed by this, and we noted that this attitude was more apparent when the death was due to natural causes or suicide.

11.29 The survey provided indisputable evidence of the need for improvements in the arrangements for inquests, particularly in respect of timing and accommodation. Accommodation problems were clearly more pressing in the county districts, where coroners often made a practice of holding inquests in several different places in order to cut down travelling time for relatives and witnesses. The assortment of buildings in use in the county areas were rarely suitable for holding inquests.

11.30 We make recommendations about the timing of inquests in Chapter 15 below and discuss the future provision of accommodation for coroners (including inquest accommodation) in Chapter 21 below.

(v) *The conduct and outcome of the enquiry*

11.31 The survey revealed that it was usual for relatives to give evidence at an inquest, although in approximately one case in 10 a relative was said to have been excused attendance because of the upset it would have caused or because of ill health.

11.32 There seems to have been fairly general satisfaction with the way in which inquests were conducted. Of those who gave evidence only 4 per cent thought that the coroner was unkind or inconsiderate. The few complaints that were made against coroners alleged impatience, rudeness, prejudice or a failure to carry an enquiry to its logical end. However, there were other complaints not directed at the coroner personally. Over one in 10 of all persons who attended inquests claimed to have difficulty in understanding all that was said and a few could not hear properly. Most significantly nearly one in four felt that they had not been free to ask questions—even though, as " properly interested persons ", they had a legal right to do so. One in five of

all respondents disagreed with some part of the conclusions of the inquest, most noticeably in cases where death was due to a road accident where responsibility for the accident was disputed. Other major reasons for disagreement arose from a belief that the investigation was not thorough enough or that medical negligence or inefficiency were not properly brought out. On a few occasions the medical cause of death was not accepted as being correct.

11.33 Respondents were almost equally divided on whether or not an inquest or autopsy had provided any new important information. Many were glad to have learned the exact cause of death and others the reasons for the death. Respondents were about equally divided on the question of whether or not they felt better knowing the results of the inquest.

11.34 A very valuable feature of this survey of the attitude of relatives to the inquest was to emphasize the need for the personal qualities of patience, understanding, and sympathy in those holding the office of coroner. It also demonstrated that there was, unfortunately, an all too prevalent lack of communication between coroners and interested parties and a failure by some coroners to ensure that witnesses and other interested parties understood all that was said and done during the course of their enquiries.

(vi) *Delays in the completion of enquiries and in learning of the cause of death*

11.35 Most people thought that the coroner's enquiry had been completed as quickly as possible, although, as we have already noted in paragraph 11.17 above, there were complaints in relation to delays in funeral arrangements. We return to this subject in Chapter 15 below, where we look in more detail at the evidence provided by the SRS survey.

11.36 Less than half of all the respondents in the inquest cases believed that they had been told of the cause of death at the inquest. Most claimed that they had been informed on another occasion by the coroner or his officer (many respondents did not appreciate the difference between these two persons). Other sources from which relatives learned of the cause of death included doctors (about 20 per cent) and the registrar's certificate (about 10 per cent). Where the coroner's enquiry had ceased after an autopsy relatives usually learned of the death from their own doctor or from the " death certificate " (a copy of the entry in the death register given to them by the Registrar). Although there were few complaints that there had been unnecessary delay in the notification of the cause of death there was a fairly prevalent lack of understanding of the medical terms used. In inquest cases, 15 per cent were uncertain about some of the information they were given and this proportion rose to 27 per cent in autopsy cases. A satisfactory explanation was more likely to be given if the death had been certified after autopsy only and if the explanation had been given by the deceased person's own doctor.

Variations in the procedure adopted by different coroners

11.37 The evidence of our surveys shows unmistakably that there is a wide variation in coroners' practice, for example, as regards communication with

relatives, the venue and timing of inquests and the amount of work delegated to subordinate officers. These facts are amply confirmed by the Work Study of the Coroners' Officer—an exercise to which we have already referred in our General Introduction and which we consider in more detail in Chapter 21 below. There is also wide and inexplicable variation of frequency in the use individual coroners make of the autopsy—a point strikingly illustrated by coroners' annual returns to the Home Office[1]. Whereas one coroner may choose to order post-mortem examinations in the case of every death reported to him, another may do so on less than half of all occasions.

11.38 Since the impact of coroners on individuals and society is irregular, fleeting and often at second hand, there is no easy way of judging what the communities they serve or coroners themselves make of the way in which the "coroners' service" operates today. But our two surveys, the Work Study of the Coroners' Officer, the evidence of our witnesses and our personal observations have all contributed to the formation of a general impression which it may be convenient for us to state here.

11.39 First, the very concept of coroners constituting a "coroners' service" is not well established. The coroner today is still an isolated individual. He is isolated to some extent by the independence of his role, but also by the chance circumstances in which individual deaths may from time to time create a focus of common interest between his office and a local hospital, a local doctor, the police, the local health authority or other local services. He is isolated too by the limitation of his resources; his staff are usually borrowed (from the police or local authority) and may therefore hold a dual loyalty; and a widespread lack of adequate accommodation means that few coroners can feel firmly established in their own offices. The fact that coroners have no strong links with a local or central authority can only add to this general feeling of isolation.

11.40 Secondly, not many coroners appear to have a clear idea of their role in contemporary society. Most are content to "take death as it comes"; many have standing instructions for their subordinates to order automatic post-mortem examinations when a death is reported to them; others find themselves personally involved in an enquiry only on those comparatively few occasions on which it is now necessary for inquests to be held. We suspect that few have fully perceived their changed role in society and see their prime task for what it is: the furnishing of accurate medical causes of death to the Registrar General together with the identification of potential health hazards and other possible sources of danger or fatal injury. Today, the rôle of the coroner as an investigator of crimes against the person has become a relatively insignificant one.

11.41 As we have noted, the evidence of our surveys indicates a fairly general, if necessarily subjective, view that there is not much wrong with the

[1] Coroners are required to indicate the number of deaths reported to them, the number of autopsies performed on their authority, and the number of inquests held. An extract from these returns for the year 1969, showing the numbers of autopsies held by different coroners, is reproduced in Appendix 3.

coroners' system today. Much the same impression emerged from the evidence of our witnesses. This consensus would have been more convincing to us if our witnesses had shown more awareness of the variations in practice and standards and of the lack of co-ordination in the framework of law and administration in which coroners have to operate. Our own assessment is less favourable. The law is flexible, but only because it is archaic and exiguous. The coroner can determine his own "style" and method because he is independent and largely beyond challenge. He can respond to local circumstances becuase he has no clear responsibility at large. These are important advantages; but they have another side to them. Flexibility can, and plainly does, lead to variations in standards as well as in procedures. The fact that there are so many coroners with small jurisdictions means that sometimes their resources, in human as well as in physical terms, are too limited for them to provide the kind of service that the public receives as a matter of course in some of the larger jurisdictions. Independence, too, has its cost. It may mean that a coroner is left without much needed supervision or guidance in particularly difficult enquiries. It certainly means that a coroner cannot, as a matter of course, look to a local or central authority with responsibility for providing him with resources or advice on operational standards.

11.42 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. We discuss the nature of these changes in more detail in the chapters that follow.

CHAPTER 12

THE REPORTING OF DEATHS TO CORONERS

12.01 We have made reference before both to the haphazard growth of the law and the high degree of interdependence between procedures relating to the investigation, certification and registration of deaths. Nowhere are these features more apparent than in relation to the reporting of deaths to coroners.

Present position

12.02 The provisions of the existing law relating to the reporting of deaths to some " authority " may be summarised as follows:—

(i) There is no duty on members of the public to report any death to the police.

(ii) There is a statutory duty on a variety of likely informants to inform the registrar when a death takes place in a house or in the open or a dead body is found but the place of death is not known.[1]

(iii) There is a duty on the registrar to inform the coroner of a death in a number of different circumstances.[2]

(iv) There is an obligation at common law on " any person about the deceased " to give immediate notice to the coroner of circumstances requiring the holding of an inquest (but this presumes that such a person knows what are the circumstances that require the holding of an inquest).

(v) There is no duty on doctors to report any death to the police or, unless the doctor is a " person about the deceased " (see (iv)), to the coroner.

(vi) There is a statutory duty on governors of prisons and persons in charge of other institutions to report to a coroner the death of a person in their charge.[3]

12.03 These provisions do not add up to any coherent code and we suspect that the general public is largely ignorant of their existence. Although the coroner has a clear duty[4] to take action when he has knowledge of a "violent or unnatural death or a sudden death the cause of which is unknown", only registrars of deaths and the persons in charge of certain institutions have a clear duty to bring a death to his attention. We have already proposed what we consider will be a substantial improvement in this situation. In Chapter 6 above we have recognised the primary role of the doctor in the procedure

[1] Sections 16 and 17 of the Births and Deaths Registration Act 1953.
[2] Regulation 51 of the Registration of Births, Deaths and Marriages Regulations 1968.
[3] See, for example, Rule 19 (2) of the Prison Rules 1964, Rule 21(2) of the Borstal Rules 1964, Rule 20 of the Detention Centre Rules 1952, Rule 46 of the Approved School Rules 1953 and Rule 20 of the Remand Home Rules 1939.
[4] Section 3, Coroners Act 1887.

for reporting deaths and we have recommended that a new statutory obligation should be placed upon him. We proposed that, depending on the particular circumstances doctors should for the first time be *obliged* either to give a medical certificate of the fact and cause of death or to report deaths to an " appropriate authority " (now identified as the coroner). In our consideration of the circumstances in which a doctor should *not* give a medical certificate of the fact and cause of death—even if he was " qualified " to give a certificate in accordance with our new definition and satisfied that he knew the cause of death—we introduced the concept of the public interest. We concluded that a doctor should have an obligation to consider the public interest in an individual death and that he should be required to have regard to this in both a particular and a general sense. It will be convenient to repeat the terms of our earlier recommendation at this point. We recommended that:

> " a fully registered medical practitioner who has attended a deceased person within seven days of his death and who has inspected the body after death should be obliged *either* to give a certificate *or* to report the death for further investigation; but that he should issue a certificate only if:
>
> (*a*) he is confident on reasonable grounds that he can certify the medical cause of death with accuracy and precision;
>
> (*b*) 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;
>
> (*c*) 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;
>
> (*d*) the cause or circumstances do not make the death one which the law requires should be reported to the appropriate authority;
>
> (*e*) he knows of no reason why in the public interest any further enquiry should be made into the death ".

In framing this recommendation, we were conscious that we were getting near to defining " reportable deaths " and we believe that, translated into practice, our recommendation should in itself be sufficient to ensure that most, if not all, deaths which we believe should be reported to coroners, will in future be reported by doctors. There are comparatively few deaths which are not brought to the attention of a doctor soon after they occur or are discovered. In short, we believe that we have already formulated the central core of a system of reporting. It is now our task to consider how far that system of reporting needs to be supplemented or strengthened either by placing obligations on other persons or by defining new categories of reportable deaths.

12.04 A point worth making at the start of this consideration is that we live in a society in which the deaths of individuals rarely pass unnoticed or without comment. Our instinctive and continuing need to our own and other people's physical well-being is a constant stimulus to curiosity about the causes and circumstances of deaths. That curiosity is in itself a safeguard against the

concealment of abuses, for when the facts are uncertain or suspicions are aroused, it is quickly transformed by a sense of moral duty or professional ethics into the first steps towards an appropriate enquiry. Thus it is that doctors frequently report deaths direct to the coroner without reference to the registrar, and that doctors and members of the public alert the police when they come upon evidence of foul play. When society acts instinctively in this way it would be as absurd as it is unnecessary to suggest replacing the present untidy set of provisions by elaborate rules designed to ensure that, in all foreseeable common circumstances, everyone who observes or has information about the death which merits investigation by the police or a coroner, knows what he must do and is statutorily required to do it.

12.05 Nevertheless, for reasons which we shall explain in the following paragraphs, we do not think that the general law (as distinct from the law relating specifically to doctors called upon to certify the fact and cause of death) should be left exactly as it is. We believe that there are some deaths in which the public interest is so great that a report to the coroner should be mandatory whatever the circumstances in which they occur. In reaching this conclusion, we have been influenced by principles already in the existing law, by the evidence of our witnesses and, to a large extent, by our appreciation of the undoubted public concern that exists in relation to certain deaths—especially those which occur in an institutional setting. There is a real and growing public interest in the welfare of persons who in life are for one reason or another cut off from the main stream of society; this interest extends into concern about the procedures for enquiring into and certifying the causes of their deaths. We can only speculate on the reasons for this. Partly it may be due to greater public sensitivity to the operation of public services of all kinds, partly to greater insistence on private rights and public duties. Partly, too, it may simply reflect widespread demands for different kinds of independent enquiry into maladministration. But whatever are the reasons for it, we are convinced from our evidence and personal observations that there is undoubted public concern about the possibility that certain deaths in an institutional setting may not always be properly investigated and certified. That concern seems to be especially strong in relation to those deaths that occur without, so to speak, some curious and articulate bystander, besides the doctor and those responsible for the care of the dead person, being ready to bring to attention unexplained matters about the death. We have great sympathy with public sentiment on these issues and we have therefore tried, at all stages of this part of our review, to pay due regard to it in reaching our conclusions.

Persons deprived of their liberty

12.06 A good example of a person living " outside society " is someone who is either temporarily or permanently deprived of his liberty by the deliberate, but lawful, actions of other persons. To a greater or lesser degree, any individual in this situation is, or may be, denied those normal everyday contacts with friends or relatives " in society " that might ordinarily lead to a report of a suspicious death to a coroner. We believe that it is in the interests of the persons detained, the interests of their relatives and, indeed, the interests of those in charge of the places in which such persons are confined, that the

deaths of those whose freedon is restricted by society should be reported to the coroner as a matter of law. These deaths touch the public interest to such an extent as to leave no room for discretion on the part of the institution authorities or the institution doctor whether or not to report their deaths to the coroner. Generally, the existing law already reflects this point of view. The persons in charge of prison service establishments, similar institutions maintained by the armed forces, approved schools and remand homes are all required to report the deaths of inmates to the coroner. But the law puts no corresponding obligation on a police officer to report to the coroner the death of a person in police custody or on a person in charge of a psychiatric hospital to report the death of a person compulsorily detained there.

12.07 In practical terms this first omission is not very important. As a matter of practice, despite the absence of any legal obligation, the death of a person in police custody is always reported to a coroner and although we have decided to recommend that, in future, there should be a statutory obligation on the officer in charge of a police station to report such a death, we must emphasise that we do so only because we think it right in principle to be consistent in this matter.

12.08 The absence of any obligation to report the death of a patient compulsorily detained in a psychiatric hospital is of much greater practical significance. Before the coming into force of the Mental Health Act 1959, the law required all deaths of patients in hospitals for the mentally disordered (whether or not they were compulsorily detained there) to be reported to a coroner. This situation was reviewed by the Royal Commission on Mental Illness and Mental Deficiency which reported in 1957.[1] The Royal Commission made a recommendation in the following terms:

> " At present the death of any temporary or certified patient, any patient detained under sections 20 or 21A of the Lunacy Act 1890 and any patient in a mental deficiency hospital or certified institution or under guardianship has to be reported to the coroner. We do not consider this necessary. The practice in relation to patients who die in psychiatric hospitals in future should be the same as for patients dying in other hospitals or at home; there should be an obligation to report the death to the coroner only in circumstances requiring the holding of an inquest or enquiry, i.e. where there are suspicious circumstances or when the death is sudden and the cause unknown."[2]

This recommendation was accepted by the Government of the day and implemented in the Mental Health Act 1959. Since that date, the deaths of psychiatric patients, whether or not they are compulsorily detained, have been reported to coroners only when there were such circumstances as would require the notification of any other death.

12.09 We appreciate, and indeed sympathise with, the thinking which we believe lay behind this recommendation, but we were somewhat disappointed

[1] Cmnd. 169 (1957).
[2] Paragraph 486 of the Commission's Report.

not to find in the Commission's Report any indication that consideration had been given to the desirability of making a distinction between the deaths of patients who were or who were not compulsorily detained. We admit that this distinction can sometimes be an artificial one—because "voluntary" patients may, and often do, share the same conditions as patients who are not legally free to walk out of a hospital and because, in practical terms, so-called "voluntary" patients may have no prospect of leaving. Moreover, there is a considerable measure of freedom afforded to certified patients. But, in the last resort, the two categories of patient are in totally different positions and we suggest that it would be fitting for the law to recognise this fact. We believe that society has a greater moral responsibility for those who have been confined under its own rules. As regards patients in psychiatric hospitals, the "rules" are contained in Parts IV and V of the Mental Health Act 1959. Part IV relates to detention on the recommendation of doctors and Part V provides the authority by which criminal courts and the Home Secretary may make orders and directions authorising the detention of a patient. We were informed that in 1969 approximately 7 per cent of all patients in psychiatric hospitals were detained under one or other of these provisions. We have concluded that it would be both sensible and practicable to make a distinction (so far as concerns the reporting of deaths to coroners) between the compulsorily detained and voluntary patients. We recommend, therefore, that it should be a requirement of the law that the death of a compulsorily detained psychiatric patient should be reported to the coroner and that 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.

Persons voluntarily resident in institutions

(*a*) *Hospitals*

12.10 Public concern for the welfare of persons living within an institutional setting is not confined to those who are compulsorily detained. The vast majority of patients in all hospitals (including psychiatric hospitals) are there "voluntarily" in the sense that, other things being equal, they can walk out of the hospital at will. Is there any justification for a requirement that the death of all or some of these patients should automatically be reported to a coroner? We looked first at the present situation.

12.11 Well over 300,000 people die every year in England and Wales in hospitals or similar institutions provided under the National Health Service. A substantial proportion of these deaths are already reported to coroners (see Chapter 1)—either because the death is in a category to which, under the existing law, coroners have a duty to enquire or because it is one which a registrar of deaths has a duty to report, or because it is one of those on a "local list" issued by a particular coroner (paragraph 6.12 above). In accordance with recommendations made in Part I of this Report, the numbers of deaths in hospitals which are reported to coroners are likely to increase. The new obligation to report deaths to the coroner, the terms of which we have repeated in paragraph 12.3 above, will apply to doctors in hospitals called upon to give medical certificates of the fact and cause of death just as it will apply to doctors outside hospitals. It is drawn in such terms as

should ensure that any death which occurs in a hospital and about which there is concern of any kind should be reported to a coroner by the doctor called upon to give the certificate. It will be noted that, in particular, the hospital doctor (like the doctor outside hospital) will be obliged to report to a coroner any death which he has reasonable cause to believe may have occurred during an operation or under or prior to complete recovery from an anaesthetic or arising out of any incident during an anaesthetic or where a report would be in the public interest.

12.12 We are not aware of any suggestion that deaths of all hospital patients should be reported to coroners, nor do we believe that any such requirement would serve any useful purpose. But we have felt it necessary to pay more attention to suggestions that particular categories of deaths in hospital should be reported. The categories of hospital patients which arouse most concern are the mentally ill, the mentally handicapped and those receiving or needing geriatric care. The first Report of the Director of the Hospital Advisory Service, published earlier this year,[1] was concerned with these three areas of hospital provision and gave what can only be described as a disturbing account of the physical conditions in many of the hospitals which were reviewed by his Service. After reading this Report, we were more than ever convinced that there is often very little practical difference between the conditions of large numbers of patients within the services reviewed and the conditions of other persons who are legally detained in institutions provided specifically for this purpose. There can be no doubt that mentally ill, mentally handicapped and geriatric patients can often be as completely cut off from society as any prison inmate; they may receive no visitors and have no existence outside the confines of the immediate environment.

12.13 Mindful of public concern for the welfare of these patients, which mirrors the concern which each of us feels as an individual, we have given the most careful consideration to the question whether any special safeguards are required in respect of the deaths in hospitals provided for these categories of patient. We looked first at psychiatric hospitals.

Psychiatric hospitals

12.14 As we have seen, before the coming into force of the Mental Health Act 1959, various legal provisions made it obligatory for the death of any patient in hospital for the mentally disordered to be reported to a coroner. The Act of 1959 repealed all these provisions and put a death in a psychiatric hospital on the same footing as a death anywhere else. Partly in consequence of this change in the law, the number of deaths of patients in psychiatric hospitals reported to coroners has fallen from approximately 10,000 in the year before the Act came into operation to about 1,000 now.

12.15 The present state of the law was briefly considered in the Report of the Committee of Enquiry into Farleigh Hospital—also published earlier this year.[2] The Committee had been set up following allegations about

[1] National Health Service Hospital Advisory Service, Annual Report for 1969–70. HMSO.
[2] Cmnd. 4557 (1971).

ill-treatment of patients at Farleigh which led to the exhumation of the bodies of two patients and to proceedings against a number of nurses. That Committee thought that the evidence available to it was sufficient to enable it

> " to challenge the wisdom of leaving these matters [reports of deaths to a coroner] entirely to the doctor's discretion with patients who in life are completely disabled from giving account of anything which may happen to them."

The Report went on to say that

> " from the standpoint of relatives of the patients and the general public a re-examination of this issue in hospitals for the mentally handicapped seems to be required."

And concluded that

> " the present discretion allowing doctors in hospitals for the mentally handicapped to decide whether or not the deaths of patients should be reported to the coroner is unsatisfactory." (Paragraph 192).

The Committee recommended that

> " the present practice of reporting deaths to the coroner in hospitals for the mentally handicapped should be reviewed." (Paragraph 203).

12.16 We think that it would be difficult, if not impossible, to conduct such a review solely in the context of patients in psychiatric hospitals. As the Hospital Advisory Service Report clearly demonstrates, there are other patients whose general situation is very similar to that of patients in these hospitals and the description used by the Farleigh Committee in relation to psychiatric patients alone (those " who in life are completely disabled from giving account of anything which may happen to them ") itself has a more general application. It could apply to other categories of patient discussed in the H.A.S. Report, as, indeed, it could apply to patients not mentioned there, including, for example, young children or any patient in the terminal stage of disease or injury. To require a report to the coroner of the death of every person to whom this description could be applied would mean introducing a major new and alien principle into the new machinery we have recommended for death certification and one for which there is no general evident need. We would be opposed to this.

12.17 The alternative course is to categorise patients in these broad classes by some other identifying criterion than a doctor's subjective judgment of their mental, personal and social inadequacy. We do not think that it would be difficult to do this by producing for example a definition which would include any patient in a psychiatric hospital (whether provided for the mentally ill, the mentally handicapped or both). It would have to be accepted, however, that such a definition would be bound to produce anomalies. In the case of the mentally ill, for example, an increasing number of those who receive psychiatric treatment in a residential setting now receive it within the general hospital provision. The situation of these patients might or might not be very different from their fellows in psychiatric hospitals, but the fact that their deaths would not be automatically reported would be decided simply by their place of residence. We have not explored all the possible anomalies, but we have probed far enough to be satisfied that any definition based on a category of institution would produce anomalies of one kind or another.

12.18 If we are right in this view it is not possible to respond to the " challenge " raised in the Farleigh Report (paragraph 12.15 above) by making a recommendation which is both rational and practical. The question is simply whether in face of the certainty of creating an anomaly it would be advantageous to recommend that the death of any patient in a hospital for the mentally ill or mentally handicapped should automatically be reported to the coroner. Looking at our general proposals for death certification and at the coroners' service as we would like to see it in the future, we are agreed that to introduce such a requirement would not cause any special operational or administrative difficulty. But we are also agreed that on the very limited evidence directly submitted to us there are quite insufficient grounds for our suggesting a course of action which would restore completely the pre-1959 situation and run counter to the advice of the Royal Commission.

12.19 When every consideration has been given to the patient's situation, to the concern of the relatives and the anxieties of the general public, the fundamental question is whether or not society can trust administrative authorities and particular sections of the medical profession (acting separately or together) to bring suspicious deaths to the notice of the coroner. The issues which give cause for concern cannot be dealt with solely in terms of the law relating to the reporting of deaths to coroners. The main focus for public concern should be the wellbeing of live patients and, although we accept that the existence of a requirement to report deaths may have a salutary effect on those whose duty it is to care for patients and that the disclosure by a coroner of facts relating to the circumstances of life and death in particular hospitals can, and does, have value, we are convinced that protection for patients can best be provided by improved administrative procedures shaped by the particular institutional setting. We are convinced, too, that it would be wrong for us to give any encouragement to the idea that the existence of a requirement to report deaths to coroners might in some way detract from the primary duty of those administrative bodies which are already in law responsible for the care of hospital patients. In these circumstances it would be unrealistic and inappropriate for us to make firm proposals as regards psychiatric hospitals.

12.20 The same considerations which we have discussed in relation to the deaths of psychiatric patients seem to us to have equal validity in relation to the deaths of any other defined category of hospital patient, including, specifically, the geriatric patient. We have not therefore made any recommendation for an automatic report to the coroner of the death of any other category of hospital patient.

(b) *Institutions other than hospitals*

12.21 The places, other than National Health Service hospitals, in which care or treatment is provided in an institutional setting defy categorisation. They range from large private clinics to small family group homes. The high standards of some of the former are internationally known and their reputation is jealously guarded. Standards in many of the smaller and less well known institutions are equally high, but, at the other extreme, there are those about which much less may be known and about which anxieties are sometimes felt.

In view of the consideration which we had already given to hospital deaths, we felt that it was necessary for us to consider also whether it would be possible to produce a definition of a patient, a death or an institution which could be used to ensure that the death which sometimes gives rise to concern is reported as a matter of law and which would leave other deaths in " institutions " other than National Health Service hospitals to be reported or not reported in accordance with the obligation which we recommend should be placed on the " qualified " doctor (see Chapter 6).

12.22 A definition by category of illness is clearly a non-starter: it will not sort out the patient most at risk and since the nature of the illness might not be accurately determined until after death, the definition is also a " question-begging " one. Length of stay in the institution concerned is another completely arbitrary concept which is most unlikely to cover exactly those patients (if there be any in the particular institution) who are most at risk. The possibility of defining an institution at first sight looked somewhat more promising. It would certainly be possible, we think, to require that all deaths in, for example, old people's homes or nursing homes should invariably be reported to the coroner—although definitions along these lines would again be bound to produce anomalies. But we can find no sufficient justification for such a " blanket " recommendation. We were, however, aware that the absence of medical supervision in particular institutions has sometimes been one of the chief factors giving rise to public concern and we therefore gave particular attention to the possibility of making a recommendation which would reflect this concern, for example by providing that any defined institution which has no resident medical practitioner or which is visited less than once a week by a medical practitioner charged with the general care of its inhabitants should be required to report every death. There are several reasons why, in the end, we decided not to make a recommendation of this kind.

12.23 First, we felt that such a recommendation would be clearly at odds with the premise on which we base much of our report—namely that society can trust its medical practitioners to accept and to operate conscientiously the new obligations which we recommend should be placed upon them. Second, a formula for reporting deaths to the coroner based simply on some minimum specified degree of general medical supervision would have to be arbitrary; it would be unpredictable in operation because it would often overlap with the doctor's ordinary obligation to report; and it would bear hardly upon persons in charge of highly respected institutions whose concern for the persons in their care could not be faulted. Third, such a formula by its emphasis on *regularity* of medical attendance would be at variance with the principle of *recent* clinical attendance which we have made the main element in the qualifications for the certifying doctor.

12.24 We are aware that, in deciding not to make a recommendation in respect of this wide category of institutions, we do nothing to remove the fears of those concerned especially for the welfare of old people who end their days in an institution which may have a resident doctor but which, for one reason or another, may have a reputation as a " death house ". We recognise

that apprehensions are bound to arise in regard to places where death is an all too likely and frequent occurrence, but we must make it clear that we ourselves have received no reliable evidence of abuse occurring in this type of institution. It is tempting to think that it would do no harm and might do good to devise some additional set of obligations to ensure that coroners are informed of deaths occurring in such institutions; but having looked diligently at the possibilities we have concluded that further safeguards are impracticable.

Foster children

12.25 It has been suggested to us that children placed with foster parents are at special risk and that there should be a specific requirement that the deaths of all foster children should be reported to the coroner. Some of those who argued this recommendation upon us asked us specifically to restore what they described as the " pre-1958 " situation, clearly believing that before the passing of the Children Act 1958 there was a requirement that the deaths of all foster children should be reported.[1] In fact the provision in the Children Act 1908 which was repealed in the 1958 Act dealt only with the deaths of children who were privately fostered for reward and required private foster parents to report the death of any of their foster children to the coroner. The majority of foster children are boarded out by the local authorities or voluntary organisations in whose care they legally are. There has never been a requirement that the deaths of those children should be reported to the coroner either by the foster parent or by the local authority.

12.26 As regards children who are privately fostered[2] the present position is that the foster parent is under a legal obligation to report the death of a foster child to the local authority in whose area he resides. We do not see the necessity to require a private foster parent to make two reports, particularly in view of our proposal that the doctor who is called upon to give a certificate of the fact and cause of death must see the body before doing so and must also report the death to the coroner himself unless he can satisfy the stringent conditions which we lay down in paragraph 6.33 above. In these circumstances, we think it most unlikely that the death of a private foster child about which there is any suspicion will not be reported to the coroner.

12.27 The majority of foster children are in the care of local authorities or voluntary organisations who have boarded them out with foster parents under arrangements for which the local authority or the organisation remains responsible. Their stay in foster homes is subject to supervision under the Boarding Out of Children Regulations 1955, which among other things include a requirement that foster children must undergo regular medical examinations. Under administrative arrangements[3] local authorities have been required to notify the Home Office (now the Department of Health and

[1] Both Havard, " The Detection of Secret Homicide," 1959, p. 96 and the BMA Report, " Deaths in the Community " (1964), para. 17 seem to have been written under this belief.
[2] The definition of a foster child in section 2(1) of the Children Act 1958 has been amended by the Children and Young Persons Act 1969 and now included all children under school-leaving age who are privately fostered for more than six days, irrespective of whether payment is made.
[3] Home Office Circular 28/64.

Social Security) of the death of any child in their care who is boarded out with foster parents. However, there has never been any requirement that the coroner should be notified automatically of the deaths of children in the care of local authorities and voluntary organisations and in view of the degree of control already exercised over these children as well as the new obligations which we propose to place on doctors we are not satisfied that there is a case for making it a statutory requirement that the death of any foster child should invariable be reported to the coroner. In any case, we are informed that there would be no difficulty in introducing such a requirement administratively (by means of a circular letter to local authorities from the Department of Health and Social Security) should the need arise.

Should there be any general obligation on non-medical persons to report deaths to the coroner?

12.28 As we pointed out earlier, the only statutory obligation upon a member of the public finding a dead body is an obligation to report the fact to the registrar of deaths. This arises from the legal requirement that all deaths should be registered and from the imposition of a duty to register which successively devolves from the nearest relative of the deceased to any person knowing of the death.[1] The existence of this obligation is not widely known and we understand that it is not considered to be very effective. It might seem logical, therefore, to strengthen the law by imposing on any person finding an apparently dead body a new duty to report to the coroner. Such an obligation would cover those circumstances in which the fact of the death might not otherwise come to light, for example, the death of an old person living alone or the discovery of a body lying in the open.

12.29 After careful consideration, we do not favour introducing such a duty. When someone is found, apparently dead, either in a house or in a public place, the finder is not likely to think immediately of reporting his discovery to the coroner. Depending on the circumstances, he may summon a doctor, but it is more likely that he will summon the police or an ambulance. This is the most sensible action to take since, if there is any doubt that death has occurred, the ambulance service are likely to be better equipped than most doctors with the means to apply measures of resuscitation. It would be difficult to define an obligation to report to the coroner in terms which would attach it to the appropriate person in all likely circumstances, be comprehensible to those who might be affected by it, and justify the imposition of a sanction for failure to comply.

12.30 Even if this were not the considerable difficulty it appears to be, we strongly doubt whether there is any real advantage to be gained by formally enlisting the help of the general public in the reporting system. As we have already stated, the ordinary public interest in death and in the disposal of the dead ensures that virtually all bodies not otherwise accounted for are reported to the authorities. Responsibly-minded members of the public will act without the spur of the law; the evilly disposed will not, even if the law enjoins. In our view it is sufficient that every member of the public

[1] Chapter 3.

should have the right which he has now to report a death to the coroner where he believes that the investigation of the causes or circumstances of the death might serve the public interest.

Reporting by the police

12.31 At present, the only legal obligation upon police officers to report deaths to the coroner is the common law duty imposed on all persons to report a death to a coroner if it appears to be one on which a coroner is required to hold an inquest. The police are the authority to which the public are accustomed to report if they find a dead body in mysterious or unexplained circumstances. The police are also accustomed to receive reports of all deaths in which there is evidence of violence, whether deliberate or accidental or where there are allegations of criminality. These are all deaths in which the coroner has had and, under our proposals, will continue to have, a lawful interest; and they are reported to the coroner by the police in accordance with police standing orders. We have already recommended (see paragraph 12.7 above) that there should be a statutory obligation on an officer in charge of a police station to report the death of any person in police custody. We do not think that there is any justification for imposing any other obligation on the police.

Funeral staff

12.32 It was suggested to us by representatives of the funeral service organisations (who were, or course, putting forward this proposal in the context of the existing law and without knowledge of our own proposals) that there might be some advantage in placing a duty to report deaths upon funeral staff. They argued that in the absence of a specific duty it was difficult for funeral directors or embalmers or their staff to contemplate reporting a death since a report would cause delay, occasion further distress to the relatives on whose behalf they were acting and perhaps call in question a doctor's certificate. We appreciate their concern to contribute towards society's defence against crime or deception. It would, however, be extremely difficult to define the persons on whom and the circumstances in which a statutory obligation of this exceptional kind could be imposed alongside the obligations that we have already recommended should be placed on doctors and others. In the general context of the recommendations we have made in this Report we do not think that they could or should be singled out for responsibility as they proposed.

Sanctions

12.33 Our view of the importance and interdependence of the various parts of the improved system we are trying to construct for death certification and related enquiries suggests that legal obligations to report must be backed by legal sanctions in the event of failure to comply with those obligations. However inappropriate the criminal law may seem to certain parts of this difficult field, it offers the only basis for effective insistence on general standards of compliance; a voluntary system based only on administrative codes would

not be satisfactorily enforceable. We therefore recommend that intentional failure by any person to comply with the obligation to report a death should be an offence punishable by a fine. We assume that such failure on the part of a person in a service having its own disciplinary code could be dealt with alternatively under that code if the occasion so warranted.

CHAPTER 13

THE POWERS AND DUTIES OF A CORONER

Territorial jurisdiction

13.01 A coroner normally has jurisdiction (the power to act) only in the area for which he has been appointed a coroner. Thus, a borough coroner may act only in the area of the borough to which he is appointed. In counties, there may be one coroner for the whole county or coroners may be assigned to individual districts in the county and, in normal circumstances, they each exercise jurisdiction only within their own district.[1] The coroner's jurisdiction is based on the presence of a body within his district and is not affected by the fact that the injury causing the death, or even the death itself, may have occurred elsewhere. However, a coroner may, with the consent of another coroner, order a body to be removed into the district of that other coroner in order, for example, to enable a single inquest to be held on several victims of the same accident.[2] If the bodies of several persons who appear to have died as a result of the same occurrence are lying within the jurisdiction of different coroners who do not, for some reason, agree among themselves to move them all into one jurisdiction, the Secretary of State may direct that such a transfer should be made.[3]

13.02 In general, we are satisfied with the present legal position whereby the coroner's power to act rests initially on the fact that there is a body lying within his district. Some means must be found of determining which coroner should be obliged to make enquiries into a death and a determination founded on territorial jurisdiction seems to us to be as rational as any. Nevertheless, there is scope for some minor improvements in the existing law relating to a coroner's territorial jurisdiction. It might sometimes be sensible, where an incident (e.g. a road accident) leading to death has taken place in one coroner's area and the death itself has occurred in the area of another, for inquiry into the circumstances of the death to be conducted by the coroner in the area in which the incident occurred. Moreover, we believe that when a competent court[4] orders an inquest, or a fresh inquest, to be held, it should not be fettered in any way in its choice of coroner. Accordingly, we recommend that:—

(i) if the coroner in the area where the death occurred has grounds for believing that an inquiry should be made into the circumstances of

[1] There are at least three exceptions to this general rule. Under section 20 of the Coroners Act 1844, during the illness, incapacity or unavoidable absence of a coroner for another district within the county, another coroner may hold an inquest within the first coroner's district. Under sections 48 and 57 of the Prison Act 1865, a county prison is deemed, for coroners' purposes, to be within the jurisdiction of the appropriate county coroner rather than within the jurisdiction of the coroner for the borough within which the prison is situated. Moreover, when the High Court exercises its power under section 6 of the Coroners Act 1887 to order an inquest, or a fresh inquest, to be held, it may direct that it should be held by a coroner other than the coroner for a surrounding or adjacent county.

[2] Section 16, Coroners (Amendment) Act 1926.

[3] *Ibid.* Section 17.

[4] See Chapter 19.

the death and that they 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;

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

The coroner's duty to enquire into a death

13.03 The statutory basis of the coroner's duty to enquire into a death is contained in section 3 of the Act of 1887, as modified by section 21 of the Coroners (Amendment) Act 1926. The law requires two conditions to be met before a coroner may act. First, he must be informed that a body is lying within his jurisdiction; second, there must be reasonable cause to suspect[1] that the death was a violent or unnatural death or a sudden death the cause of which is unknown, or that the death occurred in prison or in circumstances which require an inquest to be held in pursuance of any Act. If these conditions are met, a coroner has a duty to make enquiries. He has a general duty to hold an inquest which is modified by discretion to dispense with an inquest in any case in which he has reasonable cause to suspect that the death is a sudden death the cause of which is unknown and he is of the opinion that a post-mortem examination may prove an inquest to be unnecessary. In any other case, the strict letter of the law requires a coroner to open an inquest.

13.04 The coroner's legal power to arrange for an autopsy to be performed rests on a number of provisions. Under section 21 of the Coroners Act 1887 a coroner has power to direct the medical attendant of the dead person (or, if no person was in attendance either at death or during the last illness, any doctor in practice in or near the place where the death occurred) to attend the inquest on that person as a witness and to make a post mortem examination of the body. Under section 22 of the Coroners (Amendment) Act 1926 he also has power, once he has decided to hold an inquest to request any medical practitioner to make a post-mortem examination or special examination in preparation for an inquest. Finally he has power under section 21 of the 1926 Act if the death appears to him to be a sudden death the cause of which is unknown and he is of the opinion that a post-mortem examination may prove an inquest to be unnecessary, to direct any practitioner whom he would be entitled to direct if an inquest were held, or he may request any other practitioner, to make a post-mortem examination. These powers are restricted by Rule 3 of the Coroners' Rules 1953 which *inter alia*[2] requires that, whenever practicable, post mortem examinations should be made by a pathologist with suitable qualifications and experience and having access to laboratory services.

[1] It has been held judicially that a coroner's jurisdiction exists if he genuinely believes information which, if true, would give him power to act. *R. v Stephenson* (1884) 13 QBD 331; *re Hull* (1882) 9 QBD 689.

[2] See Chapter 23 below where we describe in more detail the restrictions on the coroners right to choose the doctor whom he will direct or request to make a post-mortem examination on his behalf.

13.05 Only if he holds an inquest is his duty in relation to the death clearly set out. It is the duty of a coroner's jury, or of the coroner himself if he sits without a jury, to determine at an inquest who the deceased was and how, when and where the deceased came by his death. If a coroner concludes his enquiries into a death without holding an inquest, his only duty is to send to the registrar of deaths for the district in which the death occurred a certificate indicating the medical cause of death revealed by the autopsy.

13.06 The previous paragraphs amply indicate the complicated state of the existing law. It is archaic, unwieldy and almost incomprehensible. It is oblique where it should be direct, rigid where it should be flexible. What is required is a restatement of the powers and duties of the coroner. A new basis must be found on which he may perform the two functions of the "appropriate authority" which we identify in Part II. Accordingly, we recommend that when a death is reported to a coroner who has a territorial jurisdiction over the death (see paragraphs 13.01–03 above), he should have a duty:

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

(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.

In order that he may carry out the above duties, we further recommend that the coroner should have a statutory power

(iv) to require a post-mortem examination to be carried out, to open an inquest or to make the reference referred to at (ii) above.

Powers of investigation

13.07 The existing statute law is silent about the existence of the coroner's detailed powers of investigation, and although it is probable that he has certain common law powers, they are not well defined. We believe that it would be useful if these powers could be clarified in the legislation which we hope will follow this Report. Accordingly, we recommend that a 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.

We further recommend that 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 or 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.[1]

Power to act in the absence of a body

13.08 When a coroner has reason to believe that a death has occurred in or near his jurisdiction in circumstances which require an inquest to be held, but the body has either been destroyed or is lying where it cannot be recovered, the Home Secretary may, upon application by the coroner, direct that an inquest be held, either by the coroner who has made the report or by any other coroner.[2] The power has been used to enable inquests to be held on many different kinds of fatal accidents, deaths in mines, quarries or presumed deaths from drowning being typical examples. Although the territorial waters around the coast are not, strictly speaking, *within* the jurisdiction of a coroner, the Home Secretary has in the past ordered that an inquest is to be held on the death of someone who disappears in coastal waters, presumably on the ground that the death occurred *near* to the coroner's jurisdiction. We believe that an inquest held in the absence of a body can often be a most valuable procedure and we understand that it frequently assists relatives of the deceased by allowing them to obtain a certificate which will serve as proof of death for a number of purposes. We therefore recommend that the Home Secretary should retain his present power to direct an inquest to be held in the absence of a body.

13.09 When an inquest is held in the absence of a body, it is, of course, possible that the body may be recovered after the inquest has been held. Two hypothetical situations may be envisaged. First, the body might turn up in the area of the coroner who had already held an inquest in the absence of the body or, secondly, the body might be discovered in the area of another coroner. In the first case, the coroner might be expected to connect this body with the subject of his previous inquest but, in the second set of circumstances, the coroner might or might not be aware that an inquest had already been held. Although the existence of two sets of papers in relation to the same death might pose minor difficulties for registrars of deaths, we do not think that there should be any objection in principle to the holding of a second inquest in either set of circumstances. The availability of the body for post-mortem examination might disclose the exact medical cause of death and

[1] The detailed recommendations in this paragraph are similar to those which appear in the Report on the Coroners System in Ontario prepared by the Ontario Law Reform Commission and published earlier this year by the Department of Justice in Ontario.

[2] See Section 18 of the Coroners (Amendment) Act 1926.

could, indeed, throw a new light on the circumstances in which the death had occurred. We recommend that 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.

13.10 We do not imagine that there will be many cases in which a body is discovered after having been thought lost but, as an aid to dealing with such situations when they do arise, we further recommend that 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 that coroners should consult the Home Office in cases where a body is found in circumstances which suggest that it might reasonably have been thought to have been lost.

Deaths outside England and Wales

13.11 We were informed that the exact nature of the coroner's power or duty to enquire into a death which has occurred outside England and Wales has been a matter of uncertainty to some coroners. The problem has been raised recently in connection with deaths on or near off-shore drilling installations, but deaths on oil rigs provide only one example of a general problem. The letter of the law requires that, if a coroner is informed that there lies within his district the body of a person who there is reasonable cause to suspect died a violent or unnatural death, he must hold an inquest regardless of where the death occurred. Some coroners, however, have taken the view that when they have within their area the body of a person who has died a violent or unnatural death outside the country, they have no jurisdiction to hold an inquest. Others appear to assume that they have a discretion in these circumstances and do not, therefore, hold inquests on bodies which have been brought home for burial or cremation from overseas.

13.12 We recommend that future legislation should make it clear that a coroner has discretion whether or not to act in any case where he is informed that within his area is the body of a person who died outside England and Wales in circumstances which had they occurred in this country would have given him jurisdiction to act. We envisage that coroners will learn of these deaths from funeral directors or from registrars of deaths when application is made for a " certificate of non-liability to register ". (This certificate takes the place of a registrar's certificate of disposal in the case of a death outside England or Wales). In accordance with the recommendations in Chapter 6 above, registrars of deaths will continue to be obliged to report to a coroner any death which appears to be one into which a coroner has jurisdiction to enquire.

13.13 There are two reasons why it is necessary that a coroner should have a discretionary power, rather than a duty, to act in relation to a death which has occurred outside this country. First, if the death has occurred in a foreign country rather than on board a ship or aeroplane (or otherwise in transit between two countries) it is likely that some enquiry will have been already been made into the death before permission was given for the body to be

removed. In these cases a further enquiry in this country may be superfluous. Second, even if there has been no other enquiry, or if such enquiry as has been made appears unsatisfactory to the persons concerned in this country, it may not always be practicable for a coroner to make worthwhile enquiries. If all the witnesses to the death are still in a foreign country he would almost certainly be unable to secure their attendance at an inquest in this country.

13.14 A completely different situation obtains if the death has occurred outside England or Wales and the body is for some reason not available. In this case, a coroner has no power to act since there is no body lying within his jurisdiction and unless there is reason to believe that the death occurred " near " to the coroner's district (e.g. within a comparatively short distance from the coast), the Home Secretary has no power to issue a direction for an inquest to be held in the absence of a body. We considered, therefore, whether in order to enable satisfactory inquiries to be made into deaths on board ships or off-shore drilling installations, the coroner's jurisdiction should be extended to cover cases where death occurs outside the country and the body has been disposed of or lost.

13.15 The present position is that in the case of a death on board foreign going British ships, there is provision in the Merchant Shipping Acts for an inquiry to be held, whether there is a body or not, by a Superintendent or Proper Officer of a local Mercantile Marine Office of the Board of Trade.[1] These inquiries are held immediately after the ship has docked and before the crew is discharged. It has been suggested to us that this is not an entirely appropriate function for an officer of this kind to undertake and that it might more conveniently be assumed by a coroner.

13.16 We can see logic in the argument that a coroner whose main business it is to make inquiries into the circumstances of a death rather than a civil servant from the Board of Trade whose functions are much more diverse may be the most suitable person to inquire into the circumstances of death on board ship; we also appreciate that the present arrangements serve to fragment the uniformity of the system for enquiring into the facts and causes of deaths. But the problem of deaths on board ships is small and rather specialised. It would not be easy to place this new responsibility on the coroners' service as we envisage it developing in future. We have already indicated our view that a coroner should continue to require a direction from the Secretary of State before holding an inquest without a body. It would hardly be possible to obtain such a direction before a ship had docked and the crew were ready to disperse. There is the complication, also, of our recommendation for prior publicity for any inquest (see Chapter 15 below). When the factors of administrative tidiness and general convenience are excluded from the reckoning it is still very doubtful whether the coroner's expertise in making inquiries into the circumstances of a death is to be preferred to the greater knowledge of ships and seamen possessed by the Board of Trade Superintendent. On balance, therefore, we do not recommend that the coroner should take over these inquiries.

13.17 The provisions in the Merchant Shipping Act 1894, to which we have just referred, do not apply to oil rigs, but the Mineral Working (Off-shore Installations) Act 1971 authorises the Secretary of State for Trade and Industry to direct that statutory inquiries should be held into accidents on installations licensed by him. We do not know how this power will be used, but unless an inquiry is ordered whenever a person dies on such an installation and the body is lost or otherwise disposed of, there would seem to be a risk that certain deaths, which would be reported to a coroner if they occurred on-shore, will not be so referred or otherwise made the subject of an independent inquiry. We do not find this to be an acceptable situation. We recommend, therefore, that 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. This would put the coroner in a position, if he thinks it desirable and practicable, to make inquiries to ascertain the fact and cause of death and, if he wishes to hold an inquest, to seek the Home Secretary's authority for this. As a simple rule of thumb, we suggest that the coroner to whom a report should be made in any such case should be the coroner whose littoral jurisdiction is closest to the scene of the death. Without knowing more about the scope of the powers in the new legislation, we do not feel able to make more specific recommendations for the detailed implementation of our general proposition.

[1] Now the Department of Trade and Industry.

Exhumation

13.18 It is an offence under common law and under section 25 of the Burial Act 1857 to disinter or disturb in any way without lawful authority a body that has been buried. It is recognised however that, under the common law, a coroner has power to order by warrant the exhumation of a body within a reasonable time after death for the purpose of holding an inquest if one has not already been held. There is no judicial authority for the length of time which might be termed " reasonable ", but it is implicit that the period of time should not be so long as to make an examination of the body useless.

13.19 As we have noted in Chapter 4 above, exhumation is already a very rare occurrence and, as may be seen from Table J below, the power to exhume a body is very rarely exercised by a coroner.

TABLE J

Exhumations ordered by Coroners 1959-1968 inclusive

Year	No.	Year	No.
1959	3	1964	2
1960	2	1965	3
1961	1	1966	NIL
1962	3	1967	1
1963	NIL	1968	2

With the continuing growth of cremation as the preferred method of disposal (see Table U below), the opportunity for exhumation will become rarer still; but we consider that it should remain open to a coroner to order the exhumation of a body if he feels that this is necessary in order to obtain evidence about the causes and circumstances of death. It would be more convenient if

his power was statutory rather than based solely on the common law. We therefore recommend that a coroner should have a statutory power to make an order for exhumation. We recognise that, in the majority of cases, exhumation is likely to be desired for the purposes of a police enquiry into a death but we believe that the decision whether or not to exhume is best taken by a judicial officer independent of the authority requesting the exhumation.

Miscellaneous functions

13.20 Besides the duty to enquire into deaths, coroners have several other duties, each of them more or less a historical survival, and bearing very little relation to the main content of their work.

(i) *Treasure trove*

13.21 The coroner's duties relating to treasure trove were preserved by section 36 of the Coroner's Act 1887, which re-enacted word for word (in translation) some of the provisions of the Act of the fourth year of Edward I. Originally there were fiscal reasons for the coroner having this jurisdiction; the sums accruing to the Crown through the discovery of hidden treasure were once a not inconsiderable portion of the King's total revenue. It remains the coroner's duty to determine whether a discovery of hidden treasure is treasure trove even though treasure trove is no longer important as a supplement to the Sovereign's revenues. In the absence of the concept of treasure trove, there would be no way of conserving discoveries of treasure for the nation; they would normally belong to the finder or the owner of the land on which they were found depending upon the circumstances of the discovery.

13.22 There is no statutory definition of what constitutes treasure trove, but the definition which is generally accepted in England and Wales is that given in Chitty's Prerogatives of the Crown:[1]

> "Any gold or silver in coin, plate or bullion found concealed in a house, or in the earth, or in a private place, the owner thereof being unknown, in which case the treasure belongs to the Queen or Her grantee having the franchise of treasure trove; but if he that made it be known or afterwards discovered the owner and not the Queen is entitled to it, this prerogative right only applying in the absence of an owner to claim the property."

A find will normally only be regarded as treasure trove if:—

1. the articles are of gold or silver;
2. the ownership is unknown;
3. it was hidden in the ground or in a building with the intention of subsequent recovery.

13.23 If it is decided at an inquest that the articles found are treasure trove they become the property of the Crown, but normally an ex gratia payment equivalent to the full market value of the treasure is made to the finder in order to encourage prompt disclosure. If the find is not held to be treasure trove, it is the practice for the inquest to say who is the owner of the articles—for example, the finder or the owner of the land on which it is found. Such a decision as to ownership is open to challenge in the civil courts.

[1] Chitty's Prerogatives of the Crown (1820), page 152.

13.24 The evidence of our witnesses, among whom were included all the learned societies in this field, suggested that the coroner's jurisdiction as it exists at present is not fully adequate for the modern purpose of protecting portable objects of archaeological value. The defects are two-fold. First only articles of gold and silver are protected, whereas from the archaeological viewpoint it is essential to regard a hoard as a whole; even the containers in which treasure is deposited are often invaluable as historical clues. The second defect is that the coroner has no jurisdiction over objects in respect of which it is not possible to demonstrate an *animus revertendi*. An example of this is where objects are buried in graves.

13.25 Although we have felt it necessary to record these criticisms, it should be noted that they are not so much criticisms of the coroner's jurisdiction as of the definition of treasure trove and this is not a matter which is within our terms of reference.

13.26 The Crown's claim to treasure trove, and the establishing of that claim by a coroner, are respectively an end and a means which are distinct and separate. We do not interpret our terms of reference as requiring us to express an opinion on the desirability of retaining the prerogative rights of the Crown in this field, but in coming face to face with this question we have become aware of the implications of any alteration of the coroner's jurisdiction which, in its modern form, provides the sole means of protection for portable antiquities. While it may appear that a coroner's treasure trove duties are an anachronism and are out of keeping with his other functions there are apparently good reasons why this function should continue to be exercised by coroners. First, in view of the possibly conflicting interests of the Crown, the finder and the owner of the land on which the find was made, it is necessary that an independent person should exercise the judicial function of deciding whether a particular find constitutes treasure trove, and if not what should be done with it. Second, the most important thing in the case of enquiries into treasure trove is to establish the facts so far as it is possible to do so and since the nature of the proceedings are inquisitorial rather than accusitorial this is a function which can better be carried out by a coroner's court rather than by, for example, a Magistrate's court. Third, it is important that there should be a local system of courts which meet, or can be convened, fairly quickly in order to decide on treasure trove cases.

13.27 We have considered whether it might not be possible to deal with treasure trove in some other way but it seems to us that the foregoing arguments have a great deal of force and that, in the absence of a completely new system of jurisdiction to deal specifically with treasure trove, there is no sensible alternative to the continued use of the coroner's court. In the circumstances, we recommend that 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.

(ii) *Fire inquests in the City of London*

13.28 In the City of London, by virtue of a local Act[1], fires occasioning loss or injury must be reported to the coroner, who may hold an inquest in respect

[1] City of London Fire Inquests Act, 1888.

of the fire if he thinks it proper to do so and must, if ordered to do so by the Lord Mayor, the Lord Chief Justice or the Secretary of State. The jury may find a verdict of arson against a named person, who must be committed for trial at the Central Criminal Court.

13.29 This local jurisdiction is a specially preserved example of what used to be a general power to hold inquests of felonies generally. It cannot be said to serve any purpose today. From the technical point of view, all serious fires are properly investigated today by professional officers. The Commissioner of Police for the City of London has told us that he attaches no value to the provisions of the Act. We recommend that it be repealed.

(iii) *Sheriff's duties*

13.30 County coroners act for the Sheriff in certain circumstances where he is disqualified by some pecuniary or other interest. These duties are ancient, comparatively trivial, very rarely exercised and apparently harmless. We have no recommendations to make for their abolition.

CHAPTER 14

THE CORONER'S PROCEDURE WHEN A DEATH IS REPORTED TO HIM

A. The Present Situation

Preliminary enquiries

14.01 When a death has been reported to him, the coroner's first concern is to decide whether or not he has the legal right[1] to make enquiries about it. It is usual for him to make some preliminary enquiries, either in person, or through his officer,[2] into the circumstances of the death and the reason why it has been reported to him. These enquiries follow no set pattern and may amount to little more than a question or two on the telephone at the moment when the death is reported to him. On the other hand, if the coroner is in doubt whether there is any need for him to investigate the death, his preliminary enquiries may take longer and may result in a decision not to take any action in relation to the death.

Pink Form A

14.02 If, after considering the results of his preliminary enquiries, the coroner is satisfied that neither an autopsy nor an inquest is necessary and that the cause of death may be certified by a doctor who has attended the deceased person, he concludes his enquiries by sending a notification to this effect to the registrar of deaths. He does this by completing Part A of a pink form issued by the Registrar General.[3] The completed certificate is known as a " Pink Form A ". Pink Form A is one half of a dual-purpose certificate (the other half is completed if the coroner concludes his enquiries after being notified of the result of an autopsy—see paragraph 14.05 below). Part A contains a space for the coroner to record the medical cause of death, but he does not take the final responsibilty for this: an instruction on the form tells the registrar that, if the deceased was attended during his last illness by a registered medical practitioner, the cause of death must be entered from that doctor's certificate and not from the coroner's notification. When the coroner completes Part A of the pink form he is simply indicating to the registrar that he does not consider that the death is one into which he has jurisdiction to enquire. On receipt of a Pink Form A, a registrar is free to proceed with the registration of the death on the information given to him by the person registering the death and in accordance with the particulars given on the medical certificate of cause of death issued by the deceased person's doctor. In 1969 approximately 11 per cent of all deaths reported to coroners in England and Wales were dealt with in this way.

Deaths requiring further investigations

14.03 Depending upon the circumstances of the particular death reported to him, a coroner will, if he decides that he has a duty to investigate a death,

[1] See Chapter 13 above.
[2] For an account of the work of the coroner's officer see the Annex to Chapter 21 below.
[3] See Figure 5 on page 163.

proceed to do so with the help of either an autopsy or an inquest, or both. The practice of individual coroners varies quite significantly (see Appendix 3), but, taking the country as a whole, autopsies are carried out in about 88 per cent of all deaths reported to coroners and in almost 99 per cent of those deaths which are not disposed of under the Pink Form A procedure.

14.04 At present, the decision that an autopsy should be performed is not always taken personally by the coroner; it is delegated to his officer who arranges for autopsies to be performed in accordance with standing instructions. We accept that such a procedure is inevitable in districts with a large number of reported deaths. But we also hold very strongly the view that responsibility for the decision to ask for an autopsy to be carried out should continue to reside with the coroner himself. This is a quasi-judicial decision which may sometimes have considerable implications for the family of the deceased person. When it is known that a relative, or other person close to the deceased, is objecting to an autopsy we consider that the decision *must* always be taken by the coroner himself.

14.05 The coroner's power to arrange for an autopsy to be performed was discussed in Chapter 13 above (see paragraph 13.04). If, when he has seen the results of an autopsy, it becomes clear to a coroner that a death was due to natural causes and that no further investigation is necessary, he will adopt a procedure, commonly described as the " Pink Form B procedure ". The coroner sends to the registrar the same pink form to which we have referred in paragraph 14.02 above but, this time, he completes the second part of the certificate. When he completes the " cause of death " section of Part B, the coroner is, in effect, certifying the medical cause of death—since the registrar must record in his register of deaths the cause of death indicated on the form. If there is already in existence a medical certificate of the cause of death given by a doctor, the registrar must disregard this certificate. From the registrar's point of view, therefore, a Pink Form B is a superior category of medical certificate of the cause of death. We recommend that the Pink Form B procedure should, in its essentials, be retained as one of the options open to a coroner when a death has been reported to him. The Pink Form B itself should, however, be replaced by a new " all purpose " certificate to which we refer in more detail in Chapter 18 below.

Attendance at an autopsy

14.06 The Coroners Rules provide for various categories of persons to be informed by the coroner, whenever this is practicable, of the date, hour and place at which the post-mortem examination will be made and for these persons to have the right to be present or to be represented at the examination.[1] They include any relative of the deceased who has notified the coroner of his desire to attend or be represented, the regular medical attendant of the deceased and if the deceased person died in hospital, the authorities of the hospital. In addition, the coroner is obliged in certain circumstances to notify the Pneumoconiosis Medical Panel for the area, the Inspector of Factories, a Government Department or the Chief Officer of Police as the case may be. The Chief Officer of Police may be represented by a police officer, the other authorities

[1] Rule 4, Coroners Rules 1953.

must be represented by doctors unless they themselves are doctors.[1] We formed the impression, after discussing these matters with some of our witnesses, that it is usual for coroners to notify the deceased person's medical practitioner and the hospital, rare for anyone to attend or be represented when the autopsy is carried out, and even more unusual for a relative to be aware of his right to be represented on such an occasion. We have received a few representations from individuals to the effect that they would have liked to have made use of their right to be represented if they had known of it. Although we do not think that it would be practicable to impose a legal obligation on coroners to inform relatives of their rights we recommend that they or their staff should seek an opportunity to mention the possibility of representation at the autopsy when they explain to relatives the reason why it is necessary for an autopsy to be carried out.

The inquest

14.07 As we indicated in the previous chapter the coroner is absolutely obliged to hold an inquest on all violent or unnatural deaths, deaths in prison or deaths occurring in circumstances in which an inquest is statutorily required. He must also do so for any sudden death the cause of which remains insufficiently determined after post-mortem examination. If the coroner proceeds to hold an inquest he becomes responsible for ascertaining not only the cause of death but also the particulars which are required for the purpose of registration. He is obliged to supply the registrar with all this information on a document known as a " Certificate after Inquest ".[2] In the column headed " Cause of Death " on this certificate, the coroner records not only the medical cause of death but also circumstantial causes of death. On receipt of this document, the registrar registers the death without requiring the personal attendance of an informant. He is required to copy the whole of the entry in the " Cause of Death " column into his register of deaths and it follows that all this appears on the copy of the entry in the register (the document commonly referred to as the " death certificate ").

14.08 The requirement that an inquest should invariably be held on all " violent or unnatural " deaths has meant that some inquests are now held which, in view of a number of our witnesses, serve little useful purpose. Several witnesses suggested that a coroner should have power to dispense with an inquest in certain cases. The British Medical Association, for example, suggested that the power to dispense should be extended to " simple accident cases " and the Police Federation made a similar suggestion in respect of " cases where the verdict is a mere formality . . . " The suggestions of other witnesses varied from a proposal that the coroner should have virtually a complete discretion to one that he should have no discretion at all. Our own conclusion, based on the evidence submitted to us and on *a priori* grounds is that the existing law is too inflexible in that it requires the coroner to hold an inquest on a number of occasions in which there seems to be no reason in the public interest for doing so. Clear cases of suicide, some deaths of elderly persons following falls at home and certain road accident deaths are most often quoted as examples of unnecessary inquests, but examples can

[1] *Ibid.*
[2] See Figure 6 on page 164.

be found within each of the categories of death in which an inquest is mandatory. We are satisfied that the only way to improve the situation is to give to the coroner what will be virtually a complete discretion as to whether or not he should hold an inquest. We consider the implications of this conclusion in the second half of this chapter.

B. Our Proposal for the Future

14.09 In Part II of our Report we have stated our belief in the value of retaining the coroner's office as the most convenient form of " appropriate authority " for carrying out two functions:—

(*a*) establishing the medical cause of death, when for one reason or another, certification by a doctor is impracticable or inappropriate, and

(*b*) for initiating enquiries into circumstantial causes of death where this seems desirable in the public interest.

For coroners to be able to carry out this role we conceive the basic requirements to be that

(i) coroners should be recipients, not seekers, of reports of deaths which call for their investigations;

(ii) coroners' enquiries should extend so far as, but no further than, is necessary to enable them to complete the task of establishing the cause of death.

14.10 We recommend that, in future, subject to three exceptions, a coroner should have a complete discretion as to the form which his enquiries may take after a death has been reported to him. In the case of the three exceptions we consider that an inquest should be mandatory. The exceptions concern

(*a*) deaths from suspected homicide,

(*b*) deaths of persons deprived of their liberty by society, and

(*c*) deaths of persons whose bodies are unidentified.

14.11 We consider that a death from suspected homicide is pre-eminently a death in which there should be some form of public inquiry. At present, the forum for this inquiry is more often a criminal rather than a coroner's court. We hope that this will continue to be the situation. We therefore recommend no change in the existing law under which a coroner must adjourn his inquest if he is informed that anyone has been charged with causing the death and which prevents him from resuming an inquest until the question of responsibility for a death has been finally determined by the criminal courts. In any case in which someone is charged with causing the death the coroner's inquest should continue to be merely formal in character. But it is important that a coroner should open an inquest even when he knows that the principal enquiry into the cause of death will be conducted in the criminal courts. When murder is an issue, the disposal of the body is too important a matter to be left to a registrar of deaths. The determination of when the disposal of a body may be allowed is essentially a judicial decision and by opening an inquest a coroner will put himself in a position to make that decision. Coroners are

accustomed to maintain contacts with the process of criminal investigation and they are likely to be much better placed than registrars to know, for example, whether or not defence counsel is likely to require a second post-mortem examination of the body and to decide when disposal may safely be allowed to proceed. We recommend in Chapter 28 below that a registrar of deaths should be responsible for the issue of certificates authorising the disposal of a body in any case in which a coroner has not opened an inquest.

14.12 It is even more important that an inquest should be held in any case of homicide or suspected homicide in which there are no criminal proceedings in connection with the death, for legitimate public interest in these deaths is it least as great as it is in deaths which become the subject of criminal proceedings. An inquest held in such circumstances could demonstrate publicly that there was no need for any further enquiry into the death (for example, because the person likely to have caused the death was himself dead) or it could indicate that police enquiries into the death were still continuing. But in any case it would be unrealistic to attempt to differentiate between a death from homicide which later becomes the subject of criminal proceedings and one which does not. At the moment when a death is reported to him a coroner will often have no idea into which category it will ultimately fall. We therefore believe that a coroner should be required to open an inquest whenever he suspects that a death reported to him may be a homicide.

14.13 By our reference to persons deprived of their liberty by society we intend to cover all those persons mentioned in Chapter 12 above, whose deaths we have recommended should automatically be reported to a coroner. We have in mind, in particular, persons detained in police custody or in prison service establishments and persons detained under the Mental Health Act 1959. Most people, we think, want to have assurance that prisoners (and other persons set apart from society as a whole) do not die from maltreatment. We accept that it is perfectly proper for a coroner's inquest to be used for this purpose and that, to be fully effective, the procedure must apply to all deaths occurring in such circumstances. We believe that the pain to family and friends caused by such inquests is likely to be minimal and that they may well have a strong desire for an independent enquiry into the death.

14.14 We propose that an inquest should also be mandatory whenever the coroner is informed that there is lying within the area in which he exercises jurisdiction the body of a person whose identity is in doubt but who appears to have died within living memory. An inquest in such a case will provide the best possible opportunity for witnesses to come forward with information. We believe that the finding and subsequent disposal of an unidentified body is always a matter of legitimate public interest.

14.15 The three exceptional categories described above are not likely to be large, so that the general effect of our proposal to give coroners a discretion to decide the form of their enquiry will be to place them in an entirely new situation. In future, a coroner will have a free choice in nearly every death which is reported to him, either to arrange for an autopsy to be performed or to hold an inquest (with or without an autopsy) or to dispose of the case on the basis of his preliminary enquiry. We now consider how he should exercise this discretion.

14.16 When a death is reported to him the coroner's first task should be to satisfy himself as to the identity of the body and that it lies within his area. After these facts have been established his principal duty should be to ascertain the medical cause of death.

14.17 We recognise that some of the deaths reported to the coroner will not require him to make more than a preliminary enquiry, e.g. of the doctor with evident knowledge of the case. There are two reasons for this. First, the operation of the new procedure for certifying the fact and cause of death, which we have recommended in Part I above, will probably ensure that some deaths are reported to coroners for "technical" reasons even though a doctor has great confidence that he knows the medical cause of death. Second, a few reports may be frivolous or malicious. Accordingly, we recommend that 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 his certificate to the registrar on the basis of the information which the doctor has provided. We would expect a coroner to decide to certify after a preliminary enquiry only in straightforward cases. He might certify in this way when, for example, a doctor who is in other respects qualified to give a certificate of the fact and cause of death is disqualified from doing so only by reason of a lack of recent attendance, or when a doctor who has been treating a patient is temporarily unavailable and a partner, who has access to the deceased person's case notes is confident that he knows the cause of death. Provided that he can be satisfied that the cause of death is already accurately known, a coroner might also choose to act in this way in relation to some of the hospital deaths reported to him because they occurred during surgery or under or before recovery from the effects of an anaesthetic.

14.18 If, however, the report made to the coroner raises any doubt as to the cause or circumstances of death, it will be his duty to resolve this doubt using the most suitable means at his disposal. In some cases, he may be able to resolve any doubt simply by making further enquiries. More often, however, it will be necessary for him to arrange for an autopsy to be performed, and, on some occasions, he may feel it necessary to hold an inquest.

14.19 We think that it is possible to identify and commend certain principles of public interest which coroners should bear in mind when they consider the form of investigation which they propose to undertake into deaths reported to them. We have already referred to the concept of the "public interest" in our consideration of what deaths should be reported to coroners (see Chapters 6 and 12 above). We now use the phrase in a slightly different context. Below we suggest some grounds of public interest which we believe that a coroner's enquiry should serve. These are:—

(i) to determine the medical cause of death;

(ii) to allay rumours or suspicion;

(iii) to draw attention to the existence of circumstances which, if unremedied, might lead to further deaths;

(iv) to advance medical knowledge; and

(v) to preserve the legal interests of the deceased person's family, heirs or other interested parties.

The determination of the medical cause of death

14.20 We have argued that it should be the principal aim of any system of death certification to ensure that the cause of death is accurately ascertained in every case because we believe that the ascertainment of the cause of death of individuals is important to the whole community. It is, therefore, with the simple intention of improving the accuracy of certificates of the fact and cause of death that we have recommended, in Chapter 6, that doctors should be placed under a new statutory obligation to report any death to the coroner if they cannot confidently certify its cause. The operation of this requirement is likely to increase the number of deaths reported to the coroner for purely medical reasons. We hope that coroners will respond by using their power to order autopsies in any case in which the medical cause of death is in doubt. We doubt if they will need to resort to inquests except on those infrequent occasions when a number of doctors are known to disagree on a point of substance, or the results of an autopsy are vitiated in any way (e.g. by the state of the body or the length of time since death), or when an inquest may be the best means of elucidating, by circumstantial enquiry, the opinions of medical practitioners.

Investigation to allay rumour or suspicion

14.21 At present the coroner fulfils an important function in the allaying of gossip and, in some cases, suspicion, to which a death can sometimes give rise. At worst, these rumours and suspicion are harmful to individuals and, even at best, they leave a feeling of unease in the community concerned. We believe that coroners should be ready either to arrange an autopsy or to hold an inquest in order to allay such rumours and suspicions. The knowledge that an autopsy has been performed by a reputable independent pathologist may often be enough to clear up such doubts. On occasions, however, coroners may well feel it necessary to hold inquests in order to demonstrate publicly that adequate enquiry has been made into the circumstances of death and that there are no grounds for alarm, suspicion or self-condemnation.

Publicity for circumstances which, if unremedied, might lead to further deaths

14.22 A coroner should consider, on the basis of his preliminary enquiry, whether it is in the public interest that he should hold an inquest in order to draw attention to a possible fatal hazard so that an adequate warning can be given to the public and precautions taken, whether by individuals or by a responsible authority, against any new fatality. In Chapter 16 we develop our views on the coroner's right to make public comments on particular matters and his right to refer his papers to an appropriate authority.

The advancement of medical knowledge

14.23 So far as we are aware, coroners' autopsies and inquests have never been overtly in order to advance medical knowledge. We do not think that the coroner's powers should be sought as a last resort by doctors who fail to get the consent of relatives to an autopsy which they wish to conduct for purely research purposes. But we do not discount the possibility that a number of deaths could occur, either within a particular district or nationally which, although they could be certified by doctors under the procedure we have proposed in Part I, might appear to indicate the presence of some hitherto

unsuspected hazard, and justify research in the interests of public health generally. We believe that if such research were promoted and the systematic co-operation of coroners were deemed essential, individual coroners would be justified in ordering post-mortem examinations, and, if necessary, in proceeding also to inquests, in order to determine the relative significance of factors leading to those deaths and in order to enable possible methods of prophylaxis to be studied.

The preservation of rights of the deceased person's family, heirs or other interested parties

14.24 A coroner's investigation can often help to safeguard the legal interests of persons affected by a death. For example, the results of a post-mortem examination can be useful in helping to decide questions of inheritance, where there may be a question as to which of two relatives died first. Again, a coroner's inquest can, on occasion, be an extremely valuable method of enabling relatives to assess the chances of a successful civil claim, and sometimes the record of evidence given at an inquest may be of prime importance in a subsequent claim for compensation. But these are incidental by-products of the system and not intrinsic to it. Indeed, we are convinced that it would be against the public interest for the scope of the coroner's investigations to be enlarged in the area of civil liability. At present the coroner is precluded (by Rule 33 of the Coroners' Rules 1953) from returning any verdict which may appear to determine any question of civil liability. We recommend that this restriction should be retained. It is inevitable, however, that a coroner should sometimes have to face the question whether a particular inquest, if held, would be likely to turn largely into a "dummy-run" for subsequent civil proceedings. We suggest that the consideration which should weigh most with a coroner in such circumstances, is whether if an inquest is not held, the true circumstances of the death will become known. If it seems to the coroner that it is most unlikely that the circumstances of a death will become known if an inquest is not held, he should have a bias towards holding an inquest.

14.25 It is an essential feature of the changes we have proposed in this and the preceding chapters that coroners should have wide discretion to decide what form of enquiry (if any) they should adopt in particular cases. By way of guidance, we have suggested some simple operational principles. There remains the question whether there will be need for some measure of outside influence. In Chapter 19, we consider proposals for rights of appeal against a coroner's decision not to hold an inquest (and other aspects of his activity). In our Conclusion we consider the need for a continuing review of the way in which the coroner's discretion works in practice so that coroners may be advised of any changes which are considered desirable in the practical exercise of this discretion.

Figure 5

NOTIFICATION TO THE REGISTRAR BY THE CORONER
that he does not consider it necessary to hold an Inquest

For completion by registrar
Entry No.

For completion by coroner | If a histological or bacteriological examination is to be made, please initial —>

A.

For use where NO POST-MORTEM has been held under Section 21 of the Coroners (Amendment) Act 1926

PARTICULARS OF DECEASED PERSON – Name and surname.....

Age.....Date and place of death.....

Cause of death :

The circumstances connected with the death of the above person have been reported to me and I do not consider it necessary to hold an inquest.

Signature.....Coroner for.....Date.....

To :.....Registrar of births and deaths.

* Where this notification relates to a still-born child this should be stated here.

B.

For use where a POST-MORTEM has been held under Section 21 of the Coroners (Amendment) Act 1926

PARTICULARS OF DECEASED PERSON – Name and surname.....

Age.....Date and place of death.....

I hereby certify that a post-mortem examination of the body of the above person was made by.....
and his report disclosed that the cause of death was :

* *I have given a Certificate E for cremation dated* .....*to*

(name).....*of*

(address) .....

* Delete words in Italics if not applicable.

and I am satisfied than an inquest is unnecessary.

Signature.....Coroner for.....Date.....

To :.....Registrar of births and deaths.

INSTRUCTIONS TO REGISTRAR

This death must be registered in the presence of an ordinary informant and spaces 1-7 should be completed in accordance with the information given by the informant and not copied from this form.
If A is filled up and the deceased was attended during his last illness by a registered medical practitioner, the cause of death must be entered from the certificate issued by him and not from this form.
If B is filled up the cause of death must be entered from this form as in Example No. 28 or 32 in Appendix O of the Handbook.

Form 100

Figure 6

* P.M.
* No P.M.

BIRTHS AND DEATHS REGISTRATION ACT, 1953

CORONER'S CERTIFICATE AFTER INQUEST
(DECEASED PERSON)

No. of entry in register. *To be filled in by Registrar*

To the Registrar of Births and Deaths for the Sub-district of ....

I HEREBY CERTIFY that at an inquest held by .... on.......... at.......... in the.......... of.......... on the body of.......... then and there lying dead *I / *the Jury †found as follows:—

PART I. FOR USE IN RESPECT OF A **DECEASED PERSON.** (NOT STILL-BORN CHILD—SEE OVERLEAF)

Columns:—1. When and where died.	2. Name and Surname.	3. Sex.	4. Age.	5. Occupation.	6. Cause of death.

PART II. TO BE FILLED UP IN ADDITION TO PART I IF INQUEST WAS ADJOURNED UNDER—

*A. Section 20 of the Coroners (Amendment) Act, 1926, and not resumed.

Criminal proceedings were instituted on a charge of: * Murder; * Manslaughter; * Infanticide; * Complicity in the deceased's suicide; * An offence against section 1 of the Road Traffic Act, 1960.

As a result of the proceedings the defendant was: * Discharged by Justices; * Convicted of..........; * Acquitted; * Found guilty but insane.

*B. Section 20 of the Coroners (Amendment) Act, 1926, and further adjourned sine die; the result of the criminal proceedings was—
*Defendant found insane on arraignment for.......... *Indictment for.......... ordered to remain on the file.

*C. Section 7 (2) of the Visiting Forces Act, 1952.

*PART III.
I have given *an Order for Burial / *a Certificate E for Cremation dated.......... to (name).......... of (address)..........

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

Signature..........
Coroner for..........

* Delete as necessary.
† If the inquest was adjourned and not resumed, substitute "ascertained" for "found".

FORM 99

PART IV—
(Accident or Misadventure)

The additional particulars below are to be given by the Coroner if the death was directly or indirectly caused by accident or "misadventure" (including death from neglect or from anaesthesia).

1. Place where accident occurred:

2. (to be completed for all persons aged 15 and over). When injury was received deceased was: *1. on way to work. *2. at work. *3. on way from work. *4. elsewhere.

3. Details of how accident happened:

4. Type of injury:

5. Part or parts of body injured:

6. Interval between injury and death: * Less than one year; * One year or more.

* Delete as necessary.

PART V—
(Marital condition, etc.)

ALL PERSONS AGED 16 AND OVER	ALL MARRIED PERSONS
* Single * Married * Widowed * Divorced	Age of surviving spouse .... years

* Delete as necessary.

FORM 99

CHAPTER 15

THE INQUEST—ADMINISTRATIVE MATTERS

15.01 This chapter deals with a number of matters to which the coroner must give attention before he actually begins an inquest. On most of them, the existing law relating to coroners has little if anything to say. This situation reflects the comparatively slight importance attached to administrative details at a time when the population was much smaller and the scope of coroners' inquests was much narrower than it is today. But it is also characteristic of the freedom which coroners have always enjoyed to conduct their affairs as they themselves think fit rather than in accordance with principles expressly established for the convenience of the public. We regard it as a matter of the highest importance that, in carrying out their central role in the public service of enquiring into and certifying the causes of death, coroners should continue to have regard to the highly personal aspects of their work in individual cases and should always be ready so far as possible to accommodate their actions, and those of their staffs, to the feelings of distressed relatives. Coroners, bereaved relatives, doctors, witnesses and other interested parties should all be partners in a collective effort to find and then to communicate the relevant facts relating to a death.

Identification of the body

15.02 It is one of the functions of an inquest to determine " who the deceased was " (Coroners' Rules 1953, Rule 26). It is usual for a corpse to be identified to the coroner or his officer by someone who knew the deceased well enough in life to make a positive identification after death.

15.03 There are no rules governing the procedure by which a coroner should satisfy himself as to a deceased's identity. A survey[1] of attitudes of bereaved relatives to the coroner system showed that the most common procedure was for a near relative or close friend to identify the body, but in the Greater London area it was notable that such persons were asked to undertake this duty in fewer than 40 of the 82 inquests in the survey. The survey also suggested that many of those concerned would welcome a greater willingness on the part of coroners to excuse relatives from a duty which is often a painful and harrowing experience. More than half the persons interviewed in the survey who had been called upon to identify bodies found the procedure " very upsetting " or " rather upsetting ".

15.04 We do not believe that the identification of bodies is a procedure that can or should be subjected to hard and fast rules. In some circumstances relatives may be anxious themselves to make the identification, in others they may feel too distressed to do so. What is chiefly important is that the coroner (and his officer) should make himself acquainted with and be sensitive to the feelings of the bereaved on this matter. In our view there is no reason why,

[1] Conducted by Sales Research Services Ltd.

when the relatives immediately concerned are known or thought to be reluctant to undertake the task themselves, the coroner should not obtain help in identification from a doctor, work-mate, neighbour, or other knowledgeable person. We have no doubt that many coroners already adopt a flexible approach to the problem of initial identification. We recognise the difficulties of finding a convenient solution that avoids distress in any particular case. But we are concerned—and urge all coroners to be concerned—that the process of identification should not be conducted as a vexatious or mechanical preliminary; it may well be the first impression that a member of the public receives of the procedures for which a coroner is responsible.

15.05 It is impossible to be dogmatic about the interval in time that should elapse between death and identification. We have been informed that when a coroner receives a report of the death of some person whose identity is in doubt it is not unusual for him to delay for a week or so before reaching a conclusion on the cause of death and sending his certificate to the Registrar. Such a period is usually sufficiently long for any friend or relative to hear of the death and to come forward.

15.06 A particular incident which well illustrates the need to take special care to avoid causing unnecessary additional suffering to persons already under emotional stress was brought to our attention during the course of our enquiries and we feel it may be salutory to make a specific reference to it. A young child was killed in a road accident and the mother was twice called upon to identify the body of her child. This happened because the death was one in which both the coroner and the police had an interest. The coroner was concerned because an inquest was necessary and the police because they were considering the possibility of taking criminal proceedings against someone for causing the death. For both purposes a formal identification of the body was considered necessary and both the police and the coroner independently arranged for one to be held, thus causing a considerable measure of completely unnecessary distress for the mother concerned.

View of the body

15.07 Except where the inquest is held by the direction of the Secretary of State in the absence of a body, or where an inquest is ordered by the High Court, or is held after a previous inquest which has not been completed, a view of the body is essential to give the coroner jurisdiction to proceed.[1]

15.08 The " view " as a means of discovering the cause of death has been rendered obsolete by the autopsy which is now a part of almost every investigation of a death which proceeds to an inquest. The " view " has no value for identification, for the identity of the deceased person is nearly always established before the inquest by someone who knew the deceased person sufficiently well in life to be able to recognise the body after death. We are satisfied therefore that the compulsory view of the body by the coroner serves no useful purpose and we recommend that this requirement should be abolished.

[1] Coroners (Amendment) Act 1926, s. 14 (1). In medieval times, the notion that inquests must be held *super visum corporis* was followed literally and the body was itself a most important exhibit. The main purpose of this procedure was to discover evidence of any injuries which might have accounted for the death; but it was also a means of demonstrating that a body existed and of establishing identity.

Notification of arrangements for holding inquests

15.09 At common law, any person who is able to give evidence about a death which is the subject of an inquest is bound to attend the coroner's court in order to do so. But a coroner is not, at present, obliged to give public notice of his intention to hold an inquest; nor is he statutorily obliged to notify witnesses, next-of-kin or other interested parties of his intentions. In practice, the procedure for notifying such persons varies from one part of the country to another. It is not entirely satisfactory, particularly so far as reaching relatives is concerned. There have been a number of instances reported to the Home Office in recent years in which relatives have had just cause to complain about the lack of information relating to a death with which they were legitimately and deeply concerned.

15.10 There are at least four distinct categories of persons with whom a coroner should be concerned when he makes arrangements for holding an inquest. They are:—

(i) witnesses of the fact or cause of death;

(ii) relatives;

(iii) other parties with an interest in the death, such as an insurance company which has issued a policy on the life of the deceased person; and

(iv) the press.

We shall discuss each in turn.

(i) *Witnesses*

15.11 A coroner is obliged by statute[1] to examine on oath " all persons having knowledge of the facts whom he thinks it expedient to examine "; it follows that he must take steps to ensure the attendance of these persons. Some coroners issue a formal summons in every case, but more often witnesses are simply told informally, usually by a coroner's officer, that their presence is required. Informality of proceedings is a valuable feature of a coroner's inquest and we suggest that coroners should continue to use their discretion to decide whether it is necessary to serve a formal summons on any witness. A witness who has been formally summoned should continue to be subject to a fine for non-attendance.

15.12 We propose one small change in the law in connection with the coroner's power to summon witnesses. At present, a coroner's summons runs only within the area of the county or borough in which he has jurisdiction. If a witness is required to attend from outside the area in which the coroner has jurisdiction, the coroner can only compel his attendance by obtaining a *sub-poena* from the Crown Office. We see no reason for this restriction on the coroner's ability to obtain evidence which he requires and we recommend, therefore, that every coroner should have authority to summon witnesses from anywhere in England and Wales. Coroners should also have a similar power to compel the production of documents and exhibits and there should be appropriate penalties for non-compliance.

[1] Section 4 of the Coroners Act 1887.

15.13 We also propose a change in practice. When a witness is notified that he is required to attend an inquest, whether that notification is given to him formally or informally, the information which he is given is usually limited to details of the place, date, time and subject of the inquest. We believe that this information could usefully be amplified by some reference to the right of " properly interested persons " to be represented at an inquest. Under Rule 16 (1) of the Coroners Rules 1953, any person who, in the opinion of the coroner is a properly interested party, is entitled to examine any witness either in person or by counsel or solicitor. Coroners are not required to publicise this fact and we have been informed that interested parties do on occasions appear at inquests without legal representation in circumstances where such representation is in their best interests. We recommend, therefore, that when witnesses are told about the arrangements for an inquest, whether formally or informally, they should be told that, if " properly interested persons ",[1] they are entitled to legal representation.

(ii) *Relatives*

15.14 It is often the close relatives of the deceased person who are placed at the greatest disadvantage by the present procedures. There is, in law, no obligation upon a coroner to inform even the closest relatives of a deceased person of the result of an inquest, let alone of the arrangements which are proposed for holding the inquest. We have been supplied with examples of the consequences of failure to keep close relatives informed of inquest proceedings. In one fairly recent case about which complaint was made to the Home Office a fatal motor accident occurred in a place some distance from the deceased person's own home. An inquest was opened and adjourned whilst criminal proceedings were first considered and later taken, but the deceased person's parents only learned of the result of the proceedings in both the criminal and coroner's courts after the coroner's certificate had been sent to the local registrar of deaths. They were understandably very concerned. Close relatives have an obvious deep interest in the process of events from the initial decision to hold an inquest right through to the outcome. We know that it will not always be easy for a coroner to trace relatives, but we think it entirely reasonable that a coroner should be obliged to make reasonable efforts to find out who is the nearest close adult relative of any person whose death has been reported to him and that, if he succeeds in finding this out, he should be obliged to notify that person[2] of the date and time of any inquest which he may decide to hold. We further recommend that if such person (i.e. the nearest surviving adult relative whose existence is known to the coroner) is for any reason 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.

(iii) *Other persons*

15.15 There are other persons, besides relatives, whose presence at an inquest may be desirable but we do not feel able to recommend that the coroner should be responsible for notifying to each and every one of these the arrangements for the inquest. Such a recommendation would be unrealistic; the coroner would have no assured means of establishing the identity of every person with a close interest in a particular death. Instead we recommend that, if a coroner is told that any person, who is a properly interested person,[1] has made a request to be kept informed of the inquest arrangements and has supplied a telephone number or address at which he can be contacted, he (the coroner) or his office should be obliged to undertake this responsibility.

[1] In Chapter 16 below we suggest that certain persons should have an absolute right to be considered as " properly interested persons "—see paragraph 16.60.

[2] This person might be advised by the coroner that he would be expected to make any necessary contact with other members of the family or friends of the deceased.

15.16 Interested persons who do not make known their interest in this way could be expected to learn about the inquest arrangements if they had opportunity to see or hear some official notification of the date and time at which the inquest is to be held. This matter is of all the greater importance because, in Chapter 16 below, we recommend the introduction of a new procedure (the short inquest) which is contingent upon interested persons having knowledge of the coroner's intentions, before the proposed short inquest is opened. We therefore recommend that every 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.

15.17 Some witnesses told us that coroners not infrequently postpone an inquest at the last moment and, conversely, that some inquests are started earlier than the time indicated to those concerned. There may sometimes be good reasons for changes of this kind, but they can and do cause distress and resentment and should be avoided where possible. We recommend that changes of this kind should not be made without adequate notice to the persons concerned.

15.18 We appreciate that for some coroners our proposals will bring a novel and unwelcome rigidity of procedure in place of the more casual methods evolved when coroners' activity was much more limited. We are convinced however that if the coroners' office is to have the increased effectiveness and status we think desirable, it must adapt itself to the demands of good public relations as well as to the technical needs of the service it offers.

(iv) *Press*

15.19 We have considered whether special facilities should be provided for the press. The National Union of Journalists proposed to us, among other things, that the local press should invariably be informed in advance of the date, time and place of the holding of an inquest. In many parts of the country there are already informal arrangements between individual coroners and individual newspapers under which the press does receive this advance notice. We believe that these arrangements can be very valuable and we hope that more coroners will adopt them. Our proposal (paragraph 15.16 above) for a list of forthcoming inquests to be publicly exhibited should also be helpful to the press.

[1] See Chapter 16, paragraph 60.

Recording the evidence

15.20 In cases of murder, manslaughter or infanticide, the coroner is required by law to take formal depositions at the inquest. In all other inquest cases, the only requirement is that the coroner should make notes of the evidence.[1] The content of the notes is left to his discretion, but he is expected to make fairly comprehensive notes in cases which are likely to be followed by subsequent legal proceedings.

15.21 Several of our witnesses criticised the existing procedures for recording evidence at inquests. The police and representatives of the legal profession complained that, for their purposes, notes made by coroners at inquests were often incomplete and sometimes bore little or no resemblance to the evidence given in court. There was criticism, too, of the length of time taken to complete formal depositions which sometimes delayed the completion of inquests. On the other hand, coroners pointed out that it was not possible for them to make comprehensive notes of all the evidence and at the same time pay proper attention to or take an active part in the proceedings.

15.22 We accept the need for a permanent record of inquest proceedings and we consider that, in general, the present methods are inadequate. Those of our witnesses who gave evidence on this aspect of the coroner's inquest suggested that in order to improve the situation, coroners should be provided with shorthand writers or tape recorders. We agree that this is desirable and if as we envisage, the total number of inquests falls off sharply as a result of our recommendation in paragraph 14.10 above giving the coroner a large amount of discretion whether or not to hold one, we do not think that it would be impracticable. Accordingly, we recommend that a transcript should be taken at every inquest.

Assessors

15.23 Although we received no representations on this subject, we have examined the question of whether there should be provision for a coroner to sit with an assessor when his inquiries involve technical matters.

15.24 The Secretary of State for the Environment (formerly the Minister of Transport) has power, upon application by a coroner, to appoint a person with special knowledge to act as assessor to a coroner at an inquest on a death arising out of a railway accident;[2] but, so far as we are aware, there is no other statutory provision for the appointment of an assessor. In practice, if a coroner feels himself in need of specialised advice, he obtains it in one of two ways. First, he may consult with whom he pleases before the inquest begins or in an interval before the announcement of a verdict. Alternatively, he may call a witness to give expert evidence on the matter before him. Frequently, a person giving expert evidence is the same person with whom the coroner has consulted informally beforehand. This arrangement has much to commend it since the evidence of an expert witness has the advantage of being given in open court and being therefore open to challenge.

[1] Coroners Rules, 1953 v. 30.
[2] Regulation of Railways Act 1871, s. 8.

15.25 We do not think that the practice of appointing assessors is particularly appropriate for coroners' proceedings. In most cases where an exhaustive enquiry is required into a death where technical matters are at issue, it is already the practice for a separate enquiry to be held. In our view, it is not a part of the function of a coroner's inquest to probe too deeply into technical matters: nor would it be right for him to indicate which persons, in a complicated range of circumstances, should bear the blame for an accident. We do not therefore recommend any change in the law with regard to the appointment of assessors.

Publicity and publication of proceedings

15.26 It was not until 1953, when for the first time coroners' procedure became subject to Rules, that it was clearly established that the public had a right to be present at an inquest. It appears from the authorities that before then, coroners had under the common law a discretion to decide on the degree to which their inquests should be open to the public. They also had for many years the power, analogous to that possessed by examining magistrates, to exclude the public from their courts if later criminal proceedings were likely to be prejudiced by their presence. The present position is that all inquests are open to the public, except where in the interest of national security the coroner decides otherwise.[1]

15.27 Apart from an Act prohibiting the publication of indecent medical details calculated to injure morals,[2] there is no restriction of Press reporting of cases in a coroner's court. It is the practice of most coroners, which we commend, to refrain from reading out the full details of notes left by suicides, and in addition coroners sometimes request the Press not to publish particular matters. Such requests, when reasonable, are usually respected. Sometimes coroners ask for publicity to be given to dangerous circumstances, and the Press are generally co-operative in this way also.

15.28 Only one of our witnesses suggested that public inquests were unnecessary. Nevertheless, we have thought it worthwhile to examine this question, since we recognise as a general principle that intimate family matters should be publicised only to the extent that the public interest requires. Our conclusion is that it is the essence of an inquest that it should be held in public. At the moment, the decision whether or not to hold an inquest lies in the coroner's hands only in a limited range of cases. One result of this situation is that among those cases where an inquest is mandatory are some where we believe there is little or no public interest served by the publication of the facts. In the future, if our recommendation (see paragraph 14.11 above) that coroners should have an almost complete discretion whether to hold an inquest is accepted, one of the first factors which coroners will wish to consider when making their decision will be the desirability of drawing public attention to the issues surrounding a death. A pause for such consideration should be enough to ensure that inquests are held only when the public interest, as opposed to the public curiosity, demand them. We do not doubt that cases of suicide will often be among those in which coroners will decide to exercise

[1] Rule 14, Coroners Rules 1953.
[2] Judicial Proceedings (Regulation of Reports) Act 1926.

their discretion not to hold an inquest. We therefore propose no change in the present requirement that inquests should be held in public—subject, as now, to the coroner's discretion in cases where national security is involved.

15.29 Criticism of press reporting of coroners' inquest proceedings has concentrated on inquests on suicides and inquests on deaths which may later be the subject of a criminal trial which, it is claimed, may be prejudiced by any premature publication of the facts of the case. Many of our witnesses chose to put their own recommendations in general terms. The British Association of Forensic Medicine suggested that the reporting of inquests should be confined to the verdict; the Police Federation proposed that the coroner should have a discretion to restrict the reporting of details at inquests; the British Medical Association, the Royal College of Physicians, the British Academy of Forensic Sciences, the Association of Municipal Corporations and a branch of the Police Superintendents' Association proposed that the reporting of inquests should be confined to brief details in all cases of suicide; and the Coroners' Society and the Law Society proposed that restrictions on the reporting of committal proceedings similar to those imposed in magistrates' courts should apply to inquests. The basis of our own approach to this question is the assumption that only very strong arguments can justify any restriction on reporting of inquests which are open to the public.

15.30 One argument in favour of a restriction on the reporting of suicide cases rests on the peculiar delicacy of the circumstances of these deaths. Notes and letters left by suicides are often recriminatory in tone, and may cause distress to, or even positively damage the reputation of, persons mentioned in them. If, however, our recommendation that the coroner should have discretion whether to hold an inquest is accepted, it seems likely that there will be many less inquests in cases of suicide and the considerations which we have set out in paragraph 27 above in respect of the admission to inquests of members of the public will apply equally to the question of Press reporting of cases. Another argument sometimes advanced in favour of restrictions is that newspaper reports mentioning a particular form of suicide may lead other persons who are contemplating suicide to adopt the same method. However, even if this is so, it is difficult to know whether the effect of the publicity is to increase the number of suicides or merely to popularise a particular method. If after one person has committed suicide in a particular way a number of other people commit suicide in the same way, there is a natural tendency to think that Press publicity increases the number of suicides, whereas the truth may be that almost the same number of people would have committed suicide, but would not, in the absence of Press publicity, have all chosen the same method. Whether this be so or not must be a matter of opinion, but we think that the argument that publicity increases the number of suicides is insufficiently supported by clear or irrefutable evidence to justify so controversial a step as the total prohibition of Press reports. Nor do we think that it would be satisfactory to give coroners a discretionary power to prohibit Press reports, since the effect of this would often be to place coroners in a most invidious position. Different coroners would almost certainly exercise their discretion in different ways and we think it undesirable that there should be local variations in the amount of reporting of these cases.

15.31 In general terms we are satisfied that the present practice of coroners in not reading out suicide letters, or only reading out the minimum necessary part should suffice, given the continued co-operation of newspaper editors, to ensure that inquests on suicides are reported in a responsible way. We are not, therefore, in favour of any legal restriction on the principle of a free press specifically to take care of suicide cases.

15.32 If the procedure at inquests in respect of deaths which may have been criminally caused is changed along the lines which we propose in the next chapter the difficulty arising out of Press reports of such proceedings should dwindle. Very little of the evidence which is submitted to a coroner is likely to be similar to the evidence advanced before examining magistrates and it is not therefore likely to be prejudicial in subsequent criminal proceedings. It might still be said that the mere publication of the facts surrounding the death would be prejudicial, but we are satisfied that this is too slender a basis on which to propose any restriction of reporting, even if such restrictions were practicable in relation to coroner's proceedings.

Delays in the completion of coroners inquests

15.33 If the completion of a coroner's inquest is unduly drawn out or delayed for any reason, it is the bereaved relatives who are likely to suffer the most. We have already made clear our belief that the coroner's enquiries should intrude as little as possible into private grief. We are equally concerned that the inquest should not be a cause of prolonging that period of anxiety in which the bereaved usually find themselves on losing a close relative or friend; nor should it inconvenience them or cause them to suffer hardships which sometimes arise because a dependant's pension is not payable until the death certificate (the copy of the entry in the register of deaths) is produced. When an inquest is held, such a certificate cannot be obtained until after the registrar of deaths receives the coroner's certificate after inquest.

15.34 Ideally, every inquest should be completed within 7 days of a death. This is the period within which most bodies are disposed of (see Chapter 27) and, since the initial stress suffered by a bereaved relative is unlikely to subside to any extent until the funeral is over, a 7 day enquiry cannot be said to prolong the suffering of the deceased. As it is, 48 per cent (140) of the 290 inquest cases covered by the Sales Research Services survey were said to have been completed within a week. We are satisfied, however, that, in many cases, it is not possible to complete an inquest within 7 days. There is a considerable amount of work involved in preparing for and holding an inquest, both for the coroner and his staff. Before the inquest stage is reached, they must find and question witnesses, take statements, inspect medical records and other relevant evidence, arrange for an autopsy to be performed and consider the evidence so obtained and summon those witnesses who the coroner considers should be present at the inquest. Having regard to the extent of the preliminary enquiry, we think that 14 days cannot seriously be regarded as an excessive period in which to complete an inquest. 71 per cent (206) of the 290 inquests in the survey were completed within this period.

15.35 We turn now to the reasons for delays in the completion of coroners' enquiries and consider what measures might be taken to improve the situation

still further. The start of an inquest is sometimes delayed because the evidence is incomplete, witnesses cannot be traced or are too ill to attend or simply because the coroner is too busy to hold it any earlier. An inquest once started may also be delayed by an adjournment.

15.36 Fortunately, many of the reasons for delays should disappear once our recommendations are implemented. The acceptance of written evidence at an inquest (Chapter 16) should reduce the number of occasions in which proceedings are held up to wait for witnesses who are temporarily incapacitated. It is to be hoped that in future there will be fewer inquests and, as a consequence, there will be less reason for a coroner to delay inquests because of his own other commitments. We hope that coroners will seek to develop and maintain a relationship with doctors both in general practice and in hospitals which will help to reduce the number of occasions when inquests are delayed because of the need to collect additional medical information. The problems involved in tracing necessary witnesses and other relevant evidence may not be so easily solved, but the new civilian coroner's officer should have considerable resources made available to him in order to minimise any delays resulting from any such difficulties.

15.37 It is reasonably clear from the results of the SRS opinion poll that, in general, coroners are mindful of the need to reach a conclusion as quickly as possible. None of the respondents suggested that there was anything but a genuine reason for such delays as did occur, which indicates that coroners use the discretion which they have over the use of the adjournment wisely. One legitimate complaint which was brought to our notice by the Home Office concerned an inquest which was adjourned until 5 months after the death of the deceased, thus causing the widow considerable inconvenience. In this case, a witness was incapacitated through injury for 2 months, but thereafter the only reason for the delay appears to have been that the coroner wanted the case to wait until such a time as he required a jury for another inquest, rather than summon one especially for one short case. We are satisfied that such incidents are rare and express the hope that coroners will see to it that they do not occur at all in future.

15.38 Delays caused by adjournments probably cause greater inconvenience than for any other reason because bereaved relatives sometimes have to wait many months before they can obtain from the registrar the copy of the entry in the register of deaths, which provides proof of their claim to entitlement to insurance monies and pensions. It was suggested by some of our witnesses that where it appears to a coroner that an inquest will have to be adjourned and its conclusion date accordingly delayed, he should be obliged to issue an interim certificate of the fact of death so as to enable dependants to claim insurances and pensions. We understand that the Coroners' Society has in the past attempted to establish a similar procedure by suggesting a form of letter that a coroner might give to insurers, but we were informed that, in many instances, insurance companies are not prepared to accept such notifications in the absence of any statutory requirement that they should do so. The Home Office has informed us that on the rare occasions when complaints have been received about such delays, they too have suggested to coroners that they should give a note explaining the reasons for the delay in issuing formal

documents and confirming the fact of death. We can see no reason why the coroner should not complete an "interim certificate of the fact of death" when he knows that this will serve a useful purpose. We believe that this would be likely to be of considerable benefit to dependants when inquests have to be unavoidably delayed for long periods. We therefore recommend that the coroner 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. We believe that this certificate should be acceptable to third parties e.g. insurance companies as evidence of the fact of death.

CHAPTER 16

THE INQUEST—PROCEEDINGS IN COURT

Introduction

16.01 In Chapter 14, we have proposed a radical change in coroners' procedure when deaths are reported to them. We have recommended that in future coroners should have what would amount to an almost complete discretion whether or not to hold an inquest in respect of every death reported to them and we have set out certain principles by which we suggest that coroners should be guided in reaching their decisions as to what course to follow. The number of inquests held annually is already falling steadily (see Appendix 3). We welcome this trend because it is our belief (see Chapter 14) that many inquests are held without real necessity. We envisage that the implementation of our recommendations would lead to a much more dramatic fall in the total number of inquests held. But there would be a number of circumstances in which, following our principles, coroners should feel impelled to hold inquests; in this chapter we are concerned with the procedures which they should follow in such a situation.

The objectives of an inquest

16.02 The present scope of a coroner's inquest is defined in Rule 26 of the Coroners Rules 1953 in the following terms:

> " The proceedings and evidence at an inquest shall be directed solely to ascertaining the following matters, namely:—
>
> (*a*) who the deceased was;
>
> (*b*) how, when and where the deceased came by his death;
>
> (*c*) the persons, if any, to be charged with murder, manslaughter or infanticide or of being accessories before the fact should the jury find that the deceased came by his death by murder, manslaughter or infanticide;
>
> (*d*) the particulars for the time being required by the Registration Acts to be registered concerning the death. "

A further limitation on the scope of inquest proceedings is contained in Rule 33 which provides that " no verdict shall be framed in such a way as to appear to determine any question of civil liability". The effect of these two provisions is to make it clear that it is no part of a coroner's function to be concerned with any matter of civil or criminal liability—with an exception for homicide cases contained in Rule 26(*c*). The coroner's proceedings are inquisitorial in nature: for the most part the task of questioning witnesses is carried out by the coroner himself, although (as we shall see in paragraph below) other persons have a right to ask questions at an inquest.

16.03 The evidence of our witnesses, and more particularly the evidence of our two social surveys, suggested that there was no widespread dissatisfaction with the nature of inquest proceedings or with the manner

in which they are conducted by individual coroners. This is scarcely surprising. At many inquests the facts surrounding the death are self-evident and all that is required from witnesses is a brief description of the circumstances in which the deceased person met his death or was found and, in the case of medical witnesses, an opinion as to the medical cause of death. But in a minority of cases contentious issues do arise. There may be more than one version of the facts and diametrically opposed views may be sincerely held by different interested parties. It is in these circumstances that an inquest may lead to controversy and even acrimony; these are the occasions on which a coroner must take the greatest care to be (and to be seen to be) completely impartial. For the most part, we believe that coroners manage this difficult task very well, but we are satisfied that there are some few occasions on which criticism of particular inquest proceedings is justified. It can happen, for example, that during the course of a coroner's inquest a person's conduct is impugned without his having received any prior notice that this might happen and without any adequate opportunity for him to prepare or put forward an explanation. Less frequent, but still an occasional source of legitimate grievance, is a situation in which a coroner allows only part of the evidence to be heard or rejects evidence which might have put an entirely different construction on the actions of someone whose conduct was being impugned.

16.04 The law does little to preclude the possibility of such situations occurring. Regardless of the circumstances surrounding a death or the sort of situation which a coroner may at the outset foresee as a possible development, the only information which he is obliged to give to a person he wishes to summon as a witness is the date, time and place of the inquest and the name of the deceased person.[1] Consequently, witnesses who are interested parties may be unaware that they are entitled[2] to be—and may need to be—legally represented at an inquest. We have already made in Chapter 15 above a recommendation designed to improve this situation. But even when a person is represented, or is otherwise prepared to reply to any criticism made of him at an inquest, there is no guarantee that the coroner will grant an opportunity for an explanation or a repudiation, because he is not required to do so unless he is satisfied that a person is an interested party and that any proposed statements or questions are relevant to the inquiry.[3]

16.05 Several witnesses suggested that the difficulties to which we have referred would be less likely to arise if inquest proceedings could be accusatorial in nature. The Law Society went so far as to suggest that

> "where there are reasonable grounds for the coroner to anticipate that an imputation of culpability or against reputation may arise, the proceedings in relation to that issue should be conducted in accordance with the rules of evidence and procedure applicable to the accusatorial system."

No-one proposed that all the proceedings could be exclusively accusatorial; and we do not ourselves believe that it would be possible to apply accusa-

[1] Coroners Rules 1953, Third Schedule, Form 6.
[2] *Ibid*, Rule 16 (1).
[3] *Ibid*, Rule 16 (1) (d).

torial rules of procedure properly to inquest proceedings where there are no parties, no indictment, no prosecution and no defence. The Law Society's proposal would involve obliging the coroner and those involved in his inquest to move from an informal to a formal-procedure without notice and with the real risk of being asked to readopt informal and then formal procedures indefinitely within the one inquest. To state the proposition is to see how difficult would be its achievement. But it would not be necessary to adopt any such procedure if the scope of the coroner's enquiries were to be limited in the ways we suggest later in this chapter. It is a sufficient purpose for a coroner's inquest to inquire into the cause of death; to identify the person who might have been responsible for causing it is properly the function of an accusatorial court.

16.06 We start therefore from the premise that the coroner must continue to conduct his proceedings in an inquisitorial fashion. Because, however, the inquest, like the coroner's other enquiries, should be directed to the limited end of ascertaining the cause of death without identification of *personal* responsibility, it is essential that in future the inquest should be divested of those features which allow, if they do not actually encourage, the examination of issues of criminal or civil liability which should be the concern of other courts. On the positive side, we think that more can be done to protect the individual party or witness to an inquest against the risk of prejudice. In this chapter, therefore we consider, first the basic question of the line of demarcation between the inquest and other proceedings in relation to issues of criminal and civil liability. We then turn to various aspects of the procedure related to the inquest in regard to which we received criticisms or proposals for change or for which we are satisfied that change is called for by the radically altered objective of the inquest that we wish to see and have already described.

THE PROBLEM OF INDIVIDUAL RESPONSIBILITY

A. Criminal Liability: Homicide Cases

16.07 Strictly speaking, the only criminal issue with which it is at present in order for a coroner's court to be concerned is the most important criminal issue of all—homicide. Although an inquest is not generally concerned to determine questions of criminal liability, it has remained a specific duty of a coroner's jury to set forth a verdict which should, in the case of any finding that a deceased person came by his death by murder, manslaughter or infanticide, name the person or persons, if any, whom they find to have been guilty of the offence, or of being accessories before the fact.[1] Such a finding has the same effect as the preferment of a bill of indictment and any living person named in such an inquisition must be committed for trial for murder, manslaughter or infanticide. The coroner must specify, in his warrant of committal, the court before which the person named is to be tried and he has to inform the Director of Public Prosecutions that he has committed this person for trial. At the assizes, the accused may be arraigned upon a coroner's inquisition in the same way as a proper bill of indictment; and he may be tried and sentenced upon it.

[1] See section 4, Coroners Act 1887, as amended by the Coroners (Amendment) Act 1926. Also Rule 26, Coroners Rules 1953.

16.08 In practice, coroners only very rarely find themselves holding inquests *in full* on deaths from suspected homicide; and the use of the power to commit for trial is even less frequent. For the most part, when a coroner deals with a murder case, he simply opens his inquest, takes evidence of identification, medical evidence of the cause of death, and other particulars required for registration purposes, and then adjourns[1] his proceedings until the results of any proceedings in the criminal courts are known. When the results of these proceedings are known, even if magistrates have found no case to answer, the inquest is, in practice, not resumed. Instead, a coroner sends to the registrar a certificate in which he records the findings of the criminal court.

16.09 It is only if the suspected murderer is dead (a situation which obtains in a remarkable number of family murders)[2] or if, in the view of the prosecuting authorities, there is insufficient evidence to justify a charge against a living person, that the inquest proceeds. The coroner is thus left to handle those cases where there is no suspicion against anybody, or where there may be an element of suspicion but for one reason or another it has not been possible to bring charges.

16.10 But these few "homicide" inquests can cause great difficulties and very occasionally do so. It can happen, for example, that the evidence given on oath by witnesses at an inquest puts a new complexion on the case, or that the coroner's jury differs from the police and the Director of Public Prosecutions in their opinion as to the weight which should be attached to the facts. When this happens, with the result that someone is charged on the inquisition with murder, manslaughter or infanticide, the coroner has no option but to commit this person for trial. It is then usual for the Director of Public Prosecutions or the police to institute separate committal proceedings before magistrates, either for the same offence, or for a lesser offence arising out of the same set of facts. If the magistrates decide to commit, the accused person will stand trial on an indictment framed on the basis of the evidence given in the magistrates' court and the inquisition is left on the file at the Assizes. But whether or not the magistrates find there is a case to answer the individual committed by the coroner must appear at Assizes.

16.11 A notorious example of what can still happen occurred in 1966. The death in question was an obvious case of murder which was investigated by the police and considered by the Director of Public Prosecutions before a decision was taken that there was insufficient evidence to justify charging anyone with the crime. In the absence of any proceedings in the criminal courts, a coroner was left with a legal obligation to hold an inquest; and his jury were left with the duty set out in paragraph 16.07 above. As it happened, features emerged at the inquest which led the jury to return a verdict of murder against a named person and the coroner had no option therefore but to commit the named man for trial to an assize court. Immediately after-

[1] Coroners (Amendment) Act, 1926, Section 20(1). See Table K—"Inquests adjourned under section 20 of the Coroners (Amendment) Act 1926, which it has been decided not to resume."

[2] See "Murder 1957 to 1968" (Report by Home Office Statistical Division), London, HMSO, 1969.

wards, committal proceedings against the same individual were instituted before magistrates, who ruled that there was no case to answer. Despite this, the accused person was kept in prison for more than a month awaiting trial on the coroner's inquisition. No evidence was offered for the prosecution at the Assizes and the man was released.

The case for reform

16.12 The duty of a coroner's jury to name the person they find guilty of homicide and the coroner's consequential duty to commit that person for trial are survivals from a time when the coroner's inquest was a substantial part of society's defence against crime. They survive from a time when the present system of investigation of crime by the police and of committal for trial by examining magistrates did not exist. These duties are now widely regarded as archaic and unnecessary. Their abolition was recommended by the Departmental Committee on Coroners which reported in 1936 and our own witnesses were almost unanimous in support of that Committee's recommendation.

16.13 The strongest argument in favour of the abolition of both these duties is that they are incompatible with present day concepts of justice, which are firmly founded in an accusatorial system incorporating proper protection for suspected persons. The inquisitorial nature of a coroner's proceedings places a suspected person in a position of considerable disadvantage. He may be compelled to give evidence in public in a court whose rules offer him protection much inferior to that which he could expect to find in a magistrates' court and which, unlike a magistrates' court, may go so far as to name him as guilty of the most serious crime of all. Moreover, the person whose reputation may suffer or whose liberty may be removed by these proceedings may be someone who, before the inquest begins, has no real awareness of the extent to which he was likely to fall under suspicion.

16.14 On those few occasions when a coroner finds himself obliged to hold a full inquest on a death from homicide, his proceedings may bear a much closer resemblance to a criminal trial than do committal proceedings before magistrates. The fact that this is so arises directly from the shape of the two sets of proceedings. At committal proceedings in the magistrates' court, a suspected person is faced with a definite charge; he need make no statement and will not normally do so; no judgment is passed on the value of the evidence in his favour and the committal proceedings can only be reported at the request of the defence. At an inquest, on the other hand, there is no restriction on press reporting, there is no specific charge against anyone and no-one has the right to address the coroner or the jury on the facts.[1] The rules of evidence applicable in civil or criminal proceedings cannot apply to inquests and, since there is no specific charge, the inquiry may range over matters which would be of no relevance to such a charge, if it were made, but which may be prejudicial to a person accused in subsequent criminal proceedings. It is true that a witness may refuse to answer questions on the ground that the answer may incriminate him, but this may sometimes appear to a coroner's jury to be an admission of guilt. Nor is it only a witness under suspicion who is placed in an awkward situation. In order to help his jury determine whether or not they should find any person to be guilty of homicide, the coroner may have to examine closely a witness against whom suspicion has been levelled in order to clarify his statement. Yet, through all this, he must try to preserve the appearance of impartiality.

[1] Rule 31, Coroners Rules 1953.

16.15 In face of these clear disadvantages attaching to the jury's duty to name an individual and the coroner's jury to commit a named person for trial, we believe that only the strongest argument on grounds of usefulness should suffice to justify the retention of these features of a coroner's inquest. We have not found any such justification.

16.16 The number of coroners' committals for the ten years 1961–1970, together with the results of subsequent trials, are shown in Table L, annexed to this chapter. Table M, also annexed to this chapter, shows the number of committals by magistrates for murder, manslaughter and causing death by dangerous driving throughout the same period. It is clear from these figures that the number of committals from coroners' courts, by comparison with the total number of cases in which proceedings are instituted for the offences in question is very small. Compared with the 8,055 persons who were committed for trial by magistrates during this period charged with either murder, manslaughter, infanticide or causing death by dangerous driving, only 105 were committed by coroners. In the great majority of these cases, proceedings were also taken before magistrates, and in about two-thirds the defendant was committed for trial on indictment as well as on the coroner's inquisition. At the Assizes, not a single conviction was recorded on the coroner's inquisition alone.

16.17 But for the coroner's inquest, would these cases have been before the magistrates at all? Our own view, based largely on evidence submitted to us by the Director of Public Prosecutions, is that inquest proceedings are scarcely ever decisive in leading to a decision to prosecute. We were told by the Director that there had been very few cases in which the view of prosecuting authorities that there was insufficient evidence to justify a prosecution had been changed as a direct result of proceedings before a coroner's court. We have concluded that, in most cases in which there are two sets of committal proceedings, before a coroner and before magistrates, the magistrates' court proceedings would have taken place in any case. There have certainly been occasions on which a prosecuting authority has deferred its decision whether or not to prosecute until the outcome of the proceedings before the coroner, but we understand that the evidence brought out by these proceedings has been only one of several factors leading to a decision to prosecute.

Abolition of duty to assess guilt and power of committal

16.18 We have concluded that the practical value of the coroner's duty to enquire into the identity of killers and of his power of committal, as factors leading to the successful prosecution of offenders who might otherwise have evaded justice, is minimal. They are not essential features of criminal investigation procedure and we have no reason to believe that, with the developing efficiency of the science of criminal investigation, the removal of the coroner from this sphere is likely to have even the least damaging effect. On the other hand, the damage which these features of a coroner's inquest can do to an

individual needs no further emphasis and we believe that the case for their disappearance is overwhelming. We therefore recommend the abolition of the duty to name an individual and of the obligation to commit a named person for trial.

16.19 Unfortunately, simple abolition of the jury's duty in homicide cases to name the guilty party and the coroner's consequential obligation to commit that person for trial will not itself be sufficient to remove from a coroner's proceedings those features which have in the past aroused justifiable concern. Unless the whole character of homicide inquests is changed, so that there is no longer any possibility that individual liability for a death may become an issue, the damage which may be done to an individual's character or reputation is unlikely to be reduced by the fact that he is no longer named in the verdict or committed for trial. The mere substitution for the power of committal of a duty to refer papers to the Director of Public Prosecutions, favoured by several of our witnesses, would therefore be no solution to what we see as the major difficulty—the investigation of the circumstances of a homicide by an inquisitorial tribunal. Nor will the changes which we have proposed remove the issue of homicide altogether from the purview of a coroner. He may still have to deal with the type of case in which the suspected murderer is dead, as well as those in which there is evidence of homicide but it is insufficient to justify a charge against anyone. He may also be confronted with a situation in which homicide is not at first an apparent issue. In all these cases an individual's reputation, and even in some cases his liberty, may be at risk; and this fact must be balanced against the need to safeguard the public by ensuring that every suspicious death is properly investigated.

Homicide inquests—our proposals for the future

16.20 We have concluded that the best way of solving the problem of balancing the interests of the individual who is liable to suspicion against the need to protect the public interest would be to give to the coroner greater discretion than he has now to terminate the inquest proceedings in order to hand over further consideration of the issue of homicide to a more appropriate authority. We recommend therefore that there should be express provision for the coroner to refer his papers to the Director of Public Prosecutions at whatever stage in the inquest seems to him to be most appropriate. At that stage, provided that he is able to certify the medical cause of death, he should normally conclude his own investigation into the death by sending his certificate to the local registrar of deaths with an endorsement to the effect that the death has been referred to the Director of Public Prosecutions.

16.21 We do not suggest that the coroner should always conclude his inquest and make his report to the Director as soon as credible evidence inculpating an individual emerges. The timing of such a decision must be left to the discretion of the coroner in the light of all the information available to him. No hard and fast rules can be laid down to suit all circumstances; a decision to refer may sometimes be more damaging to a particular individual than a decision to carry on with the inquest and a coroner will wish to hear enough evidence to satisfy himself that he is fully justified in taking the serious

step of reporting to the Director. But as a general rule, we suggest that when the coroner realises, as a result of evidence adduced during his inquest, that there is a real likelihood that if his proceedings are continued they will lead, directly or by inference, to a suggestion of guilt against a particular person he should conclude his inquest at that point and refer the matter to the Director of Public Prosecutions.

16.22 A decision to refer a case to the Director should be announced, in neutral terms, in open court. We appreciate that such an announcement may have the effect of pointing the finger of public suspicion at a particular individual, but this is a disadvantage inherent in all forms of public investigation and can only be eliminated by holding all enquiries in private or by not holding them at all; neither is a course which we can recommend. What we can do is to take away from the coroner his function of assessing the extent of an individual's criminal liability and to make it clear that this function is one which belongs to the prosecuting authorities and the criminal courts.

16.23 It may be helpful if we now consider how this new procedure might work in relation to the kind of circumstances mentioned in paragraph 16.19 above.

16.24 In the first case, in which the suspected murderer is dead and the police are satisfied that there is no need to make any further enquiries into the death, the procedure is not appropriate at all. Nothing could be gained from a report by the coroner to the Director. We suggest that the coroner holding the inquest on the victim should take medical evidence of the cause of death and such other evidence as is necessary to show that the deceased died as a result of homicide. He should then take a statement from an appropriate representative of the police force which has investigated the death. It would be convenient for this statement to be in standard form and for it to be to the effect that it was not proposed to take proceedings in relation to the death and that police enquiries had been completed. The coroner should avoid making any statement directly implying that the dead person thought by the police to be the murderer was, in fact, responsible for the death. The argument which we outlined and accepted before recommending (in paragraph 16.18 above) that there should no longer be any duty on a coroner's jury to name any living person as guilty of homicide applies with equal, if not greater, force to the naming of a dead person. The coroner who holds the inquest on the suspected person may not always be the same individual as the coroner who holds the inquest on the victim. He also should avoid as far as possible any implication that the subject of his inquest may be a murderer.

16.25 An inquest held in circumstances in which there is no reason to suppose that the murderer is dead but in which there is insufficient evidence to bring charges against any living person, is likely to prove much more difficult. Here, the coroner's problem will be to avoid asking, or allowing others to ask, questions which bear on the responsibility of any individual for the death. As we have already indicated, we do not believe that it should be any part of a coroner's function to assess these matters. We suggest that when an inquest is held in circumstances such as those which we have just outlined,

the coroner should begin his inquest in the way which we have suggested in the previous paragraph. Having taken medical evidence and whatever other evidence is necessary to show that the death was homicide, it should be open to the coroner to explore the circumstances in which the death took place, but, following the guide line which we indicated in paragraph 16.21 above, he should conclude his inquest as soon as evidence is taken which appears to indicate that an identifiable individual may be responsible for the death. Taking the case quoted in paragraph 16.11 as an example, the coroner would, under our proposal, have been able to cut short his proceedings and report to the Director of Public Prosecutions as soon as it seemed to him that suspicion was beginning to fall on an identifiable person. The present law is too rigid to permit this. Once a coroner has opened an inquest in circumstances similar to those which we have been considering, he has no option but to continue to the point at which his jury may conclude that a named individual, who has not been on trial, is nevertheless guilty of the crime of homicide. Our proposal would do away with that necessity.

16.26 The remaining circumstance in which a coroner may find himself dealing with the issue of homicide is one in which the possibility of homicide emerges only after an inquest has been opened. No trouble need arise so long as there is no evidence to suggest who might have committed the homicide. The coroner will be able to pursue his enquiries into the acts and events which led up to death without any danger of suggesting that any particular individual may be guilty. On the other hand, where the identity of the person responsible for the acts in question is known or suspected, it may be impossible to ascertain the facts without identifying, expressly or impliedly, the person responsible. In some circumstances such an identification might amount to a statement of guilt. The prejudice which might result from such a situation needs no underlining: it is the basis of our recommendation to abolish the power of committal.

16.27 A fictitious example will illustrate the situation we have in mind. An elderly woman is found burnt to death beside her fireplace, and at the material time there is only one other person in the house with her. Preliminary enquiries suggest that she fell into the fire when alone in the room, but during the inquest evidence emerges which shows that the lady may not have fallen accidentally but may well have been pushed and that, if she was pushed, the only person who could have done it must have been the other person in the house. If, in such a case, the coroner were to hear the evidence in full and then announce a finding (as he is entirely free to do at present) that the deceased was deliberately pushed into the fire, that would be tantamount to a statement of the guilt of the other person in the house, even though the coroner were to be precluded from actually naming that person or committing him for trial. In terms of prejudice to the individual at risk, such a conclusion would be scarcely less damaging than a finding of guilt and a committal. Under our proposal, a coroner would no longer be required to pursue his enquiries to the point at which an individual is manifestly at risk. In the hypothetical example we have quoted, we believe that the coroner should conclude his inquest and refer the case to the Director as soon as he hears the new evidence that the woman may not have fallen accidentally.

16.28 It is conceivable that there will be occasions when, having received the inquest papers from the coroner, the Director of Public Prosecutions will conclude, after any further enquiries he may make, either that there is still insufficient evidence on which to base a case for prosecution or that the person whose actions were implicitly questioned by the coroner's decision to refer his papers to the Director of Public Prosecutions is found to be absolutely blameless and there were no concrete grounds for suspicion in the first place. Should this happen, it is vitally important that the good name of the individual should be restored immediately and, as the effects of the adverse publicity following the coroner's action are liable to be felt by that individual more within his own area than elsewhere, the most suitable and effective manner in which to right the situation would be through the local press. This would not be an appropriate task for the office of the Director of Public Prosecutions. We therefore recommend that, in a case where a coroner has concluded his inquest and sent his inquest papers to the Director of Public Prosecutions, and no further court action ensues, no matter for what reason, the Director should notify the coroner and the coroner should publish a statement to the effect that the Director of Public Prosecutions is satisfied that upon the evidence presently available there is no case for any criminal proceedings. The Director's notification would be likely to be in non-committal and standard terms covering indiscriminately the case where there was no evidence of an offence and the case where the occurrence of an offence was clear but the evidence against the suspected offender was insufficient.

16.29 We appreciate that, in some cases, this formula might not entirely dispel all suspicion about the circumstances of the death and the part played by an individual in contributing to it. We have to recognise, however, that it would not be open to the coroner to make more elaborate public statements interpreting the detailed circumstances of particular decisions by the Director. Nevertheless, it should be clearly understood that when, under our proposed procedure, a coroner reported the Director's conclusion that there was no case for criminal proceedings this would not necessarily imply that an offence had actually been committed, let alone that suspicion had pointed to any particular individual being responsible.

16.30 At present, the results of criminal proceedings are required to be included with the registrable particulars on the coroner's Certificate after Inquest and, because he cannot complete an inquest until after the conclusion of any related criminal proceedings, it is usually necessary for the coroner to adjourn the inquest until such time as the required information is available to him. This situation will be changed by our recommendations. In accordance with the flexible procedure which we have recommended in Chapter 14 above, a coroner will be able to conclude his enquiries into a death in respect of which there are also criminal proceedings as soon as he has established the identity of the deceased and the medical cause of death. At this point, he will be able to send his certificate to the registrar of deaths. There will no longer be any need for an inquest on a death which is also the subject of criminal proceedings to drag on until those proceedings are finished. The same situation will obtain if a coroner feels compelled by the evidence adduced at an inquest to exercise his power to conclude his enquiries and send his papers to the Director of Public Prosecutions (see paragraph 16.20 above).

He will send his certificate to the registrar at the same time as he makes that reference. It remains to be considered, therefore, how a registrar is to learn of the results of criminal proceedings or of the further enquiries made by the Director, or by the police on his behalf. We believe that the simplest and most practical solution would be to give to the coroner the responsibility for notifying the registrar. As proposed in paragraph 16.28 above, the coroner will be notified by the Director of Public Prosecutions of the result of his reference to his Office and there is already an arrangement under which the clerk to the appropriate court notifies the coroner of the result of criminal proceedings.

B. Criminal Liability—Cases Other than Homicide

(i) *Road accident cases*

16.31 A coroner is at present obliged by law to hold an inquest on the victim of a road traffic accident. It is usual for a coroner to open his inquest as soon as convenient after the death in order to take evidence of identification and medical evidence of the cause of death and then to adjourn his proceedings while the possibility of a criminal charge is considered. He is obliged to adjourn his inquest for at least 14 days if he is required to do so by a chief officer of police on the ground that a person may be charged with that offence and he may adjourn for longer periods at his own discretion.[1] If someone is charged under section 1 of the Road Traffic Act 1960 with causing death by dangerous driving the coroner is obliged to adjourn his inquest until the result of those proceedings is known and if there is to be a prosecution for a lesser offence the coroner often similarly adjourns his own proceedings. In those cases in which criminal proceedings are taken in relation to the death the coroner need not resume his inquest and, in practice, scarcely ever does so. Instead he sends his certificate to the registrar notifying him of the medical cause of death, the other registrable particulars which he is bound to supply and the result of the criminal proceedings.

16.32 It follows from what we have said in the previous paragraph that before the coroner finds himself holding a full inquest in a road traffic case the police are likely to have given at least some preliminary consideration to the question whether someone should be charged in connection with the death. For this reason it is unlikely that there will be many occasions on which there is a real possibility that the culpability of an individual may be indicated for the first time at an inquest. If a coroner does decide to hold an inquest on a road traffic death which has not been the subject of any criminal proceedings, we suggest that he should have available to him the same power to refer a case to the appropriate prosecuting authority as we have recommended should be available to him in homicide cases. He should exercise this power in accordance with the same principles which we have previously discussed in relation to homicide cases.

(ii) *Other offences*

16.33 Leaving aside questions of homicide, it is possible that evidence of other offences may come to light at an inquest. If, during the course of an

[1] Coroners Rules 1953, Rule 22 (1).

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. He should not, however, concern himself with an alleged offence which has nothing to do with the circumstances in which the death occurred.

C. Civil Liability

16.34 As we have noted in paragraph 16.02 above, the scope of a coroner's inquest is limited by Rules 26 and 33 of the Coroners Rules 1953 in such a way as to preclude an inquest from touching on any question of civil liability. We do not wish to see any change in these provisions for we take the view that the arguments against involving the coroner in matters relating to criminal responsibility apply with equal force to questions of civil liability. But we are not entirely satisfied that the spirit of the Rules is always strictly followed. Some of our witnesses admitted frankly to us that inquests were sometimes used as "dummy runs" for subsequent civil proceedings. We have no doubt that the early obtaining and recording of evidence at an inquest can and does play a valuable part in ascertaining the merits of a claim for damages by the dependants of a deceased person. In some cases it is only as a result of evidence taken and recorded at inquests that it is possible for a relative to establish a civil claim. We can see the merits of this procedure from the point of view of relatives and we do not wish to recommend that it should cease. Indeed, we have argued in Chapter 14 above that the preservation of the civil rights of a deceased person's family is a legitimate ground of public interest on which a coroner might decide to hold an inquest. But it will be convenient to repeat here the note of caution which we have already expressed in that chapter. Questions from interested parties at inquests should be confined to the elucidation of facts which bear on the issues to be determined by the coroner, irrespective of whether or not they affect matters of civil liability.

The verdict

16.35 The official record of an inquest is embodied in a written document called an Inquisition. On the form of Inquisition contained in the Third Schedule to the Coroners Rules 1953, there is provision for the findings of the court to be described under five headings:

1. The name of the deceased (if known).
2. The injury or disease causing death.
3. The time, place and circumstances at or in which the injury was sustained.
4. The conclusion of the jury/coroner as to the death.
5. Particulars for the time being required by the Registration Acts to be registered concerning the death.

It is the " conclusion of the jury/coroner as to the death " which is popularly referred to as the "verdict", and it is in this sense that we use the term verdict in this chapter.

16.36 A standardised range of verdicts is recommended in the Rules. The complete list comprises the following categories:—

Murder	Justifiable or excusable homicide
Manslaughter	Natural Causes
Infanticide	Industrial disease
Killed himself	Want of attention at birth
Attempted/Self-induced abortion	Chronic Alcoholism/Addiction to drugs
Accident/Misadventure	Aggravated by lack of care/self-neglect
Execution of sentence of death	Open verdict

Some of these verdicts are classifications which have some meaning and consequences in law; others are expressed in medico-social terms. An analysis of verdicts in coroners' courts for the period 1901–1969 can be found at Appendix 4.

16.37 One of the original purposes of an inquest was to determine whether a death had resulted from a criminal act and, if so, the identity of the person responsible for the act. Thus, the verdict was in its origins (and still is) the pronouncement by a coroner's jury which decided whether a person was to stand trial for homicide. It is this function of the inquest which accounts for the existence not only of the verdicts of murder, manslaughter, and infanticide, but also, by necessity, for the existence of the residual categories of misadventure and natural death, justifiable and excusable homicide, and execution of sentence of death.

16.38 A verdict of suicide was also in origin a verdict which had legal consequences. Until the beginning of the last century, suicide attracted barbaric penalties. The goods of a person who committed self-murder (*felo de se*) were forfeited to the Crown and his body was unceremoniously buried with marks of infamy to denote the ecclesiastical condemnation of his offence. If, however, the deceased person was "of unsound mind" at the time, he was not guilty of self-murder and none of these harsh consequences followed his death. It was for this reason that juries began the practice of returning a verdict that the deceased person killed himself whilst of unsound mind and, although the verdict of *felo de se* disappeared following the recommendations of the Departmental Committees of Coroners 1910 and 1936, the practice of finding that the deceased person was insane at the time when he killed himself continued up to 1953, when the new Coroners Rules introduced a standard list of verdicts. Many coroners even today still add the words "while the balance of his mind was disturbed" to their verdict in suicide cases—although the practice has fallen off since 1961, when suicide ceased to be a criminal offence.

16.39 The remaining verdicts do not purport to have any legal consequences, but they are surprisingly similar in character to the verdicts which impute criminal guilt. The Coroners Rules 1953 make clear (in Rule 26) that the sole purpose of the inquest, save in cases of murder, manslaughter or infanticide, is, in accordance with section 3 of the 1887 Act, to establish who the deceased was, how, when and where the deceased came by his death, and

the particulars for the time being required by the Registration Acts. Since the purpose of this Rule is presumably to discourage comment upon the civil, criminal or moral responsibilities of the parties concerned, it is curious that, upon examination, the recommended categories of conclusion should appear to have been framed so as to answer the question "was someone responsible for this death?" Even those which attempt to categorise the nature of the responsibility of a deceased person for his own death can bear this interpretation.

16.40 The conduct of any legal proceedings is inevitably affected by the character of the conclusions which they are required to reach, and inquests are no exception. We have already seen (paragraphs 16.07–19 above) how far the conduct of an inquest may be influenced by a requirement to decide whether the cause of the death was unlawful and, if so, who was guilty of the crime. If this requirement is abolished the original purpose of the verdict, which, as we have seen, was to indicate legal responsibility for the death, will virtually have disappeared. In future the function of an inquest should be simply to seek out and record as many of the facts concerning the death as the public interest requires, without deducing from these facts any determination of blame. A continuing requirement to reach a conclusion in terms like those prescribed in the Coroners Rules would be inconsistent with this purpose. In many cases, perhaps the majority, the facts themselves will demonstrate quite clearly whether anyone bears any responsibility for the death; there is a difference between a form of proceeding which affords to others the opportunity to judge an issue and one which appears to judge the issue itself.

16.41 In Chapter 14, we have attempted to define the categories of public interest which in our view justify the holding of an inquest. None of these purposes is any better served by a requirement that the court should reach a formal conclusion than it would be by a duty of a coroner to record the facts of death. Even rumour or suspicion could, we think, be dispelled by proceedings which do not conclude with a formal attribution of or exoneration from blame. The facts themselves will be sufficient for this purpose.

16.42 But will these facts be sufficient for the Registrar-General's statistics? The coroners service is an indispensable part of the procedure for certifying the causes of deaths and it is important that registrars should receive adequate information upon which to register and classify the death—as much in cases which call for inquest (where, by the nature of the case, the cause of death is often more complicated) as in non-inquest cases. The first essential, that the registrar should learn the medical cause of death, presents no difficulty. In the case of a death which is solely due to a natural cause, a description of this will be all that is required. Where there is some circumstantial element in the cause of death, the coroner must give the registrar sufficient information about the circumstances of the death to enable the Registrar General's office to ascribe the death to one or other of the statistical categories which are used in the international classification of cause of death. To a great extent, coroners already shape their descriptions of the circumstances of the death to meet this requirement. For instance, in the case of a motor accident, the coroner will normally record on his inquisition, and on the Certificate after Inquest, whether the deceased person was the driver of or a passenger in the

vehicle and whether any other vehicle was involved. For the benefit of the registrar, he will also record on the Certificate, not as part of the verdict but separately, such details as whether the death occurred at the deceased's home or in a public place. We recommend that the coroner should continue to record circumstantial details of this kind and that in future he should do so on a new certificate on which he should notify the registrar of births and deaths of his conclusions in respect of all deaths reported to him whether or not he has held an inquest, In Chapter 18 we discuss in more detail the whole question of documentation after a coroner's enquiries and we append to that chapter a suggested draft form of our proposed new certificate.

16.43 We consider it essential that a change be effected in what the public expect of an inquest, away from the attribution of blame and towards a merely fact-finding inquiry. In the long term, we can think of no more effective means of achieving this change than to abolish the " verdict " in its popular sense by abolishing the form of inquisition and with it the requirement to reach a formal " conclusion as to the death." We recommend that the term " verdict " should be abandoned and replaced by " findings."

The coroner's jury

16.44 Since 1926, a coroner has had discretion to sit without a jury in certain cases, but he must always empanel a jury if there is reason to suspect that:

(*a*) the deceased came to his death by murder, manslaughter or infanticide; or that

(*b*) the death occurred in prison or in such place or in such circumstances as to require an inquest under any Act other than the Coroners Act, 1887 or that

(*c*) the death was cause by an accident, poisoning or disease, notice of which is required to be given to a Government Department, or to any inspector or other officer of a Government Department, under or in pursuance of any Act; or that

(*d*) the death was caused by an accident arising out of the use of a vehicle in a street or public highway; or that

(*e*) the death occurred in circumstances the continuance or possible recurrence of which is prejudicial to the health or safety of the public or any section of the public.[1]

In 1969 only 31 per cent of all inquests were held with juries[2].

16.45 For a coroner's jury not less than seven and not more than eleven jurors must be summoned[3]. Coroners' juries have often to be called together quickly and for this reason the ordinary rules for summoning juries do not apply to them. So long as the coroner obtains the statutory number of duly qualified persons, the method by which he does so is left to his discretion. Under common law he can direct a sheriff to return a jury before him, but in practice the jury warrants are directed to coroners' officers, who make out the summonses to be served on the persons selected. While the jurors

[1] Section 13, Coroners (Amendment) Act 1926.
[2] See Table N annexed to this chapter.
[3] Coroners Act 1887 section 3 (1).

summoned do not need to be on the register of electors, it is often the practice to make use of the register in summoning the jury.

16.46 The only qualification required of persons summoned to serve on a coroner's jury is that they should be " good and lawful men "[1]. Jurors may be of either sex. The statutory age limit, (21 to 60) imposed by the Juries Act 1825, section 1, does not apply to coroners' juries, but it is usual not to summon persons over sixty.

16.47 The exemptions contained in the schedule to the Juries Act 1870, as extended by subsequent enactments, apply to coroners' juries as they apply to other juries. Persons in the following categories are disqualified from serving on coroners' juries:

(i) where an inquest is held on the body of a prisoner who dies within a prison, an officer of the prison or a prisoner therein or a person engaged in any sort of trade or dealing with the prison;[2]

(ii) where an inquest is held on the body of a sailor in detention who dies in a naval prison, a member of the staff of, or a person detained in such prison, or a person engaged in any sort of trade or dealing with the prison;[3]

(iii) a person having a personal interest in, or employed in or about, or in the management of the factory in or about which an accident occurred or an industrial disease was contracted;[4]

(iv) a person who has been attainted of any treason or felony or convicted of any crime that is infamous, unless he has obtained a free pardon;[5]

(v) aliens, until they have been domiciled in England and Wales for ten years;

(vi) persons having any knowledge of the facts of the inquest or such strong prejudices as to render them biased;[6]

In addition, Rule 35 of the Coroners Rules 1953 requires that no person may be summoned on more than three occasions in a year.

16.48 Several of our witnesses suggested, and we accept, that the role of a coroner's jury today is no more than symbolic. Despite the habitual care of coroners in explaining to their juries the procedure of an inquest, we believe that jurors often approach their task with a sense of bewilderment, as they realise the extremely limited nature of the role they have to play. Unless they have some expert knowledge upon which to base pertinent questions to witnesses, as for instance in an industrial accident case—and it is rare for jurors to be selected with this sort of consideration in mind—they can play no effective part in the proceedings until the time comes for the verdict to be given and a rider, if any, attached. The range of verdicts is limited and in many cases the final verdict is effectively, and of necessity, dictated to them

[1] Coroners Act 1887, section 3 (1).
[2] Coroners Act 1887, section 3 (2).
[3] Naval Detention Quarters Regulation 1942, reg. 32.
[4] Factories Act 1961, section 83 (2) (*a*).
[5] Juries Act 1870, section 10.
[6] This is a common law requirement.

by the coroner. Where juries have returned a verdict contrary to the guidance of the coroner—most notably a verdict of " manslaughter " in road traffic cases—subsequent proceedings have usually shown that their judgment was in error.

16.49 So long as it has remained one function of an inquest to determine the responsibility of an individual for the death of another person, it has been difficult to consider the abolition of a coroner's jury. But this situation will be changed by our recommendations, which should alter the whole character of a coroner's inquest. In this new situation we see no reason why it should continue to be mandatory for a coroner to summon a jury to deal with any particular category of death. At the same time, we can see that occasionally a coroner may feel the need for a jury to assist him, or he may feel that the finding might be more acceptable if given by a jury than by himself. We recommend that the mandatory requirement to summon a jury for inquests in certain categories of death should be abolished, but that a coroner should retain the power to summon a jury where he considers that there are special reasons for doing so.

16.50 If in these exceptional cases a jury is summoned, care should be taken to ensure that those who are summoned are fully representative of the local community. In particular, we think that women, who are rarely, if ever, called for service on a coroner's jury, should in future be given the opportunity to perform this service. When a coroner decides to sit with a jury, we recommend that it should be summoned in accordance with the same rules as are used by the High Sheriff in summoning juries for other courts.

Riders, recommendations and animadversions

16.51 Several of our witnesses saw considerable merit in the power of a coroner (and his jury if he is sitting with one) to draw attention to a public danger by means of a rider attached to the verdict of the court. We have some sympathy with this point of view. The publicity given to the attachment of a rider can result in action being taken which is urgently required and which might not otherwise have been taken. On the other hand, riders have been criticised (also with some justification in our view) on the ground that they give, or appear to give, a judgment on issues which have only been superficially considered in the evidence. In addition, it is argued that a rider can sometimes cast blame on individuals or on institutions who have had no opportunity to make a proper reply. Since we sympathised with both points of view on this question, we considered whether a way might not be found of retaining the advantages of the rider without its objectionable features.

16.52 The right to attach a rider to a verdict is already limited to the extent that a coroner is prohibited from recording any rider which is not, in his opinion, designed to prevent the recurrence of fatalities similar to that in respect of which the inquest is being held;[1] and he is required to draw the attention of his jury, if he has one, to the existence of this provision.[2] But, as the opponents of riders point out, the existence of this prohibition still

[1] Rule 34, Coroners Rules 1953.
[2] *Ibid*, Rule 32.

leaves the coroner or his jury with plenty of scope for recording riders which, in certain circumstances, may be unfair to individuals or to public authorities. When there is concern, for example, about the circumstances of a particular death in hospital, the coroner is, at present, in a somewhat invidious position. If it appears to him that someone's conduct is blameworthy and he says so in public, then he may, in fact, be doing an injustice to the person criticised. However, if he says nothing, then it may well appear to those close to the deceased person that the coroner is evading his duty. Our own position in this particular controversy may be simply stated: a coroner's court is not the right place from which to attribute blame and the coroner should not therefore do so. Our solution to the difficulty which may arise when it appears to a coroner that there may have been some departure from proper standards which, if uncorrected, might result in further danger to individuals, is to suggest that he should have a right to announce in public and in neutral terms that he is referring the circumstances of a death to an appropriate expert body or public authority for such enquiry and action as it may think fit. We have considered, whether, after a referral, the coroner should be empowered to call for a report from the authority concerned. While we have no doubt that, as a matter of courtesy, the authority would send him a reply in any event, we think it would be unwise for this to be made an obligatory procedure. The decision whether any further action is required may depend on many factors of which the coroner will know nothing and we think that these matters would best be left to the expert authorities concerned.

16.53 We therefore recommend that the right to attach a rider to the findings of a coroner's court should be abolished; that 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 that, where he thinks that action should be considered to prevent recurrence of the fatality, he should have a right to refer the matter to an appropriate expert body or public authority, and he should announce that he is doing so.

16.54 Most of the factors of which we have taken account in our consideration of the coroner's power to attach a rider are relevant also to a consideration of his practice in making comments or recommendations during the course of inquest proceedings. Comments by coroners are often well publicised, particularly when they are critical of action (or, sometimes, lack of action) by a named individual. Relative to the number of inquests held annually, animadversions are uncommon, but, because they may be extensively reported, they may harm reputations far more than the coroner ever intended. Comments on the morals, ethics or professional standards of those who have no opportunity to answer back made by someone who speaks from a position of privilege are reprehensible and we should like to see them discontinued.

16.55 At present, a coroner is prohibited from expressing any opinion on matters other than those which it is the business of an inquest to determine.[1] We do not think that any further restriction is necessary to banish the mischief of the animadversion. We have no wish to " gag " the coroner. We do not want to prevent him, for example, from commending the conduct of an individual or an institution, provided that this can be done without prejudice

[1] Rule 27, Coroners Rules 1953.

to others. Nor do we think that coroners should be precluded from drawing the attention of the public to the existence of a danger which might be averted by the taking of sensible precautions. Such a public warning may often prove just as beneficial in its results as a publicly announced reference to an authority with power to take remedial action. Indeed, it may sometimes be the preferable course. Not every danger is capable of being removed or mitigated by action which it is within the power of an expert body or public authority to take.

MISCELLANEOUS PROCEDURAL MATTERS AND REFORMS

16.56 We turn now to a review of various aspects of the proceedings of an inquest which have an important bearing on the character of this form of enquiry and on the protection of the persons who have an interest in it.

(i) *The right to participate in inquest proceedings*

16.57 Rule 16(1) of the Coroners Rules 1953 provides that any person who, in the opinion of the coroner, is a properly interested person, shall be entitled to examine any witness either in person or by counsel or solicitor. This rule has often been interpreted wrongly as meaning that no-one has a right to examine witnesses at an inquest unless the coroner so decides; and, in consequence it has been the subject of unjustified criticism. What the rule means is that, once the coroner has established that a person is a properly interested person, that person has an absolute right to put relevant questions to witnesses. It is true, however that difficulties may arise from the fact that it is not until an inquest has begun that a party or his legal representative can know for certain whether a coroner will permit him to ask questions. We think that there would be some advantage in removing some of this uncertainty by defining the more obvious categories of properly interested persons so as to give them an automatic right to be present and to ask relevant questions. Accordingly, we recommend that the following categories of persons should be given an absolute right to be present 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;

(*f*) any person appointed by a government department to attend the inquest.

In addition we recommend that the coroner should retain a discretionary right to allow any other person to appear. 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.[1]

16.58 Under the present law a chief officer of police (unless he is present only in a personal capacity) has the right to examine a witness only through counsel or solicitor. We appreciate that there may be occasions on which it is desirable that a police officer who may take an active part in subsequent proceedings in another court should not appear personally before a coroner, but equally there are other occasions on which no possible harm could follow from questions by a police officer. Other interested parties (e.g. insurance companies or representatives of Trades Unions) need not be represented and we recommend that coroners should have a discretionary power to waive the requirement that the police should appear only by legal representative.

(ii) *Legal aid*

16.59 There is power in the Legal Aid and Advice Act 1949 for the Lord Chancellor to make a statutory instrument which would enable legal aid provisions to apply to proceedings in coroners' courts, but this power has not yet been exercised. We understand from the Lord Chancellor's Office that there has been little or no demand for legal aid to be made available at inquests and we must record that our own witnesses were almost all silent on this question. Since there are, strictly speaking, no parties at an inquest there is *prima facie* less reason for the persons involved to require legal assistance than is the case in either civil or criminal proceedings. Nevertheless we cannot profess ourselves wholly satisfied with a situation in which a person's ability to be represented at an inquest which may be of very great personal importance to him may depend entirely on whether or not he has the means to pay for such representation.

16.60 The general arguments which led to the introduction of legal aid in relation to other forms of legal proceedings apply also to that minority of coroners' inquests in which legal representation is desirable. They are well known and they need no elaboration here. Legal aid offers important assistance to those who are unable, financially, to appoint solicitors or counsel to represent them when the circumstances in which they are placed make such representation essential. Such circumstances arise only rarely in coroners' courts even under present law—and our own proposed changes in coroners' procedure should be able to make them still less likely—but we consider that legal aid should be able to meet them when they do occur. Accordingly we recommend that existing legal aid provisions should be extended so as to cover the representation of properly interested persons (as defined in paragraph 16.57 above) at an inquest. Such persons should be told when they are notified of the inquest arrangements (see paragraph 15.04 above) that legal aid may be available.

16.61 We do not consider ourselves competent to consider the technical details of the arrangements for making legal aid available, but, bearing in mind the strong desirability that inquest proceedings should be concluded as soon as possible after death we hope that whatever arrangement is devised

[1] See Factories Act 1861, s. 83 (2) (*b*) and Rule 16 of Coroners Rules 1953.

will impose a minimum of delay. One possibility might be to allow the Secretary of the Local Legal Aid Committee (to whom residents of England and Wales normally apply for the grant of legal aid in civil proceedings) to issue an emergency legal aid certificate pending proper consideration of an applicant's means. Another might be to allow the coroner himself to grant legal aid on application rather as a clerk to a magistrates' court can do in criminal cases.

(iii) *Written evidence*

16.62 At present, documentary evidence as to how the deceased person came by his death is not admissible at an inquest unless the coroner is satisfied that there is good and sufficient reason why the maker of the document should not attend the inquest. If such documentary evidence is admitted, the inquest must be adjourned to enable the maker of the document to give oral evidence if either the coroner or any properly interested person so desires.[1] Although, therefore, the existing law makes it possible for a coroner to accept documentary evidence, the bias is against this and we are informed that in practice documentary evidence is only rarely admitted at inquests.

16.63 It is understandable that hitherto the law has placed a certain emphasis on the value of oral evidence: the inquest is, and is intended to be, a public enquiry to serve the public interest. We are satisfied, however, that, provided the " public " features of the inquest are preserved, there is nothing to be lost and much to be gained by allowing the coroner greater discretion to accept written evidence. It often happens that the evidence of a particular witness, although essential to the coroner's enquiries, is uncontroversial, appears unlikely to be disputed and is not, in the event, questioned. If the attendance of every such witness has to be arranged in every case the whole process of convening and conducting the enquiry is unnecessarily made more complicated, burdensome and productive of delay. Accordingly, we recommend that, subject to the same right of objection for properly interested persons as exists under the present law,[1] coroners should in future have a general discretion to accept documentary evidence from any witness at an inquest.

16.64 We appreciate that this recommendation opens up the possibility that the coroner may be able to hold an inquest at which all the evidence is given in writing. We believe that subject to safeguards (which we specify in pragraphs 16.66 and 67 below) coroners should indeed have discretion to hold a " short inquest " in this form. Such a procedure would have important advantages for the witnesses who would not have to attend court: they would be spared a possible ordeal; they would save time; and they would possibly save also the expenses of legal representation. There should also be some saving of time for coroners in the disposal of inquests and the community as a whole would gain from the procedure since there would be a saving to public funds.

16.65. It might be asked why, if a particular inquest can be turned into a " paper exercise ", it should be held at all: why complicate the law by allowing

[1] See Rule 28, Coroners Rules 1953.

for an all-documentary inquest? Why not encourage the coroner to dispose of the matter privately on the basis of the written evidence already obtained as a result of his preliminary enquiries? We have considered these questions with care, but we have concluded that it is neither realistic nor desirable to draw a hard and fast line between private and public enquiries in these terms. There are a number of inquests held today which are completely non-contentious but which serve a useful purpose by drawing attention to hazards or dangers which may be avoided by the taking of proper precautions. There are some inquests at which, although the facts themselves are not in dispute, some public reference to the evidence and findings of a coroner's court may be desirable. The total number of inquests which the individual coroner might think it appropriate to conduct on the basis of exclusively written evidence might be small, but we think that at this stage in the evolution of the coroners' service it would be advantageous and sensible to introduce this further measure of flexibility.

16.66 A prime virtue of the inquest procedure is that any person having a proper interest can come forward with fresh evidence or, with the leave of the coroner, can probe the evidence already given. It would obviously be important, therefore, to introduce safeguards against possible allegations that matters had been " hushed up " at an all-documentary inquest. Our proposals for this are as follows:

(*a*) a properly interested person[1] should have the right, and be given the opportunity, to object to the holding of an inquest based exclusively on documentary evidence;

(*b*) a coroner should be obliged to give at least 48 hours notice of his intention to hold such an inquest;

(*c*) 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 the coroners' court, and by written notice to the person to whom he proposes to issue a certificate allowing the disposal of the body;

(*d*) 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.

16.67 If an inquest based exclusively on documentary evidence is to preserve its character as a public enquiry serving the public interest, it is essential that the evidence on which the coroner bases his finding should be given in public. We recommend therefore that in any case in which a coroner has decided to hold an exclusively documentary inquest, he should be obliged to read out those statements or portions of statements which are directly relevant to his investigation before announcing his finding.

(iv) *Hearsay evidence*

16.68 Hearsay evidence is already admitted a great deal more frequently in a coroner's court than in other courts—a situation which reflects the different

[1] As defined in paragraph 16.57 above.

nature of his proceedings. The coroner is conducting an enquiry into the facts, not a trial. The value of his enquiry would be diminished if there were any attempt to restrict the evidence which he could hear to evidence that would be admitted in an accusatorial court. Provided, therefore, there is no objection from a properly interested person (see paragraph 16.57 above), we can see no harm in the present practice of admitting hearsay evidence at inquests.

(v) *Leading questions*

16.69 The Society of Labour Lawyers suggested that leading questions should, in general, be prohibited at inquests. The present practice, we understand, is less restrictive. A witness is usually taken through his proof by the coroner, who may well find that leading questions are the quickest way of disposing of non-controversial matters. The witness may then be examined successively by advocates who may be against or on the side of the witness concerned. In the former case, the witness's credibility may, on occasion, be challenged; in the latter case leading questions are likely to be suggested to the witness for his ready assent. The one is not easily separable from the other—and when pushed to extremes can certainly put undesirable pressure on witnesses. There is a risk—accentuated by the limited resources in many coroners' courts for recording the proceedings—that the resulting depositions may be misleading, particularly if they are later used in other proceedings. This problem would be made even more significant if, as we recommend in Chapter 19, provision is made in the law for new forms of appeal against a coroner's findings.

16.70 We have much sympathy with the aim behind the proposal of the Society of Labour Lawyers, but we do not think it would be helpful to impose a general restriction on leading questions as they suggested. The fact that its procedure can be informal is, in our view, one of the merits of an inquest. If however, informality is to be encouraged, it is important that the coroner himself should exercise strict supervision to see that it is not exploited for purposes other than the true purpose of the inquest and to the prejudice of any properly interested persons. It is, therefore, our firm conviction that, in general, coroners should allow advocates and other representatives to make only sparing use of leading questions and questions challenging a witness's credibility and then only when such questions will help to carry out the purpose of the inquest, namely to establish the cause and circumstances of the death.

TABLE K

Inquests adjourned under section 20 of the Coroners (Amendment) Act, 1926, which it has been decided not to resume—1969

Total number of inquests adjourned and results of criminal proceedings	Number of inquests adjourned because of a charge of:-			
	Murder	Manslaughter	Infanticide	Causing death by dangerous driving
1. Accused acquitted (and not found guilty of any lesser offence).	21	21	—	162
2. Accused found guilty of offence charged.	64	69	11	403
3. Accused found guilty of offence charged but insane.	3	2	—	14
4. Accused indicted for offence charged but found insane on arraignment.	7	—	—	—
5. Other results.	84	18	—	46
TOTAL	179	110	11	625

Committals from C… Courts 1961–1970
Source: Directo… Prosecutions

Year	Committals from Coroners' Courts (Cases)					Proceedings Before Magistrates			Results in Court of Trial					
									Inquisitions				Indictments	
	Man-slaughter (Motor) a	Man-slaughter (Other) b	Infanti-cide c	Murder d	Total Cases	Taken before Magis-trates	Commit-ted for Trial	Refu… to Com…	No Evidence Offered	Acquittals	Convictions	Other Result	Acquittals	Convictions
1961	10	2	—	—	12	12	10	2	12 {10a 2b	—	—	—	3	5a Causing death by dangerous driving. 1b Manslaughter. 1b Common Assault.
1962	6	1	—	—	7	7	5	2	5 All a	1b	—	1a Not Proceeded With	3	1a Causing death by dangerous driving. 1a Dangerous Driving.
1963	10	5	1	1	17	17	13	4	16 {10a 4b 1c 1d	—	1b*	—	5	3a Causing death by dangerous driving. 4b* Manslaughter.
1964	4	6	—	—	10	9	7	2	9—4a	—	—	1b Not Proceeded With	1	3a Causing death by dangerous driving. 1b s. 1 Children and Young Persons Act 1933. 1b Using instrument to procure abortion. 1b Assault.
1965	9	1	—	2	12	11	9	2	9 {7a 2d	3 {2a 1b	—	—	3	1a Dangerous Driving. 1d Murder. 1d Grievous Bodily Harm. 3a Causing death by dangerous driving.
1966	5	4	—	1	10	9	6	3	6 {4a 2b	3 {1a 1b 1d	—	1b Unfit to Plead	3	1a Causing death by dangerous driving. 1d Manslaughter. 1b Manslaughter.
1967	3	3	1	—	7	6	5	1	4 {1a 2b 1c	3 {2a 1b	—	—	—	2a Causing death by dangerous driving. 1a s. 1 Children and Young Persons Act 1933. 2b SI Children and Young Persons Act 1933.
1968	6	—	—	—	6	6	4	2	4 All a	2a	—	—	1	3a Causing death by dangerous driving.
1969	7	5	—	1	13	10	9	1	6 {4a 2b	4 {2a 2b	—	1a Nolle Prosequi 2 b & d Suicide	4	1 s. 6 R.T.A. 2 Causing death by dangerous driving. 2 Child and Young Persons Act 1933.
1970	9	2	—	—	11	11	10	1	7 {6a 1b	1a	—	1a Quashed 2 a & b remain on file	—	8 Causing death by dangerous driving. 1 Wounding. 1 Manslaughter by neglect.
Totals	69	29	2	5	105	98	78	20	78	17	1	9	24	54

* Plea of guilty to manslaughter on both inquisition and indictmen…

TABLE M

Number of Persons Committed for Trial by Magistrates' Courts 1961–1970

Source: Home Office Criminal Statistics for England and Wales, 1961–1970

Year	Murder	Manslaughter	Infanticide	Causing death by dangerous driving	Total
1961	144	44	13	428	629
1962	155	55	17	371	598
1963	149	55	13	393	610
1964	161	58	15	513	747
1965	189	64	15	590	858
1966	242	61	17	593	913
1967	227	82	17	633	959
1968	267	81	22	496	866
1969	279	78	14	561	932
1970	283	66	12	582	943
TOTALS:	2,096	644	155	5,160	8,055

TABLE N

Analysis of Inquests Held, 1969

1. Number of inquests held (excluding treasure trove)	
a. with juries	7,747
b. without juries	17,359
TOTAL	25,106
2. Number of inquests held on treasure trove	15
3. Inquests held by order of the High Court	1
4. Inquisitions quashed or amended by the High Court	1
5. Number of exhumations ordered by the coroner	1

CHAPTER 17

THE CORONER'S PROCEDURE IN RELATION TO PARTICULAR CATEGORIES OF DEATH

17.01 We have already dealt, in general terms, with the coroner's procedure when a death is reported to him and with the conduct of an inquest, should he be required or decide to hold one. In this chapter we look in more detail at the coroner's procedure in relation to particular deaths. The deaths which we single out for special mention in this chapter are necessarily selective. We do not presume to suggest to coroners how they should behave in every conceivable circumstance. But we are anxious to do justice to those of our witnesses who were concerned about the coroner's interest in particular categories of death and we also think that it will be useful to follow up some of the consequences of our earlier conclusions as they will apply in different situations.

Deaths from Industrial accidents and diseases

17.02 At present, a coroner is obliged to hold an inquest on any death which he has reason to believe may have been caused by an industrial accident. This is not a consequence of any specific provision in the law; it arises rather from his duty to hold an inquest on any " violent or unnatural " death. In accordance with our recommendation in paragraph 6.33 above, such a death will continue to be reported to the coroner, but, in future, in accordance with our recommendation in paragraph 14.10 above, a coroner will have a discretion whether or not to hold an inquest. None of our witnesses suggested that inquests on industrial accidents had been held unnecessarily in the past and we are not ourselves of this opinion. It seems to us that an inquest on the victim of an industrial accident may often be justified on the ground of " public interest " which we describe in paragraph 14.19. Other enquiries may be held (e.g. by Government Departments) under statutory powers or in connection with claims for industrial death benefit under the Industrial Injuries Acts; but an inquest may be the only form of public enquiry into the circumstances of a death. Indeed, we are aware that an inquest can have an important effect on the outcome of a claim to benefit under the industrial injuries scheme. In exercising his discretion whether or not to hold an inquest on the victim of an industrial accident the coroner should have these factors in mind. In particular he should take into account the known wishes of relatives and other interested persons (for example, representatives of employers or trade unions) and the views of any Government Inspector, if the death is one notice of which must be sent to a Government Department. In any event, it should be standard practice for him to ascertain whether or not any other enquiries are to be held into the accident and whether proceedings under the criminal or civil law are being contemplated. If the coroner decides to open an inquest, he may find it appropriate to adjourn it while these matters are being considered. Such a procedure need not cause any inconvenience to relatives through delay in registering the deaths if, in accordance with a

recommendation which we make in paragraph 15.38 above a coroner is given power to issue an interim certificate of the fact of death and the appropriate authorities are willing to accept the certificate as proof of death for the various purposes for which a certificate issued by a registrar of deaths is usually required.

17.03 The operation of the existing law ensures that any death which is known or suspected to have been caused by an industrial disease is reported to a coroner—either by a doctor or by a registrar of deaths. In accordance with the recommendation we made in Chapter 6 above, this will continue to be the situation. The coroner's position in relation to an industrial disease prescribed under the Industrial Injuries Acts is somewhat obscure. Although he is required to summon a jury[1] if he holds an inquest on such a death, his duty to hold an inquest arises (like his duty to hold an inquest on an industrial accident) from his general duty in relation to violent or unnatural deaths. In law, therefore, a coroner is required to consider in every case whether a death which seems likely to have been caused by a prescribed industrial disease is or is not "unnatural." In practice, coroners invariably have the results of a post-mortem examination to assist them in this consideration. Many coroners feel obliged to hold an inquest whenever there is reason to believe that a prescribed industrial disease may have contributed to a death. Others have been known to conclude their enquiries into such deaths after seeing the results of a post-mortem examination without proceeding to an inquest, even if the post-mortem examination confirms that death was due to an industrial disease. In other words, some coroners use the "Pink Form B" procedure. Whether the certificate sent to the registrar of deaths is a Pink Form or a certificate after inquest, the cause of death entered in the register is provided by the coroner and it is the copy of the entry in the register which is used by relatives as a "death certificate." The cause of death entered on this document can have more than ordinary significance for relatives because it may raise false hopes in connection with a claim for industrial death benefit under the Industrial Injuries Acts. It is not, however, the cause of death found by a coroner which decides the question of entitlement to benefit in these cases. The Industrial Injuries Acts provide an entirely separate procedure for deciding whether death was the result of an industrial accident, or prescribed industrial disease.

17.04 The industrial disease with which coroners are most often concerned is pneumoconiosis and several of our witnesses drew our attention particularly to the coroner's procedure for enquiry into deaths which it is suspected may have been caused by this disease.

17.05 Where under the Industrial Injuries Acts a death is accepted as having been caused by pneumoconiosis, industrial death benefit may be payable. Under the Acts, the question whether or not benefit is payable is determined by independent statutory authorities. In "death" cases, they take into account the evidence obtained by coroners and, in particular, the reports of post-mortem examinations carried out on their behalf. The statutory authorities

[1] Coroners (Amendment) Act 1926, s. 13 (2).

also have the benefit of an opinion by the members of pneumoconiosis medical panels, who make their own independent examination of the thoracic organs and whose duty it is to consider whether, for the purposes of the Industrial Injuries Acts, pneumoconiosis has caused or materially accelerated death. We were informed by the Department of Health and Social Security that the panel doctors have a wide experience of pneumoconiosis in all its forms and that they have the advantage of being able to correlate the findings of medical examinations they have made in life in connection with claims for disablement benefit, with the findings at death.

17.06 The existence of two separate enquiries causes no difficulty so long as there is no conflict in their conclusions. Unfortunately, this is not always the case. We were informed by the Department of Health and Social Security that there had been a significant minority of cases in which the statutory authorities (in the last resort, the National Insurance Commissioner) have decided that there were no grounds for a conclusion that pneumoconiosis had contributed to a death, even though the disease has appeared as a cause of death on the coroner's certificate. In all these cases, a dependant, usually a widow, had suffered a grievous disappointment. It is, however, only fair to point out that we were informed by coroners of cases in which appeals against the initial refusal of death benefit had succeeded on the statutory authorities' interpretation of all the evidence, including that provided by the coroner's pathologist. We have no wish to take sides in this matter; rather we have considered how these conflicts of opinion could best be avoided in future. As background to this consideration, it will be convenient for us to look first in a little more detail at the operation of the present arrangements.

17.07 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."[1] 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.[2] The Rules prevent a coroner from requesting or directing a member of the pneumoconiosis medical panel to carry out the post-mortem examination.[3] The procedure laid down in the Rules has been supplemented by advice[4] from the Home Office, in which coroners are asked to supply the medical panel with the thoracic organs and any other relevant pathological material in good condition.

17.08 It was made clear to us that, in the absence of the report of a post-mortem examination carried out for a coroner and the pathological material which is usually made available to the panel after this examination has been made, the task of the statutory authorities in determining claims to industrial death benefit would be much more difficult. We recommend therefore, that

[1] Rule 3 (*a*).
[2] Rule 4.
[3] Rule 3 (*d*).
[4] Home Office Circular 40/56 and 79/69.

coroners should continue to arrange for post-mortem examinations to be made whenever a suspected pneumoconiosis death is referred to them, 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 sent to the pneumoconiosis panels. We were informed by the Department of Health and Social Security that the assessment of non-perfused lungs cut before fixation is extremely difficult and we understand the association representing clinical pathologists has strongly recommended that the lungs in pneumoconiosis cases should always be perfused with formalin via the trachea. We endorse this recommendation.

17.09 We have referred (in paragraph 17.06 above) to the disadvantages that follow from different conclusions by the coroner and the pneumoconiosis medical panel about the significance of the presence of pneumoconiosis in a deceased person.[1] We are convinced that the possibility of such disagreements would be substantially reduced if there could be a better liaison than evidently exists in some areas between the two forms of inquiry. Liaison must be a two-way affair. It is not enough that a pathologist acting for a coroner should supply information and material to the pneumoconiosis medical panel. Panel members should also be ready to supply pathologists with the results of their examinations. We think that there might also be advantages to both parties if, in a given area, there was one centre at which thoracic organs could be examined both by panel members and by the pathologist acting for the coroner; although the two parties would make their own examinations, they would, in appropriate cases, meet and discuss any difference in their findings. Disagreements might also be avoided if coroners would invariably postpone their own conclusions on the cause of death until the advice of pneumoconiosis medical panels was available to them. This is already the practice in some areas and we understand that it now has the support of the Council of the Coroners Society of England and Wales. While we appreciate the necessity for the pneumoconiosis medical panels to make thorough enquiries, we trust that they will pursue these urgently and make their opinons available to coroners as soon as possible. Conversely we hope that coroners will arrange for copies of post-mortem reports to be sent to the appropriate panel as soon as they are available.

17.10 In accordance with our recommendation in Chapter 14 above, there will no longer be any question of its being mandatory for the coroner to hold an inquest on every death which is known or suspected to be caused by pneumoconiosis. In future, he will have a discretion whether or not to do so. We suggest that, in exercising that discretion, coroners should have regard to the factors which we have already mentioned in paragraph 17.02 above. If a coroner does decide to hold an inquest, he will probably wish to adjourn his

[1]It was suggested to us by the Department of Health and Social Security that this sometimes happens because of the presence on the standard form of a post-mortem report of a section under the heading (II) in which the pathologist is asked to record the presence of " other significant conditions, contributing to the death, but not related to the disease or condition causing it." The Department suggested that because pathologists are accustomed to list as many pathological conditions as possible, the present wording of the form encourages a tendency to record under this heading conditions which did *not* materially contribute to the death. Our own proposals for a new certificate of the fact and cause of death which, *mutatis mutandis*, should be applied also to the form of the post-mortem examination report should do away with this difficulty (see Chapter 7 above).

proceedings until he has the findings of the pneumoconiosis medical panel, but, even if he decides that an inquest is unnecessary, we hope that he would delay the issue of his certificate until the panel's findings are known. In suitable cases, at the request of relatives or executors of the deceased, he should be prepared to issue an interim certificate of the fact of death (see paragraph 15.38 above).

Deaths associated with surgery and anaesthesia

17.11 We have recommended in Chapter 6 above that a doctor called upon to certify the fact and cause of death should not give such a certificate if he has reason to believe that the death " occurred during an operation or under or prior to complete recovery from an anaesthetic, or arose out of any incident during an anaesthetic." The operation of such a rule should ensure that coroners receive reports of a number of deaths in which the " public interest " is only slight, and several in which the medical cause of death is not in doubt. A major surgical operation carried out for therapeutic purposes just before death may be as successful in revealing the exact cause of death as a post-mortem examination carried out afterwards. We express the hope, therefore, that coroners will consider the circumstances of these deaths most carefully before deciding whether to arrange for an autopsy to be performed or deciding to open an inquest.

17.12 Our expert witnesses (i.e. those representing surgeons and anaesthetists) recognised the need for the coroner to have the fullest possible information to assist him in the investigation of these deaths. Indeed, the Association of Anaesthetists of Great Britain and Ireland suggested to us that coroners might find it helpful to receive a standard form of report to assist their investigation of " deaths associated with therapeutic or diagnostic procedures." This term was used by the Association in place of the more usual reference to deaths associated with surgery or anaesthesia. The Association suggested to us that this report should be completed both by the surgeon and by the anaesthetist concerned with the particular operation. We agree that this might be a useful procedure and we append a copy of the Association's draft form as an Annex to this chapter.

17.13 There are very few of these unexpected deaths associated with therapeutic or diagnostic procedures, but they are amongst the most important which will continue to be reported to coroners. They are important because successful research into their causes may prevent other deaths of a similar nature.

17.14 We were advised that the exact cause of an unexpected death on the operating table (e.g. the death of a young person undergoing a " routine " operation) is often difficult to detect during the course of a gross autopsy. It may be due, for example, to a disturbance of physiology or biochemistry and, in these circumstances, a comprehensive investigation by a number of experts may be necessary. Such an investigation can rarely be conducted quickly and it may not always be possible for a coroner to wait for the results of such an investigation before giving the certificate which relatives will require if the death is to be registered. If a coroner knows that a long and detailed investigation will be necessary, we suggest that he should be prepared

to issue his certificate (see Chapter 18) on the basis of the information available to him.

17.15 It is outside our terms of reference to recommend the setting up of an expert body to examine the small minority of deaths under anaesthesia which are " true " anaesthetic deaths (i.e. deaths which would not have taken place but for the administration of an anaesthetic), but we are aware that there is substantial evidence[1] that the existence of such a body examining reports made on a voluntary basis by the anaesthetist principally concerned with a fatal incident can actually reduce the number of preventable deaths. If and when such a body is established in this country, we hope that coroners and those who undertake pathology on their behalf will co-operate fully with its activities.

Cot deaths

17.16 The term " cot-death " is used to describe the circumstance in which a baby is found dead with no obvious explanation of the cause of death. Although the term is sometimes used as though it were a cause of death, it does not usually appear on medical certificates of the cause of death. It is not known with any certainty how many " cot-deaths " occur in England and Wales each year. We have seen estimates varying between 600 and 6,000. Our own guess is that the true figure (i.e. the number of deaths of young children for which no plausible cause can be found even after an expert post-mortem examination and extensive tests) is nearer the lower figure.

17.17 Before the last war, it was usual for these deaths to be reported to the coroner and for them to be certified by him as being due to some form of accidental suffocation—usually with some implication of negligence on the part of the parents. Modern paediatric knowledge has disproved the old theories of " over-lying " by the mother or suffocation by bedclothes and there is a general acceptance among doctors of the view that such a death is rarely due to any negligence or ill-treatment. It is clearly in the interests of medical science, and hence of children and their parents generally, that " cot deaths " should be investigated from the medical aspect as fully as possible. A report to a coroner provides an opportunity for this investigation to take place. The new obligation to report deaths to coroners, which we have recommended in Chapter 6 above, should ensure that, in future, doctors report all " cot deaths " to coroners. We must now consider the procedure which a coroner should follow when such a death is reported to him.

17.18 Our witnesses told us that the investigation of a cot-death often involves difficult problems of interpretation and that it may require knowledge and experience only possessed by pathologists who have specialised in paediatric work. It could best be carried out in a hospital with a special interest in paediatric pathology and with good facilities for microscopic work. One of our specialist witnesses told us that there were about 50 such pathologists holding posts in hospitals all over the country. Interest in paediatric pathology is growing and we believe that it should be possible, without too much inconvenience to the people involved, for these comparatively few autopsies on infants to be carried out in the best possible conditions.

[1] See, for example, the Medical Journal of Australia 1970 1:573 (March 21)—Report of Special Committee Investigating Deaths under Anaesthesia 1960–68.

17.19 In the investigation of a "cot death", a good clinical history is almost as important as a good post-mortem examination. Where the death is reported to the coroner by a doctor, his report should contain a good deal of the necessary information, since he will need personally to have considered the circumstances of the death in order to arrive at the decision whether or nor to report it to the coroner. If the report does not contain all the necessary information, or if the death was reported by someone other than a doctor, the coroner will need to make his own enquiry into the circumstances leading up to the death. We hesitate to offer guidance on how this enquiry should be carried out. We hope, however, that the peculiar poignancy of the "cot-death" situation will encourage the coroner to make imaginative use of all sources of information, which may sometimes include the social work department of a local authority. A coroner should consider with the greatest care whom he should ask to visit the home and attempt to obtain from the parents relevant information about the history of events leading to the death.

Deaths of " donors " in transplant operations

17.20 Tissue or organ transplant operations raise controversial issues, some of which have implications for the subject of our enquiries. One issue about which there has been public concern is whether the moment of time at which death occurs is always properly determined. That is essentially a question for clinical judgment—falling well outside our terms of reference—and we therefore express no opinion about the various tests for death which have been proposed from within the profession. In Part I of this report we were concerned with the circumstances in which a doctor may issue a certificate of the fact and cause of death, but we excluded from our discussion any consideration of the clinical procedure which a doctor should follow before giving such a certificate. Similarly, in our consideration of the role of the coroner in relation to a transplant operation we shall avoid expressing any view on the question of when death can be presumed to have occurred.

17.21 The law relating to the removal of organs and tissues from human bodies in Great Britain is contained in the Human Tissue Act 1961. When the Act was passed, the transplantation of vital organs, such as the kidney, had hardly begun; the tissues then being grafted, such as cornea, skin and bone, did not have to be removed immediately after death. Moreover, tissue could be obtained in a satisfactory condition from most dead bodies and there was no danger that delay in obtaining tissue in any particular case might impede the saving of life. It was therefore generally accepted at the time that the Act should make some provision for consultation with surviving relatives and, if the donor had died in circumstances which made the death one into which the coroner had a duty to enquire, with the coroner. The Act provides that " where a person has reason to believe than an inquest or post-mortem examination may be required by the coroner " authority for removal of tissue should not be given or acted upon " except with the consent of the coroner,"[1] and that, unless the deceased himself has authorised the removal of tissue from his body after death, " such reasonable enquiry as may be practicable " should be made to ascertain that neither the deceased nor his surviving spouse nor any other surviving relative would object.[2]

[1] Section 1 (5), Human Tissue Act 1961.
[2] Section 1 (2) Human Tissue Act 1961.

17.22 We understand that, since 1961, the transplantation of such tissue as cornea, skin and bone has proceeded without difficulty, but that since the transplantation of kidneys from dead bodies has become an established procedure and a start has been made on the transplantation of other vital organs, there have been suggestions that the need to obtain the consents required by the Human Tissue Act has given rise to unnecessary and unacceptable delays. Indeed, we have seen suggestions that the time involved in obtaining these consents has made it so difficult to obtain the organs that patients whose lives could have been saved by transplant have died for the lack of the necessary organ. The bodies of persons who have been killed in road accidents, or who have otherwise died suddenly while still in good general health, can provide vital organs in the condition most suitable for transplantation. But the number of persons who die in this way (and so the number of potential donors) is relatively small and the fact that the identity of an accident victim is not always immediately apparent can make it difficult to trace relatives. Further limitations on the use of vital organs flow from the fact that the tissues of donor and recipient need to be closely matched if transplantation of any vital organ is to have the best chance of success, and from the fact that the vital organ must be removed from the donor within a very short time after death—the time varies with the organ concerned.

17.23 But alongside the publicly expressed desire of surgeons and others with a close interest in the development of transplant surgery for an easement of the "consent" conditions of the Act of 1961, there have been equally sincere calls for the establishment of proper safeguards for potential donors.

17.24 Following a period of intense public discussion of the problems and implications of operations to transplant vital organs, the government of the day appointed an Advisory Group on Transplantation Problems in January 1969. The Group was asked to advise on problems arising in the field of transplantation which were of public concern and in particular to advise urgently on any amendment of the Human Tissue Act 1961 which might seem to be desirable.

17.25 The Group's report was published in July 1969 (Cmnd. 4016). It unanimously recommended a number of safeguards in the interests of possible donors. The principal safeguard recommended by the Group was concerned with the determination of death. They emphasised their belief that this was a clinical matter and pointed out that the doctor clinically responsible for the care of a potential donor would not be the same doctor as the one clinically responsible for a prospective recipient. They recommended that before organs are removed two doctors should certify in writing that life is extinct. At least one of the two doctors should have been registered for five years and each should be independent of the transplant team and should take his decision without regard to the possibility of a transplant. The Group went on to recommend that where resuscitation is being maintained by artificial means, the decision to continue or discontinue such support should be reached without regard to the possibility of a transplant, that the two doctors should record their findings independently and that these records together with those of subsequent action should be available to the coroner or procurator fiscal.

17.26 The published Advice from the Group said very little about the role of the coroner in relation to a transplant operation. At paragraph 3 (*g*) they remarked as follows:

> "Co-operation of coroners and procurators fiscal is essential. It should be made clear that coroners can rely, in appropriate cases, upon authoritative pathological reports from hospitals. This point is commended to the attention of the Brodrick Committee and of the Crown Agent in Scotland."

We are not sure whether this remark was intended to be a statement or a recommendation. We are not clear, for example, in what context "the co-operation of coroners is essential." We presume that in referring to "authoritative pathological reports" they had in mind pathological reports on the state of the deceased person's organs on removal. We agree that this would be very relevant to the coroner's enquiry into the cause of death of the donor of a vital organ. At paragraph 5 (*a*) the Group also recommended that the written record of the findings of the two doctors, who they had previously recommended should be required to decide that life was extinct, should be made available to the coroner. This last recommendation is important since much of the controversy that surrounded Britain's third heart transplant operation centred on the fact that the coroner who held the inquest on the donor did not take any evidence about the circumstances in which it was decided that death had occurred and that the heart might be removed.

17.27 Under the existing law, a coroner may be concerned with the circumstances of a transplant operation at two distinct points in time. First, as we have noted, if the body of a donor is one on which there is reason to believe an inquest may be held or on which a post-mortem examination may be required by a coroner, the coroner's consent is necessary before an organ can be removed.[1] Second, after the death has been reported to him it becomes the coroner's duty to establish the cause of death. We shall consider his role on each occasion separately.

The coroner's consent to the removal of an organ

17.28 Because time (i.e. the interval between the death of a donor and the moment when the organ is transplanted into another person) is often of crucial importance to the success of a transplant operation, there have been suggestions that the law should be amended so as to give a coroner an explicit right to give consent to the removal of an organ before it has been decided that the donor is dead. The Human Tissue Act does not specify when a coroner's consent should be obtained, but he can have no legal right to give that consent until a potential donor has in fact died. Since the coroner has no jurisdiction over a live body, the most that he could do in the period before death is to state an intention to give consent when it has been decided that the donor is dead. We do not believe that he should be allowed or required to do any more than state this intention. Quite apart from the legal difficulties, we think it would be quite wrong to put the coroner in a position in which it could be suggested that his consent amounted to permission to switch off a machine which was keeping a potential donor alive. We agree with the several eminent

[1] Section 1 (5), Human Tissue Act 1961.

members of the medical profession who have stated that the decision to switch off such a machine is a clinical decision that can be taken only by those charged with the medical care of the patient.

17.29 Nevertheless, we see a great deal of value in what we understand to be the present practice of consultation between doctors and the coroner at an early stage in the consideration of a potential transplant operation. The prime advantage of early notification is that it enables a coroner to make what enquiries he thinks necessary before death takes place so that he will be the better able to express an opinion when he has jurisdiction to do so.

17.30 The present requirement that a coroner should be consulted and should consent to a transplant operation before it can legally be carried out, bears the implication that the coroner has a right to refuse his consent. His discretion to give or refuse his consent appears to be absolute, although, in our view, a coroner should never object in principle to transplant operations. It is not his function to place obstacles in the way of the development of medical science or to take moral or ethical decisions. He should refuse his consent only if he is aware that there may be later criminal proceedings in which the organ may be required as evidence or if he believes that the removal of the organ might impede his own further enquires.

17.31 At the present time the demand for vital organs for transplantation is mostly for kidneys as kidney transplantation is the most successful of the major organ transplants. Defects in the kidneys are not in practice the cause of accidents so that coroners can give permission for their transplantation relatively freely. The position with regard to the heart, however, is different. Sudden and sometimes brief failure of its pumping action is a well recognised cause of accidents particularly on the road. Therefore, before giving permission for the use of the heart from the victim of an accident, the coroner should ascertain that the deceased has been the passive victim of violence—as for instance in the case of a motorist struck by a car crossing over the central reservation, in contrast to the case of the driver of a car which has suddenly and mysteriously deviated from its normal course. Such a precaution is also an aid to the surgeon proposing to transplant the heart as it provides a measure of protection against unwittingly transplanting a defective organ. The demonstration of a significant defect requires such a detailed, and to the organ itself destructive, examination that it would be rendered useless for transplant purposes. It is essential that, before taking his decision, the coroner should seek advice from the police and from expert medical opinion. In order to be useful for transplant purposes, it is necessary that the required organ is healthy; therefore, the possibility that it has contributed to the death of the donor is never anticipated. Nevertheless, it will occasionally happen that the organ is found to be unsuitable. In such cases it should be the duty of the surgeon to make it available to the coroner along with a report of his grounds for regarding it as unsuitable.

The coroner's enquiries into the death of a donor

17.32 Because of the circumstances leading up to the death, coroners already find themselves with a duty to enquire into the death of many donors

in a transplant operation involving a vital organ. We envisage that this will continue to be the case when effect is given to our recommendation in Chapter 6 that a new obligation to report deaths to coroners should be placed on doctors called upon to certify the fact and cause of death. What should be the coroner's procedure when he is called upon to investigate such a death?

17.33 In Chapter 14 we recommended that a coroner should have discretion whether or not to proceed to an inquest on almost every death reported to him. We suggested that he should be guided in reaching his decision whether or not to hold an inquest by reference to some principles of " public interest " which we set out in that chapter. When a coroner comes to take this decision in the context of the death of the donor of a vital organ, he will often have to evaluate difficult and delicate factors. On the one hand he will be aware of the public interest in the development of transplant surgery and of the argument that the public has a right to know what is done in its name. On the other hand, he may have to pay due regard to the wishes for privacy of the relatives of both the donor and the person receiving the organ. We considered whether we should recommend that, for the foreseeable future, a coroner should always hold an inquest on the death of the donor of a vital organ, but we concluded that it would be more consistent with the general line we have taken in this report to leave the coroner with a completely unfettered discretion to take his decision in the light of all the circumstances known to him.

17.34 However, if a coroner does decide to hold an inquest on such a death we believe that he should always make the fullest possible enquiry. In particular, we suggest that he should always take evidence[1] from the doctor or doctors who took the clinical decision that the donor was no longer alive. Medical evidence of the cause of death should not be restricted, as on occasion it has been restricted in the past, to evidence from the pathologist who has conducted a post-mortem examination and who may be able to describe the injuries resulting from an accident but who can say nothing about the vital organ used in the transplant operation other than that it has been surgically removed. We hope that the evidence taken from doctors responsible for the decision that death has occurred will always be taken in such a way as to demonstrate publicly that they are entirely independent of the doctors involved in the transplant operation, that they had no personal interest in its success or failure and that the best available treatment had been given to the donor before the decision was taken that life had ceased. Such a demonstration seems to us essential if public confidence in transplant operations is to be maintained.

Deaths of members of certain religious groups

17.35 A category of death which is invariably reported to a coroner under the existing arrangements and which will continue to be so reported under the new system which we have proposed in Part I of this Report, is the death of someone who has not been attended before death by a doctor. If such a death is not reported by a doctor called in to establish the fact of death,

[1] In accordance with our recommendations about the use of documentary evidence at inquests (see paragraph 16.63 above), this evidence could be given in writing. We would expect a coroner to adopt this procedure, provided that he has no reason to suppose that a properly interested person would object to this.

it will certainly be reported by a registrar as an "uncertified" death. We recognise that there are some persons to whom the perpetuation of this situation may be particularly unwelcome. We refer to those whose religious beliefs prevent them from receiving orthodox treatment from medical practitioners and whose deaths will, therefore, be reported to coroners as a matter of course. Perhaps the best known of those who take this attitude to the ministrations of the medical profession are Christian Scientists, from whom we received both written and oral evidence.

17.36 In a Memorandum prepared for our benefit, the First Church of Christ, Scientist, explained that its members

> "seek to maintain their health entirely through the practice of their faith, rather than by having recourse to the more usually accepted remedies of the medical profession."

17.37 In their evidence, Christian Scientists told us that they accept that a report to a coroner is an inevitable consequence of the faithful practice of his religious beliefs by one of their members, but they were critical of some of the consequences of a report under existing arrangements. They were particularly concerned about the involvement of the police. As we point out in Chapter 21 below, the coroner's officer (the person with whom the relatives of a deceased person are most concerned after a death has been reported to a coroner) is almost invariably a police officer. In those areas where there is no regular coroner's officer, the duties are performed *ad hoc* by a number of different police officers, who quite frequently exercise their duties in uniform. The Church complained that the police officers acting as agents of the coroner were often unaware of the aims and beliefs of Christian Scientists and in consequence adopted a suspicious attitude to the circumstances of the death, and claimed that, as a result, "unpleasant incidents and misunderstandings not infrequently occur." We believe that that part of the Church's concern with the existing arrangements which stems from the involvement of police officers on the coroner's investigation should largely disappear in the future if our proposals for a different kind of supporting service for coroners are accepted—see Chapter 21 below. In the short term, we hope that coroners will be prepared to recognise the feelings of Christian Scientists, and others who have also expressed their concern about the coroner's use of uniformed officers, by taking steps to ensure that police officers who act as coroners' officers as far as possible act in civilian clothes.

17.38 The aspect of coroners' procedure which most troubles the Christian Scientists is the post-mortem examination. Our witnesses told us that it is already the invariable practice of coroners to order a post-mortem examination to be held on the bodies of faithful members, and they questioned the necessity for this examination. They pointed out that, in Scotland, the procurator fiscal was usually satisfied with an external examination of the body by a doctor, who would afterwards certify that death had resulted from natural causes. We have already pointed out in Part II above that there is, even under the existing law, an essential difference between English and Scottish procedures. In Scotland the ascertainment of an accurate medical cause of death is subsidiary to the investigation of possible criminality or negligence; and

procurators fiscal are not usually concerned to establish the precise cause of death in a medical sense once the possibility of criminal proceedings has been ruled out. It will be clear from all that we have said in Part I of our Report that we consider that ascertainment of an accurate medical cause of death in every case should be a prime aim of the new arrangements for certification which we there propose. It follows that we cannot endorse the suggestion by the Christian Scientists that an arrangement like the one operating in Scotland should be introduced into this country. We sympathise with the feelings of Christian Scientists, as we do with others who object to post-mortem examinations on religious grounds, but we do not think that coroners should be encouraged to make a particular exemption from general practice solely to take account of such feelings. It must be for the coroner to decide, in all the circumstances of the case, whether a post-mortem examination is necessary.

17.39 The Christian Science Church also drew our attention to what it admitted is now the practice of only a few coroners, namely, the making of unwarranted critical remarks about the practices of Christian Scientists. We agree with our witnesses that it is no part of a coroner's duty to express at an inquest what can only be a personal opinion about the beliefs of Christian Scientists (or indeed other religious organisations) and we hope that the practice of making such remarks will totally cease. It will be noted that we have already expressed an opinion in this sense in Chapter 16 above (see paragraph 16.54).

ANNEX TO CHAPTER 17

DRAFT OF A SUGGESTED STANDARD FORM OF REPORT TO THE CORONER OF A DEATH ASSOCIATED WITH A THERAPEUTIC OR DIAGNOSTIC PROCEDURE

(Suggested by the Association of Anaesthetists of Great Britain and Ireland)

This form is to assist the coroner in arriving at the cause of death and in deciding whether an inquest should be held. It should be completed by the surgeon and anaesthetist concerned, but they are requested to seek the assistance of others in making the form as complete as possible, especially with respect to the timing of events. Any reply to question 17 is a matter of discretion and is not in itself the certified cause of death.

(1) *Name of patient:*.....(2) *age*.....(3) *sex* .....

(4) *Home address:* .....

.....

(5) *Hospital:* .....(6) *Hospital No.:* .....

(7) Case history and preoperative clinical findings (including physical status, general condition, concomitant pathological conditions, diagnosis and other relevant details).

(8) *Preoperative treatment:* (including amount and type of i.v. fluids, drugs and premedication).

(9) *Anaesthetic:* (including drugs, dosage, i.v. fluids given, apparatus used, technical difficulties and other relevant details).

(10) *Operation proposed:* (11) *elective or emergency*

....

(12) Operation performed (including estimated blood loss, technical difficulties and other relevant details).

(13) *Date and time of admission to hospital:* .....

(14) *Date and approximate time of:*

giving pre-medication ..... first untoward sign .....

starting induction ..... respiratory failure (where relevant).....

starting operation ..... circulatory failure .....

ending operation ..... death or abandonment of resuscitative efforts .....

(15) *Date and place of death* (anaesthetic room, ward, other).

(16) *Untoward events and resuscitative measures used:*

.....

(17) *Opinion as to cause of death:* (optional—see introduction) and any other general observations.

(18) *Name* (in block letters), status and signature of operator:

(19) *Name* (in block letters), status and signature of anaesthetist.

(20) *Date:*

[Space for instructions (in small print) as to circumstances in which this form should be completed].

CHAPTER 18

THE CORONER'S CERTIFICATES AND RECORDS

A. CERTIFICATES

18.01 As we have noted, a coroner, at present, adopts one of three procedures when a death is reported to him. He may conclude his enquiries into a death (*a*) without holding a post-mortem examination or an inquest (the Pink Form A procedure) or (*b*) after post-mortem examination but without proceeding to an inquest (the Pink Form B procedure) or (*c*) after an inquest with or without a post-mortem examination. In every case he completes a form or certificate which he sends to the registrar.

18.02 Under our proposals for changes in the coroner's procedure when a death is reported to him (see Chapter 14), a coroner will be able to certify the cause of death

(*a*) on the basis of the information provided for him by a doctor who has knowledge of the deceased person's last illness (not necessarily a doctor who attended during that illness) or

(*b*) after he has seen the results of a post-mortem examination and is satisfied that no further enquiries are necessary; or

(*c*) after he has held an inquest with or without a post-mortem examination.

We think that consequential changes may be necessary in the form of the documents which the coroner sends to the registrar.

18.03 Our recommendation in paragraph 13.06 above to the effect that a coroner should be responsible for certifying the medical cause of *every* death which is reported to him will remove the main difference between the "Pink Form A" and "Pink Form B" procedures. On those occasions when a coroner decides that an autopsy is not necessary to determine the cause of death (at present, the "Pink Form A" cases) the responsibility for certifying the medical cause of death will in future rest with him and not with the doctor who has given or is willing to give a medical certificate. It follows, therefore, that the certificate sent by the coroner to the registrar will always contain a cause of death to be used for registration purposes.

18.04 Our recommendation in Chapter 14 that the coroner should have greater flexibility in his choice of proceedings when a death is reported to him and that, in particular, he should have more discretion than he has now to decide whether or not to proceed to an inquest, will also have implications for the certificate which the coroner sends to the registrar. It is to be expected that in the exercise of this discretion some coroners will decide not to hold inquests on deaths which, under the present law, must be investigated in this

way, e.g. simple accidents or suicides. Since the Registrar General will still need to know for statistical purposes whether a particular death was, for example, an accident or suicide, it will still be necessary for the documents sent by the coroner to the registrar to be in a form which will allow this distinction to be made whether or not an inquest has been held.

18.05 The Registrar General, who is responsible for the statistical analysis of the cause of deaths occurring in England and Wales, must be able to distinguish between homicides, suicides and deaths due to accidents or misadventure. He is obliged to classify all "violent" deaths in order to conform with international rules which require both the "nature" and the "external cause" of death to be given. For example, in the case of a death due to a fractured skull, he must record not only the "nature" of the death (i.e. fractured skull) but also how the fracture was caused. In the case of a motor vehicle accident he needs to know how the circumstances of the accident, the type of vehicle or vehicles involved, and whether the deceased was a driver, passenger or pedestrian. If the death followed an accidental fall, he would need to know whether the fall was on stairs, off a ladder or from a window etc. In a case of poisoning, the information is required to indicate the nature of the poisonous substance and to show whether the poisoning was accidental, suicidal or homicidal.

18.06 Whatever the nature of the coroner's enquiry, he must send a minimum of information to the registrar and it seems to us a logical consequence of this new flexibility in a coroner's procedure that he should in future, use only one form of certificate. This form should be comprehensive in character, but the extent to which it would be necessary for a coroner to complete it in any particular case would depend upon the nature of the death and the extent of the coroner's enquiries into it. We append, at the end of this chapter, a possible format for such a new certificate. (See Figure 7.)

The Coroner's new certificates of the fact and cause of death

18.07 The certificate must always contain sufficient information to enable the registrar to identify the deceased and to record the medical cause of death. For the first purpose, we suggest that the present layout of the coroner's certificate after inquest, with the addition of a space for the inclusion of the deceased person's N.H.S. number[1] will serve perfectly well. For the second purpose, the coroner's certificate should be similar in form to our proposed new medical certificate of the fact and cause of death (see Chapter 7). Unless the death is a violent or unnatural one, we do not envisage a coroner will find it necessary to complete more than Parts I, II and III of our proposed new certificate.

18.08 In the case of a violent or unnatural death, the registrar must be supplied with some additional information in order that the Registrar General can classify the death for statistical purposes. We recommend that the coroner should provide this information on Part IV of our proposed new certificate and that the information should include, in appropriate cases,

[1] See paragraph 7.08 above.

a finding that death was the result of homicide. We have recommended (see paragraph 14.11 above) that the coroner should be obliged to open an inquest whenever a homicide or suspected homicide is reported to him and there will be several circumstances in which he will be compelled to record finding of homicide. He will do so, for example, when someone has been charged with the murder of the deceased, in which case his own proceedings will be purely formal. He will also record a finding of homicide when the police are satisfied that murder has been committed and that the person responsible is himself dead. This is the situation in respect of about one-third of all murders committed in England and Wales. In all cases, the coroner should be required in future, to record the medical cause of death and the basic circumstances of the homicide on the certificate which he sends to the registrar; but he should not name any person or persons as being responsible for the death. If he knows that proceedings are being taken against a person for causing the death, he should also be required to inform the registrar of this fact. We have already recommended (in Chapter 16) that the coroner should inform the registrar of the outcome of the criminal proceedings so that, if necessary, the homicide classification of the death may be changed.

18.09 As we indicated in Chapter 16 above, the most difficult situation from the coroner's point of view will be one in which the circumstances of the death suggest strongly, or even conclusively, that homicide has been committed, but there is, at the time when he opens the inquest, insufficient evidence available to bring charges against any person. We have suggested that, in such circumstances, a coroner should conclude his proceedings and refer his papers to the Director of Public Prosecutions, at the point where he is satisfied that continuing with his enquiries might incriminate or prejudice the position of some person who might eventually be charged with causing the death. We think that the certificate which the coroner sends to the registrar at this point should make it clear that a report has been made to the Director; we have therefore included this item in Part IV. The coroner should inform the registrar in due course of the outcome of the Director's consideration and the result of any proceedings in the criminal courts.

18.10 Part V of our new certificate is in the same form and serves the same purpose as Part IV of the present certificate after inquest. It should be completed in the case of all accidental deaths.

18.11 We have included a new Part VI in our certificate as a direct consequence of our decision to restrict Part II of the certificate to the medical cause of death. Part VI should always be completed in the case of accidental or suicidal deaths and the details recorded should include (i) the nature of the injury, (ii) the form of violence causing the injury and (iii) the means or instrument of violence. It might also be appropriate, on occasion, to record here other details of the circumstances of the death which might be of interest to those who have access to the Registrar General's statistics.

18.12 Part VII of our new certificate should be completed in every case in which an inquest is held. The information which it should contain is all required for the Registrar General's purposes and most of it already forms part of the certificate after inquest.

The Coroner's certificate of perinatal death

18.13 It will be remembered that in Chapter 8 we have already recommended that doctors should complete a new certificate of perinatal death in the case of still-births and deaths of children during the first seven days after birth. The same reasoning leads us to recommend that a coroner should complete a similar certificate when a perinatal death is reported to him. It would be convenient if the same certificate could be completed no matter what form the coroner's investigation takes. This certificate should state clearly whether the child was stillborn or died in the first seven days of life. We have not attempted to suggest the precise form which such a certificate might take, but it would be appropriate for the details to be recorded to be in line with those demanded by the new medical certificate of perinatal death (see Chapter 6 above). It should also include Parts IV, VI and VII of our own draft multi-purpose coroner's certificate.

What should happen to information sent by the coroner to the registrar?

18.14 Under the present procedure, when a registrar receives either a "Pink Form B" or a certificate after inquest he is obliged to copy all the coroner's "findings" into his register of deaths before sending the coroner's certificate to the Registrar General's office. Thus, in a "Pink Form B" case he copies the medical cause of death as stated on the pink form and in inquest cases he copies the whole of the findings of the inquest. It follows that all this information appears on the copy of the entry in the register which the registrar issues to relatives or others connected with the deceased and which serves as a "death certificate". We have been informed that relatives have sometimes been caused embarrassment because of the details on this certificate which may have to be produced to the several different authorities who are concerned with benefits payable on death. Embarrassment most often arises if the certificate clearly indicates that the deceased committed suicide.

18.15 This display of the complete inquest findings on a certificate which relatives may have to produce at various times is unnecessary for its main purpose, which is to serve as evidence of the fact of death. While it is essential for certain information to go to the Registrar General for statistical purposes, it is not necessary that it should all go into the register—and thus on the death certificate. We recommend that the Registrar General should prescribe by regulation the information which the registrar should be obliged to copy into his register. This information should include identifying information and the medical cause of death; but the details of the circumstances in which the death occurred need not be included. The Registrar General should continue to be supplied, as now, with all the details of the coroner's findings on receipt of the certificate sent by the coroner to the local registrar.

Coroner's interim certificate of the fact of death

18.16 In Chapter 15 we recommended that where an inquest has been adjourned and, as a result, a bereaved relative is likely to suffer delay in the receipt of pension or insurance benefits, the coroner should issue a certificate of the fact of death to the dependant in order to minimise the delay. A suggested form for such a certificate is appended to this chapter. (See Figure 8.)

B. RECORDS

18.17 A coroner must keep an indexed register of all deaths reported to him or to his deputy or assistant deputy. The register must contain particulars of the date on which the death was reported, the name, address, age and sex of the deceased, the cause of death and the procedure used for disposing of the case.[1] Some coroners, particularly those in the larger urban jurisdictions, supplement this record with individual files relating to particular deaths. These files contain, for example, medical reports from the deceased person's own doctor, post-mortem reports and records of telephone conversations relating to the particular death. We do not believe that it is necessary for the law to seek to regulate all the details of a coroner's administrative arrangements, but we commend the practice of keeping an easily accessible record of the details of a coroner's action in relation to particular deaths.

18.18 We do, however, see rather more advantage in coroners keeping a formal record of their conclusions in a standard form. At present, a standard form of record is used only in inquest cases when a coroner completes a document known as an "inquisition"—the form of which is prescribed in the Coroners Rules 1953. Briefly, the coroner is required to record the time and date of the inquest proceedings, the particulars of the deceased required by the Registration Acts to be registered (where and when died; name and surname; sex; age; and occupation) and the findings as to

(*a*) the injury or disease that caused the death;

(*b*) the circumstances in which the injury was sustained, or, in the case of death from disease, the morbid conditions, if any, giving rise to the immediate cause of death, and

(*c*) the conclusions of the jury or the coroner.

The inquisition is signed by the coroner and, if the inquest was held before a jury, by the jurors. It will be noted that, to a very large extent, the inquisition contains the same information as the current certificate after inquest which we have recommended in paragraph 18.05 above should be replaced by a comprehensive document to be sent to the registrar on the completion of the coroner's inquiries into *every* death reported to him. There would in future, be no need for an inquisition to be completed. It would seem both appropriate and practical for the formal record of a coroner's conclusions to take the form of a duplicate of the comprehensive document to which we have already referred. We recommend that coroners should be required to make and retain a copy of this certificate as the formal record of their action in respect of every death reported to them.

18.19 The effect of Rule 38 of the 1953 Rules is to require a coroner to keep all documents relating to a death reported to him for a period of fifteen years, with a proviso that he may instead deliver a document to a person who seems to him to be a proper person to have possession of it. The Rule applies to such things as notes of evidence, reports of post-mortem examinations or other examinations and reports of preliminary enquiries.

[1] Coroners Rules 1953, Rule 2 and Second Schedule.

We received no evidence to suggest that this requirement is other than satisfactory and we have no proposals for its amendment. We are satisfied, too, with the general provisions[1] relating to the preservation of and access to coroner's documents as public records. As to preservation, the effect of these provisions is to require that coroners' indexed registers of deaths reported to them and papers relating to treasure trove, matters of historical interest or papers of earlier date than 1875 should be preserved permanently and that other papers should be destroyed after fifteen years. As regards access to coroners' records, the law allows suitable access at the discretion of the person having custody of them (e.g. a local authority archivist) and a coroner may give special written authority to any person to inspect records at any time. Subject to these exceptions, coroners' records are not available for public inspection until they have been in existence for 100 years. We understand that the reason for this lengthy interval is solely to prevent embarassment to living persons who may be mentioned in police reports, statements of witnesses or suicide notes.

The availability of documents held by coroners

18.20 The existing law dealing with the release of information from documents by a coroner is concerned only with those which are "put in evidence at an inquest", but the inquest need not be completed before the coroner supplies copies of documents connected with it. Under Rule 39 of the Coroners Rules 1953, a coroner must supply to any properly interested person who applies to him a copy of any depositions, any report of a post-mortem examination or special examination, notes of evidence or any document put in evidence at an inquest. He may charge a fee for doing so if one has been prescribed.[2] Alternatively, a coroner may allow a properly interested person to inspect any document without charge and the right to inspect a document carries with it the right to make a copy.[3] The coroner has discretion to decide who is a "properly interested person" (see paragraph 16.57 above). We understand that coroners exercise this discretion liberally. Copies of relevant statements are usually supplied without question to those who may need them for the purposes of subsequent civil proceedings. Moreover, we understand that, even if no inquest has been or is being held, coroners are often prepared to make post-mortem reports or other medical evidence available to relatives or medical practitioners. However, our proposals that there should be greater flexibility in the coroner's procedure when a death is reported to him (see Chapter 14 above) carries with it the implication that there may, in future, be many fewer inquests. It is necessary, therefore, that we should consider the principle which should govern the release of documentary information in this new situation.

18.21 The documentary information which a coroner will acquire in the course of an investigation into a death may take many forms. It will consist of medical reports (e.g. reports from a deceased person's own doctor, reports of post-mortem examinations or of special examinations or analyses), reports

[1] The Public Records Act 1958 and Orders made by the Lord Chancellor under that Act.
[2] For the current authority to charge fees, see the Coroners (Fees and Allowances) Rules 1969.
[3] *Nelson* v. *Anglo American Land Mortgage Agency (1897)* 1. Ch. 130.

from the police, or other agencies who may have an interest in a death, or who the coroner may have asked to enquire on his behalf, and statements from witnesses made either to the police or to his own civilian officer.[1] Similarly, the information held by the coroner may be required by different people for different purposes. Relatives may simply be anxious to discover more about why the death occurred in a medical sense; relatives and other persons may be concerned with legal questions arising from the death, including the possibility of civil or criminal proceedings. The multiplicity of documents and the variety of circumstances in which the documents may be required make it difficult to lay down hard-and-fast rules which can apply fairly in every situation. We think that it would be unwise to attempt to govern this procedure in legislation. Difficult questions of confidentiality and possible embarrassment to third parties may arise and, for this reason, we think the only sensible course is to leave a coroner with a wide discretion to make documents available as he thinks fit, within a general framework of guidance which we hope will be provided by the Home Office.

18.22 It was suggested by some of the doctors who gave evidence to us that a coroner should be obliged to make available, free of charge to the deceased person's own doctor a copy of the report of any post-mortem examination carried out on his behalf. We understand that copies of these reports are usually made available to doctors by coroners on request and that a fee is sometimes charged; but they are not provided as a matter of course. We consider that the deceased person's general practitioner has a moral right to know the findings of an autopsy on his former patient and accordingly, we recommend that a coroner should be obliged to supply a copy of a post-mortem report to the deceased person's family doctor on request and that no charge should be made for this service. The supply of copies of the report to other doctors and other persons who may ask for it should continue to be a matter for the coroner's discretion.

18.23 In relation to requests for information which are made for the purposes of furthering, or exploring the possiblity of starting civil proceedings in connection with a death, we suggest that coroners may wish to be guided by the same principles as are used by chief officers of police in broadly similar situations. In the case of road traffic accidents and other types of accident raising similar issues, it is police practice to withhold all information (except statements by defendants) whilst criminal proceedings or inquests are pending. Subject to this, and to an overriding discretion on the part of chief officers to decline to release information or any particular information in individual cases, it is the general practice to allow copies of statements made to the police in connection with an accident to be released to the following categories of persons:—

(*a*) bona fide parties to civil proceedings or their solicitors, and

(*b*) representatives of insurance companies, trade unions or friendly societies genuinely acting on behalf of parties.

These statements are made available without the consent of the persons who made them, but witnesses are protected by the chief constable's discretion

[1] See Chapter 21 below.

to refuse to allow the disclosure of information which is either irrelevant or which may be personally embarrassing to those who made the statements or to third parties. We understand that this procedure on the whole works well and *mutatis mutandis*, we commend it to coroners.

Figure 7

CORONERS (Amendment) ACT 197

Form prescribed by Coroners Rules 197

File No.

CORONER'S CERTIFICATE OF THE FACT AND CAUSE OF DEATH

I CERTIFY that, in respect of the death of the person named below,

(a) I am satisfied that neither autopsy nor inquest is necessary and that the cause of death was as shown below.

(b) having received a report of an autopsy I am satisfied that an inquest is unnecessary and that the cause of death was as shown below.

(c) an inquest was held on ..... at ..... and the cause of death and other findings were as shown below.

PART I PARTICULARS OF DECEASED

Name and surname ..... N.H.S. Number .....

Usual residence ..... Sex .....

.....

Date of death ..... Date of birth (or year if date unknown) .....

Place of death .....

PART II CAUSE OF DEATH

These particulars not to be entered in death register

		Approximate interval between onset and death
I	I	
Disease or condition directly leading to death	(a) ..... due to (or as a consequence of)	.....
Antecedent causes. Morbid conditions, if any, giving rise to the above cause (The underlying condition to be recorded last)	(b) ..... due to (or as a consequence of)	.....
	(c)	.....
II	II	
Other significant conditions contributing to the death but not related to the disease or condition causing it	.....	.....
	.....	.....

PART III SUPPLEMENTARY INFORMATION - to be completed where relevant

Please record any available details of:-

Morbid conditions present but NOT contributory to death .....

Surgical operations performed within 28 days of death .....

Accidents suffered by deceased within 3 months of death .....

PART IV

If death was violent or unnatural, was it due to

☐ * (i) accident

☐ (ii) suicide

☐ * (iii) or other (ie inflicted by another person)

*If death was due to an accident, please complete Part V

† I have /have not referred the case papers to the Director of Public Prosecutions.

* Delete as necessary

PART V (Accident)

The additional particulars below are to be given by the Coroner if the death was directly or indirectly caused by accident or "misadventure" (including death from neglect or from anaesthetics).

1. Place where accident occurred:

2. (to be completed for all persons aged 15 and over). When injury was received deceased was:
   *1. on way to work
   *2. at work
   *3. on way from work
   *4. elsewhere

3. Details of how accident happened:

4. Type of injury:

5. Part or parts of body injured:

6. Interval between injury and death:
   *Less than one year
   *One year or more

*Delete as necessary

PART VI

Other findings relating to the circumstances of death

PART VII

To be completed in all inquest cases

Occupation of deceased .....

Inquest held with*/without* jury.

☐ The inquest was adjourned under section 7(2) of the Visiting Forces Act, 1952

(Marital condition, etc)

ALL PERSONS AGED 16 AND OVER	ALL MARRIED PERSONS
*Single *Married *Widowed *Divorced	Age of surviving spouse

*Delete as necessary

I have issued an interim death certificate to .....

I have given a disposal certificate to (name) .....

of (address) .....

Signature .....

Coroner for .....

Date .....

Figure 8

CORONER'S INTERIM CERTIFICATE

OF THE FACT OF DEATH

To whom it may concern.

(Name) .....

of (address).....

.....

died on .....

The precise medical cause of death *was as follows/*has yet to be established

.....

Signed .....

Coroner for .....

Date .....

* Delete whichever is inapplicable

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 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.

[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.

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 certification 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] 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.

[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 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.

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

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.

(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 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] Nor has the Greater London Council.

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

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

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.

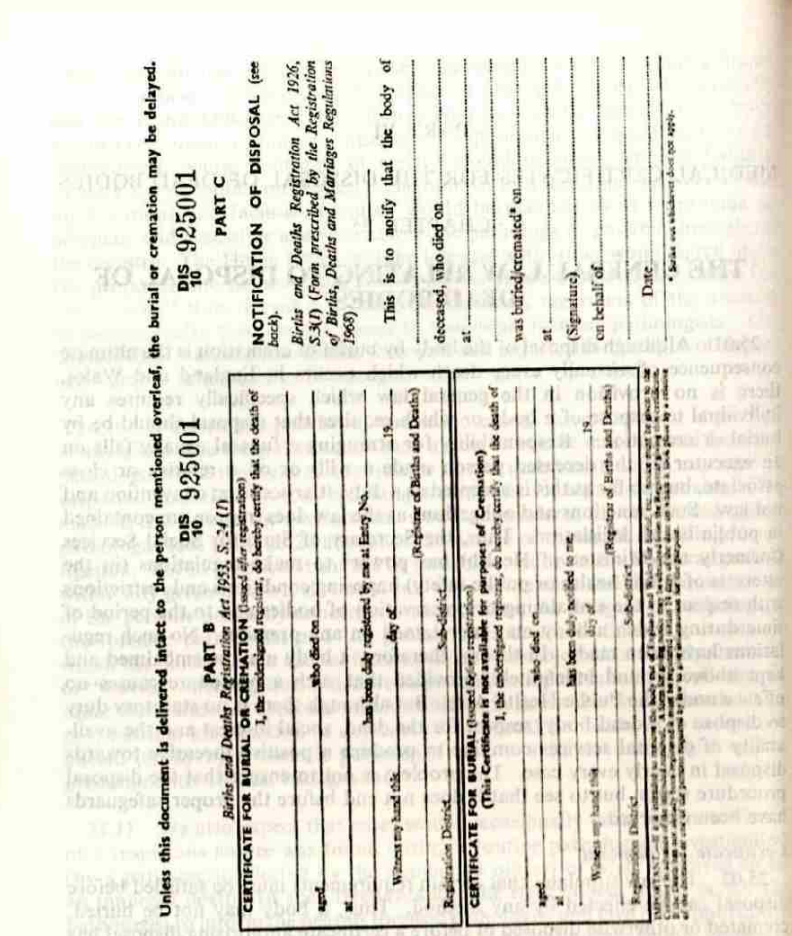
[2] Public Health Act 1936, section 161.

[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

DIS 10 925001

PART B

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

DIS 10 925001

PART C

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

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

Name of deceased .....

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 after* Registration / before

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 .....

Mode of disposal .....

Date of disposal .....

Place of disposal .....

Enquiry duly made on .....

Enquiry made on .....

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 .....

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.

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

Total number of cremations		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	
		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, 1965 and 1966
Showing Number Authorised by the Different Procedures and the Number Involving Formal Challenge of Some Kind

Date of Opening	Name of Cremation Authority	Number of Cremations Authorised by this Procedure: Total number of cremations		Forms B and C		Form D		Form E		Form E as per cent of Total Cremations		Form H		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	
		1965	1966	1965	1966	1965	1966	1965	1966	1965	1966	1965	1966	1965	1966	1965	1966	1965	1966
		Local Authority Crematoria																	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1956	Accrington B.C.	654	718	—	—	—	—	[illegible]6	213	15·9	17·1	—	—	—	—	—	—	—	—
1959	Airedale and Wharfedale J.C.C. ...	1,111	1,243	698	882	—	—	[illegible]7	227	21·4	18·2	—	—	—	—	—	—	—	—
1960	Aldershot B.C.	1,111	1,252	874	1,016	—	1	[illegible]6	122	15·7	11·5	—	—	—	—	—	—	—	—
1959	Altrincham, Bowden and Hale D.C.B.	932	1,062	785	938	—	—	[illegible]1	198	30·0	31·9	—	—	—	—	—	—	—	—
1922	Barnet B.C.	469	615	328	417	—	—	[illegible]1	198	30·0	31·9	—	—	—	—	—	—	—	—
1962	Barnsley B.C....	988	1,196	732	887	5	9	[illegible]5	289	24·7	24·1	2	2	4	9	—	—	—	—
1962	Barrow-in-Furness C.B.C.	606	631	553	555	—	1	[illegible]3	75	8·7	11·9	—	—	—	—	—	—	—	—
1961	Bath B.C.	1,505	1,694	1,230	1,403	1	—	[illegible]3	291	18·1	17·2	—	—	1	—	—	—	—	—
1955	Bedford B.C.	865	938	719	758	—	—	[illegible]6	180	16·7	19·1	—	—	—	—	—	—	—	—
1934	Birkenhead Corporation	2,581	2,160	2,151	1,772	2	—	[illegible]3	387	16·6	17·9	—	1	—	—	—	—	—	—
1937	Birmingham Corporation (Lodge Hill Crematorium) ...	3,087	3,150	2,534	2,631	4	4	[illegible]6	509	17·7	16·2	3	6	4	2	1	1	—	—
1952	Birmingham Corporation (Yardley Crematorium)	2,056	2,225	1,692	1,820	4	5	[illegible]0	400	17·5	17·9	—	—	4	2	3	2	—	—
1957	Birtley B.C.	1,249	961	1,036	812	3	2	[illegible]4	145	16·7	15·2	—	—	2	2	—	—	—	—
1956	Blackburn C.B.C.	944	1,059	724	890	1	1	[illegible]8	168	23·2	15·8	—	—	1	—	—	—	—	—
1935	Blackpool Corporation	1,898	1,898	1,625	1,643	—	—	[illegible]3	255	14·4	13·4	—	—	—	—	—	—	—	—
1956	Blyth and Bedlingtonshire J.C.C. ...	710	797	673	693	8	9	[illegible]9	95	4·1	11·8	—	—	8	—	—	—	—	—
1954	Bolton C.B.C.	3,008	3,288	2,380	2,615	—	1	[illegible]2	658	20·7	20·0	—	—	—	1	6	13	—	—
1966	Boston B.C.	—	305	N.I.U.	259	N.I.U.	—	[illegible].U.	46	—	14·8	N.I.U.	—	N.I.U.	—	N.I.U.	—	—	—
1938	Bournemouth Corporation	3,199	3,480	2,615	2,951	7	15	[illegible]6	544	17·7	15·6	4	—	7	4	—	2	—	—
1905	Bradford Corporation	1,951	2,016	1,607	1,649	—	—	[illegible]4	366	17·6	18·1	—	—	—	—	—	1	—	—
1957	Breakspear J.C.C.	3,439	3,399	2,496	2,485	—	—	[illegible]9	909	27·0	26·7	4	5	—	—	—	—	—	—
1930	Brighton Corporation	1,682	2,086	1,389	1,731	1	6	[illegible]1	348	17·3	16·7	—	—	1	1	—	—	—	—
1956	Bristol City C.	1,889	1,823	1,553	1,474	2	2	[illegible]2	344	17·6	18·9	—	—	2	2	—	1	—	—
1958	Burnley C.B.C.	1,370	1,468	1,071	1,195	—	—	[illegible]9	273	21·8	18·6	—	—	—	—	—	—	—	—
1939	Cambridge City C.	1,494	1,494	1,207	1,207	—	—	[illegible]3	275	18·5	18·5	11	11	—	—	1	1	—	—
1953	Cardiff C.B.C.	1,987	2,357	1,581	1,888	—	—	[illegible]5	465	20·4	19·7	1	4	—	—	—	—	—	—
1956	Carlisle City C.	1,016	1,145	877	992	7	10	[illegible]9	138	12·6	12·0	—	—	3	5	—	—	—	—
1960	Central Durham J.C.C.	1,273	1,386	1,053	1,139	2	—	[illegible]6	247	17·0	17·8	—	—	2	—	—	—	—	—
1961	Chelmsford B.C.	868	988	674	798	—	—	[illegible]4	190	22·6	19·2	—	—	—	—	—	—	—	—
1965	Chester City C.	131	1,029	106	848	—	—	[illegible]5	181	19·2	17·6	—	—	—	—	—	—	—	—
1959	Chesterfield and District J.C.C. ...	1,142	1,369	897	1,081	1	4	[illegible]9	278	20·9	20·3	—	—	1	4	4	2	—	—
1938	Cheltenham B.C.	1,462	1,512	1,230	1,270	1	—	[illegible]1	242	15·8	16·0	—	—	—	—	—	—	—	—
1966	Chilterns J.C.C.	—	720	N.I.U.	562	N.I.U.	1	[illegible].U.	156	—	21·7	N.I.U.	1	—	—	—	—	—	—
1905	City of London Corporation ...	3,512	3,678	2,763	2,868	—	—	[illegible]9	810	22·3	22·0	—	—	—	—	—	—	—	—
1957	Colchester B.C.	1,419	1,746	1,203	1,529	—	—	[illegible]6	217	15·2	14·5	—	—	—	—	—	—	—	—
1957	Colwyn Bay B.C.	1,259	1,498	1,065	1,292	11	14	[illegible]8	183	14·1	12·2	—	—	5	9	—	—	—	—
1956	Cornwall J.C.C.	1,166	1,413	1,024	1,193	—	3	[illegible]0	211	11·1	14·9	—	—	—	3	2	3	—	—
1943	Coventry Corporation	2,625	2,658	2,137	2,132	—	—	[illegible]7	526	18·5	19·8	—	—	—	—	—	—	—	—
1957	Croydon London B.C.	2,525	2,650	1,981	2,053	—	—	[illegible]4	597	21·5	22·5	—	—	—	—	—	—	—	—
1958	Crewe B.C.	600	706	543	625	—	—	[illegible]7	81	11·2	11·4	—	—	—	—	—	—	—	—
1963	Crosby, Litherland and Waterloo J.C.B.	625	619	535	534	—	—	[illegible]8	85	13·9	13·7	—	—	—	—	2	—	—	—
1901	Darlington C.B.C.	1,214	1,416	1,018	1,212	—	—	[illegible]6	202	16·2	14·2	—	—	—	—	—	2	—	—
1956	Derby C.B.C....	2,865	3,037	2,302	2,415	—	—	[illegible]3	586	19·6	19·3	—	—	—	—	—	—	—	—

TABLE *continued*

Table of Cremations 1965 and 1966

Showing Number Authorised by the Different Procedures and the Number Involving Formal Challenge of Some Kind

Date of Opening	Name of Cremation Authority	Number of Cremations Authorised by 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	
		Total number of cremations		Forms B and C		Form F		Form E		Form E as per cent of Total Cremations		Form H					
		1965	1966	1965	1966	1965	1965	1966	1965	1966	1965	1966	1965	1966	1965	1966	1965	1966
		Local Authority Crematoria																
		1	2	3	4	5	7	8	9	10	11	12	13	14	15	16	17	18
1960	Dewsbury Moor Cremation Board	1,093	1,196	891	957	—	202	239	18·5	19·1	—	—	—	—	—	—	—	—
1960	Doncaster C.B.C.	1,539	1,745	1,220	1,394	—	117	348	20·6	19·9	—	—	—	1	1	—	1	1
1953	Dukinfield J.C. and C.C.	1,539	1,672	1,258	1,361	—	281	311	18·2	18·6	—	—	—	—	—	—	—	—
1960	Eastbourne C.B.C.	1,540	1,625	1,318	1,350	2	220	269	14·3	16·5	—	—	—	2	—	—	—	1
1955	Eccles B.C.	844	996	680	838	—	164	158	19·5	15·9	—	—	—	—	—	—	—	—
1956	Eltham Crematorium J.C.	2,914	3,079	2,145	2,269	—	768	801	26·4	26·3	1	—	—	—	—	—	—	—
1956	Folkestone B.C.	519	570	430	483	—	89	87	17·1	15·3	—	—	—	—	—	—	—	—
1966	Gateshead C.B.C.	—	334	N.I.U.	285	N.I.U.	N.I.U.	45	—	13·6	N.I.U.	—	N.I.U.	2	N.I.U.	—	N.I.U.	—
1953	Gloucester C.B.C.	1,016	1,095	814	914	—	200	180	19·6	16·5	—	—	—	1	—	—	—	—
1966	Grantham Burial J.C.	—	210	N.I.U.	163	N.I.U.	N.I.U.	47	—	22·4	N.I.U.	—	N.I.U.	—	N.I.U.	—	N.I.U.	—
1954	Grimsby C.B.C.	1,554	1,508	1,301	1,300	—	253	208	16·3	13·8	—	—	—	—	—	—	—	—
1966	Guildford B.C.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
1956	Halifax C.B.C.	1,610	1,780	1,336	1,484	—	274	295	17·0	16·6	—	—	—	1	—	—	—	—
1955	Hastings B.C.	1,317	1,422	1,129	1,184	2	186	231	14·1	16·2	—	—	1	—	—	—	—	—
1938	Haringey London B.C.	4,684	4,778	3,622	3,741	—	862	1,037	20·6	21·7	—	—	—	—	—	—	—	—
1961	Harlow U.D.C.	326	453	267	355	2	56	97	16·9	21·6	—	—	2	—	—	—	—	—
1936	Harrowgate B.C.	718	944	605	840	—	113	104	15·7	11·1	—	—	—	—	—	—	—	—
1956	Hereford City C.	501	573	423	492	2	66	74	13·2	13·0	—	—	10	12	—	—	—	—
1958	Huddersfield C.B.C.	1,631	1,831	1,324	1,475	—	307	356	18·8	19·5	—	—	—	—	—	—	—	—
1961	Isle of Wight J.C.C.	794	734	606	628	—	118	106	14·9	15·9	—	—	—	—	—	—	—	—
1928	Ipswich C.B.C.	1,381	1,572	1,165	1,286	—	213	285	15·4	18·1	—	—	—	—	—	—	—	—
1937	Islington London B.C.	755	936	591	716	—	164	218	21·9	23·2	—	—	—	—	—	—	—	—
1960	Keighley B.C.	364	433	313	374	—	51	59	14·2	13·7	—	—	—	—	—	—	—	—
1940	Kettering B.C.	1,452	1,495	1,208	1,235	8	236	236	16·3	15·7	—	—	8	12	—	—	—	—
1901	Kingston Upon Hull Corporation	2,230	2,408	1,794	1,941	—	436	465	19·6	19·3	—	—	—	1	2	—	—	—
1952	Kingston Upon Thames London B.C.	1,272	1,352	962	1,206	—	310	326	24·4	24·1	—	—	—	—	—	—	—	—
1958	Lambeth London B.C. (Lambeth Crematorium)	497	—	368	—	—	129	—	25·8	—	—	—	—	—	—	—	—	—
1915	Lambeth London B.C. (West Norwood Crematorium)	389	424	284	310	—	105	114	26·9	27·1	—	—	—	—	—	—	—	—
1938	Leeds Corporation (Cottingley Hall Crematorium)	1,282	1,425	1,015	1,048	—	266	371	20·8	25·9	1	6	—	—	—	—	—	—
1905	Leeds Corporation (Lawnswood Crematorium)	3,090	3,127	2,456	2,452	1	630	673	20·4	21·5	3	2	—	—	—	—	—	—
1902	Leicester City C.	2,691	2,784	2,286	2,279	6	499	496	14·8	17·8	—	—	6	4	—	—	—	—
1956	Lewisham London B.C.	1,278	1,278	918	897	—	360	381	28·1	29·8	—	—	—	—	—	—	—	—
1896	Liverpool Corporation	3,410	3,344	2,751	2,768	—	651	459	16·2	13·7	3	—	—	—	105	103	—	—
1960	Loughborough B.C.	757	828	658	725	3	96	98	12·6	11·8	—	—	3	5	—	—	—	—
1960	Luton B.C.	1,492	1,671	1,294	1,428	—	198	248	13·3	14·6	—	—	—	—	—	—	—	—
1958	Lytham St. Annes B.C.	775	934	671	814	—	104	120	13·3	12·9	—	—	—	—	—	—	—	—
1960	Macclesfield B.C.	608	745	495	622	3	110	122	18·0	16·3	—	—	2	—	1	—	—	—
1962	Maidstone and District Crematorium J.C.	835	927	693	779	—	142	148	16·9	15·9	—	—	—	—	4	—	—	—

TABLE continued

Table of Cremations 1965 and 1966

Showing Number Authorised by the Different Procedures and the Number Involving Formal Challenge of Some Kind

Date of Opening	Name of Cremation Authority	Number of Cremations Authorised by 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	
		Total number of cremations		Forms B and C		Form D		Form E		Form E as per cent of Total Cremations		Form H							
		1965	1966	1965	1966	1965	1966	1965	1966	1965	1966	1965	1966	1965	1966	1965	1966	1965	1966
		Local Authority Crematoria																	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1959	Manchester City Council	836	860	710	708	—	—	125	152	14·9	17·7	1	—	—	—	—	—	—	—
1960	Mansfield and District Crematorium J.C.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
1959	Medway Crematorium Comm. ...	1,621	1,636	1,338	1,350	3	—	279	286	17·2	17·4	1	—	1	—	—	—	—	—
1961	Merton London B.C.	960	1,163	758	949	—	—	202	214	21·0	18·4	—	—	—	—	—	—	—	—
1952	Middleton B.C.	339	424	267	352	—	—	72	72	21·1	17·1	—	—	—	—	—	—	—	—
1961	Middlesborough C.B.C.	1,630	1,943	1,346	1,572	—	—	284	371	17·4	19·4	—	—	—	—	—	—	—	—
1966	Monmouth and Newport J.C.C. (Gwent Crematorium)	1,424	1,652	1,190	1,402	—	—	234	250	16·5	15·2	—	—	—	—	1	—	—	—
1963	Morecombe and Heysham B.C. ...	1,026	1,241	868	1,070	—	—	158	171	11·1	13·7	—	—	—	—	—	—	—	—
1939	Mortlake Crematorium Board ...	2,923	2,965	2,199	2,191	—	—	723	769	24·8	25·9	1	—	—	—	4	—	—	—
1934	Newcastle Upon Tyne City C. ...	3,600	3,464	3,190	3,008	26	11	379	438	10·5	12·7	5	2	26	9	1	—	1	—
1965	Newcastle under Lyme B.C. ...	385	437	261	300	—	—	124	137	31·8	31·1	—	—	—	—	1	—	—	—
1966	North Devon Crematorium Comm.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
1958	North East Surrey Crematorium Board	1,246	1,292	919	955	—	—	326	333	26·1	25·8	—	—	—	—	—	—	—	—
1966	North West Durham J.C.C. (Mountsett Crematorium) ...	—	198	N.I.U.	154	N.I.U.	—	N.I.U.	44	—	22·0	N.I.U.	—	—	—	—	—	—	—
1964	Norwich City C.C.	415	409	337	340	—	—	78	66	18·6	16·1	—	—	—	3	—	—	—	—
1931	Nottingham City Council	4,205	4,352	3,316	2,405	—	—	889	945	21·1	21·0	—	1	—	1	—	4	—	—
1957	Nuneaton B.C.	686	729	541	589	—	—	145	140	21·0	19·2	—	—	—	—	—	—	—	—
1953	Oldham C.B.C.	1,349	1,502	1,067	1,167	—	—	282	334	20·9	22·3	—	—	—	1	—	—	—	—
1959	Osgoldcross J.C.B.	1,004	1,078	786	859	—	—	218	219	21·8	20·3	—	—	—	—	—	—	—	—
1958	Peterborough C.C.	1,313	1,319	1,124	1,110	—	—	189	208	14·4	15·6	—	—	—	—	—	—	—	—
1934	Plymouth C.C.	1,767	1,883	1,457	1,589	5	—	305	290	17·2	15·4	—	—	5	1	—	—	—	1
1924	Pontypridd B.B. and C.A.	1,989	2,157	1,511	1,622	—	—	478	535	24·0	24·8	—	—	—	—	—	—	—	—
1966	Pentrelychan (Wrexham) J.C.C. ...	—	90	N.I.U.	69	N.I.U.	—	N.I.U.	21	—	23·3	N.I.U.	—	N.I.U.	—	—	—	—	—
1958	Porchester Crematorium J.C. ...	3,076	3,160	2,525	2,560	12	1	537	590	17·4	18·7	—	—	1	1	—	—	—	1
1962	Preston C.B.C.	801	920	642	757	—	—	156	161	19·5	17·5	—	—	—	—	3	2	3	—
1932	Reading Corporation	1,731	1,857	1,448	1,569	3	—	280	284	16·2	15·3	—	—	3	4	1	—	—	—
1938	Rochdale Corporation	1,434	1,534	1,134	1,257	—	—	297	272	20·8	17·8	—	—	—	—	—	—	—	—
1962	Rotherham C.B.C.	784	913	633	732	—	—	151	181	19·4	19·9	—	—	—	—	—	—	—	—
1962	Rowley Regis B.C.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—
1957	Salford B.C.	930	980	749	822	—	—	181	158	19·5	16·1	—	—	—	1	—	—	—	—
1960	Salisbury City	714	894	631	762	—	—	83	131	11·7	14·7	—	—	—	—	—	—	—	—
1961	Scarborough B.C.	908	993	812	879	—	—	96	113	10·5	11·4	—	—	—	—	—	—	—	—
1964	Scunthorpe B.C.	622	1,476	505	617	—	—	117	121	18·9	13·3	—	—	—	—	—	—	—	—
1960	Sedgley, Dudley and Brierly Hill J.C.	752	911	610	735	—	—	141	175	18·8	19·2	1	—	—	1	4	2	—	—
1905	Sheffield Corporation	4,482	4,160	3,885	3,444	3	1	593	711	13·2	17·1	1	3	3	2	1	—	—	—
1955	Shipley U.D.C.	977	1,067	839	913	—	—	138	154	14·8	14·4	—	—	—	—	—	—	—	—
1958	Shrewsbury B.C.	1,125	1,146	987	980	—	—	138	166	12·3	14·4	—	—	—	—	—	—	—	—
1952	Skipton U.D.C.	795	887	680	792	1	—	113	95	14·3	10·7	—	—	—	—	—	—	—	—
1963	Slough B.C.	1,183	1,183	955	946	—	—	228	236	19·3	20·0	—	—	—	—	—	—	—	—

TABLE *continued*

Table of Cremations 1965 and 1966

Showing Number Authorised by the Different Procedures and the Number Involving Formal Challenge of Some Kind

Date of Opening	Name of Cremation Authority	Number of Cremations Authorised each Procedure: 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	Form E 1965	Form E 1966	Form E as per cent of Total Cremations 1965	Form E as per cent of Total Cremations 1966	Form H 1965	Form H 1966	Number of Cremations where original certificates were unsatisfactory, a post-mortem was made and cremation authorised on basis of Form D 1965	1966	Number of cases where death was reported to Coroner by Medical Referee 1965	1966	Number of cases where Medical Referee declined to allow cremation 1965	1966
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
		Local authority Crematoria																	
1958	Solihull B.C.	1,152	1,224	941	995	—	—	211	229	18·3	18·8	—	—	—	—	—	—	—	—
1961	South Shields C.B.C.	864	836	758	745	—	—	106	91	12·3	10·8	—	—	—	—	—	—	—	—
1932	Southampton Corporation	2,098	2,370	1,696	1,906	1	—	401	464	19·1	19·6	—	—	1	—	2	—	—	—
1953	Southend-on-Sea C.B.C.	2,043	2,335	1,572	1,875	4	3	467	457	22·9	19·5	—	—	4	3	—	—	—	—
1957	South Essex Crematorium J.C.	1,910	2,085	1,554	1,657	—	—	356	427	18·6	20·4	—	1	—	—	—	—	—	—
1959	Southport C.B.C.	954	998	795	831	—	—	159	166	16·7	16·8	—	1	—	—	—	—	—	1
1939	Southwark, London B.C.	2,402	—	1,609	—	—	—	791	—	33·0	—	2	—	—	—	—	—	—	—
1962	St. Helens C.B.C.	503	586	425	498	—	—	78	88	15·6	15·8	—	—	—	—	—	—	—	—
1964	Stafford B.C.	331	399	275	348	—	—	56	51	17·0	12·8	—	—	—	—	—	—	—	—
1940	Stoke-on-Trent Corporation	1,811	1,875	1,196	1,232	7	10	608	643	33·5	34·2	—	—	2	4	—	—	—	—
1960	Stourbridge B.C.	855	964	699	803	—	—	156	161	18·1	16·8	—	—	—	—	4	3	—	—
1951	Sunderland C.B.C.	1,776	1,979	1,542	1,673	—	—	234	306	13·1	15·5	—	—	—	—	—	—	—	1
1964	Sutton Coldfield B.C.	594	800	502	639	—	1	92	160	15·4	20·0	—	—	—	—	—	—	—	—
1954	S.W. Middlesex Crematorium Board	2,345	2,499	1,681	1,718	—	—	660	779	28·1	31·2	4	—	—	—	5	2	—	—
1956	Swansea C.B.C.	2,173	2,455	1,779	2,036	—	—	394	419	18·2	17·0	—	—	—	—	—	—	—	—
1966	Swindon B.C.	—	361	N.I.U.	293	—	—	—	68	—	18·9	—	—	—	—	—	—	—	—
1966	Thanet Crematorium J.C.	—	527	N.I.U.	441	—	—	—	86	—	16·4	—	—	—	—	—	—	—	—
1963	Taunton J.B.C.	1,019	1,195	855	1,038	6	9	158	149	15·5	12·4	—	—	6	8	—	—	—	—
1958	Tunbridge Wells B.C.	1,341	1,427	1,113	1,190	2	2	226	235	16·8	16·4	—	—	—	—	—	—	—	—
1959	Tynemouth C.B.C.	629	657	557	591	5	3	67	64	10·6	9·7	—	—	5	3	—	—	—	—
1961	Wakefield City Crematorium	555	683	405	531	—	—	150	152	26·8	22·4	—	—	—	—	—	—	—	—
1955	Wakall C.B.C.	867	990	666	771	—	—	201	216	23·1	21·8	—	—	—	—	—	—	—	—
1938	Wandsworth, London B.C.	1,679	1,756	1,315	1,373	—	—	364	383	21·7	21·8	—	—	—	—	—	—	—	—
1962	Warley C.B.C.	299	314	234	258	—	—	65	56	21·7	18·1	—	—	—	—	—	—	—	—
1964	Warrington and Runcorn Rural J.C.C.	634	903	549	680	—	—	85	123	13·5	13·7	—	—	—	—	—	—	—	—
1961	West Bromwich C.B.C.	782	976	632	810	—	1	150	165	19·2	16·8	—	—	—	1	—	—	—	—
1954	West Hartlepool C.B.C.	574	656	472	556	—	—	102	98	17·9	14·8	—	—	—	—	—	—	—	2
1958	West Hertfordshire Crematorium J.C.	2,596	2,666	2,210	2,186	2	—	384	480	14·8	18·0	—	—	2	—	—	—	—	—
1937	Westminster, London B.C.	1,656	1,674	1,251	1,233	—	—	404	441	24·3	26·4	1	—	—	—	—	—	—	—
1966	Weston-super-Mare B.C.	—	381	N.I.U.	289	—	—	—	91	—	23·9	—	—	—	2	—	2	—	—
1939	Weymouth and Melcome Regis B.C.	862	1,033	769	894	—	—	93	139	10·8	13·5	—	—	—	—	—	—	—	—
1960	Whitley Bay B.C.	542	567	467	503	4	3	71	61	13·1	10·7	—	—	—	—	—	—	—	—
1959	Widnes B.C.	400	399	348	338	—	—	52	61	13·0	15·3	—	—	—	—	—	—	—	—
1955	Wigan C.B.C.	903	944	780	804	—	—	123	140	13·7	14·9	—	—	—	—	—	—	—	1
1954	Wolverhampton B.C.	1,771	2,033	1,493	1,703	—	1	278	328	15·7	16·2	—	—	—	2	—	—	—	—
1962	York City Corporation	1,120	1,340	929	1,114	—	—	191	225	17·1	16·8	—	—	—	—	—	1	—	—
1960	Worcester City	845	966	725	833	—	—	120	133	14·1	13·7	—	—	—	—	10	7	—	10
	SUB-TOTAL	201,678	216,408	163,966	175,715	173	34	37,180	39,970	18·5	18·4	51	59	137	127	169	160	2	10
		Private Crematoria																	
1903	Birmingham Crematorium Co. Ltd.	2,555	2,375	2,117	2,032	3	4	435	339	17·0	14·3	—	—	3	4	1	—	—	—

Table [illegible]

Table of Cremations [illegible] and 1966

Showing Number Authorised by the Different Procedures: Number Involving Formal Challenge of Some Kind

Date of Opening	Name of Cremation Authority	Number of Cremations Authorised by Procedure: Total number of cremations		Forms B and C		Form D	Form E	Form E as % of Total Cremations		Form H		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	
		1965	1966	1965	1966	1965	1966	1966	1965	1966	1965	1966	1965	1966	1965	1966	1965	1966
		1	2	3	4	5	6	8	9	10	11	12	13	14	15	16	17	18
	Local Authority Crematoria																	
1941	Brighton and Preston Cemetery Co. Ltd.	4,541	4,368	3,663	3,622	28	[illegible]	720	18·7	16·5	—	—	—	—	—	—	—	—
1928	Bristol General Cemetery Co. ...	2,547	2,589	2,078	2,108	1	[illegible]	472	18·4	18·2	—	6	1	3	2	1	—	—
1956	Crystal Palace District Cemetery Co. Ltd. (Beckenham Crematorium)...	1,595	1,625	1,195	1,230	—	—	395	25·0	24·2	—	—	—	—	—	—	—	—
1939	Counties Crematorium Ltd. (Northampton Crematorium) ...	1,290	1,352	1,096	1,170	—	[illegible]	181	15·0	13·4	—	—	—	—	—	—	—	2
1954	East London Cemetery Co. Ltd. ...	316	337	216	235	—	—	102	31·4	30·0	—	—	—	—	—	—	—	—
1963	Exeter and Devon Crematorium Ltd.	1,837	2,077	1,618	1,810	—	—	267	11·9	12·8	—	—	—	—	—	—	—	—
1957	Great Northern Crematorium Co....	608	546	462	403	—	—	146	23·9	25·1	—	—	—	—	—	1	—	—
1939	General Cemetery Co. (West London Crematorium) ...	1,159	—	822	999	—	—	368	29·1	—	—	2	—	—	—	—	—	—
1956	Kent County Crematorium Ltd. (Barham)	2,422	2,228	2,049	1,809	—	—	419	15·4	18·8	—	—	—	—	—	—	—	—
1936	Kent County Crematorium Ltd. (Charing)	1,351	1,387	1,131	1,153	—	—	234	16·3	15·3	—	—	—	—	—	—	—	—
1902	London Crematorium Co. Ltd. (Golders Green)	4,867	4,719	3,599	3,545	—	—	1,242	26·0	26·3	—	4	—	—	1	—	—	—
1885	London Crematorium Co. Ltd. (Woking St. Johns)	2,890	3,011	2,326	—	—	—	—	19·5	—	—	—	—	—	—	1	—	—
1892	Manchester Crematorium Ltd. ...	3,392	3,540	2,870	2,954	—	[illegible]	557	15·4	15·7	—	27	—	1	5	8	—	—
1955	Manor Park Cemetery Co. Ltd. ...	707	805	550	633	—	—	172	22·1	21·2	—	—	—	—	—	—	—	—
1937	Norwich Crematorium Ltd. ...	2,236	2,257	1,905	1,890	1	—	367	14·7	16·2	—	—	1	—	—	—	—	1
1938	Oxford Crematorium Ltd.	2,283	2,239	1,894	1,875	—	—	364	17·1	16·3	—	—	—	—	—	—	—	—
1936	South London Crematorium Co. Ltd.	4,175	4,398	3,028	3,194	—	—	1,169	27·3	26·6	5	35	—	—	—	—	—	—
1934	Stockport Borough Cemetery Co. Ltd.	2,168	2,212	1,798	1,843	2	[illegible]	368	16·9	16·6	—	—	2	1	—	—	—	—
1956	Torquay Cemetery Co.	1,671	1,792	1,440	1,561	—	—	231	13·8	12·9	—	—	—	—	—	—	—	—
1956	The Crematorium Co. Ltd. (Surrey and Sussex)	1,788	1,968	1,453	1,628	—	[illegible]	338	18·7	17·2	—	1	—	—	—	—	—	—
	SUB-TOTAL	46,041	44,214	37,310	35,694	35	[illegible]	8,448	18·8	19·1	5	75	7	9	9	11	—	3
	GRAND TOTAL	247,719	260,685	201,276	211,409	208	[illegible]	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

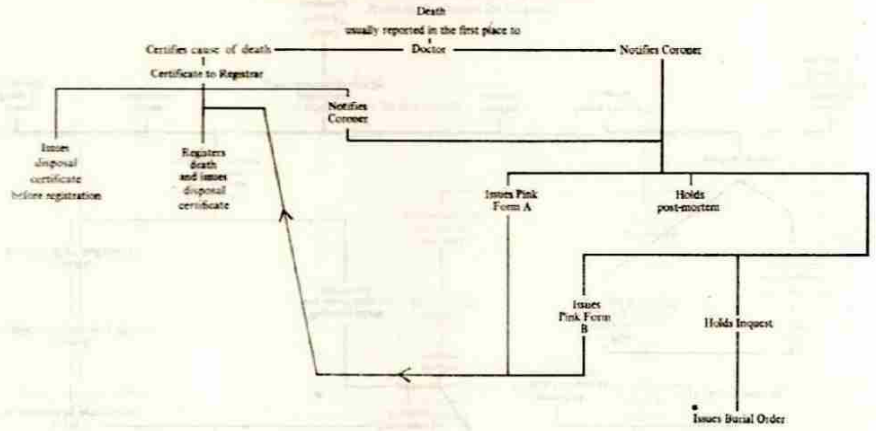
Time Taken to Register a Death, According to the Method of Certification

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 Diagram A

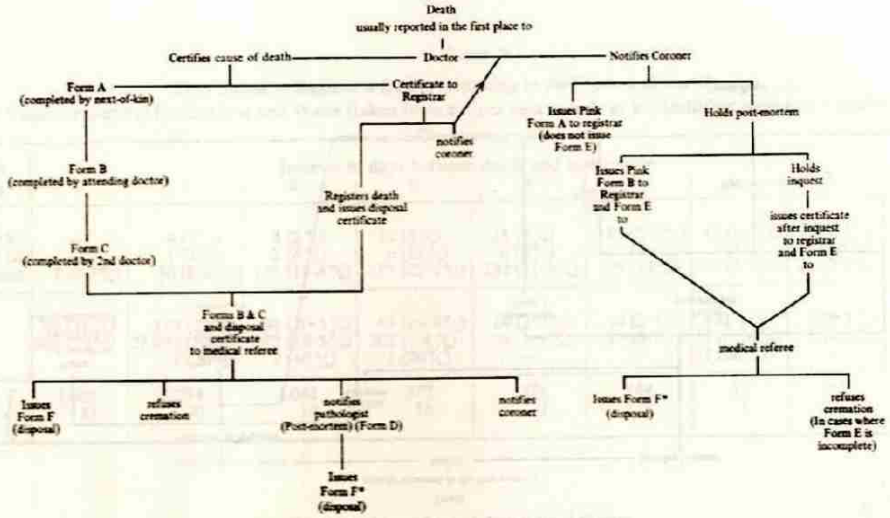
Sequence of events leading to the disposal of a body by burial



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

Diagram B

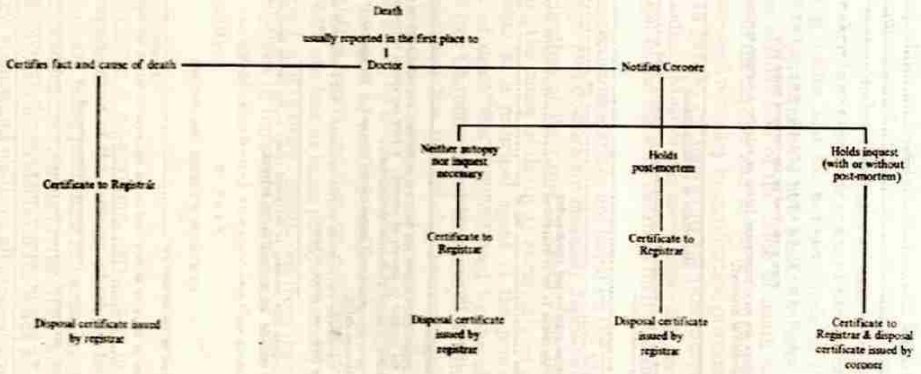
Disposal - Cremation
Sequence of events leading to disposal of a body by cremation



* 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.

STATISTICS OF CORONERS' WORK 1901–1969

Source: Coroners' Returns to the Home Office

Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
	Total number of deaths in England and Wales	Deaths reported to Coroner			Number of prelim. Inquiries not followed by Inquest			Number of Inquests										
		Total number	Lunatics and mental defectives	Other persons				Total 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
1901	551,585				18,653			37,184	5,471	3,803	1,132	214	1,746	2,485	14,495	7,736	102	368
1902	535,538				18,841			36,092	5,817	3,477	1,034	214	1,646	2,322	13,996	7,500	86	
1903	514,628				18,320			35,861	5,583	3,553	1,070	212	1,463	2,261	14,209	7,422	88	
1904	549,784				19,399			36,269	5,702	3,640	1,104	212	1,555	2,284	14,029	7,682	61	
1905	520,031				19,464			36,027	5,187	3,569	1,077	213	1,626	2,307	14,332	7,652	64	
1906	531,281				19,170			36,570	5,296	3,664	1,037	209	1,647	2,223	14,438	7,960	96	
1907	524,221				18,627			36,576	5,171	3,624	943	215	1,598	2,244	14,666	8,226	69	
1908	520,456				19,054			37,092	4,895	3,531	1,230	279	1,655	2,256	14,757	8,393	96	
1909	518,003				19,594			36,724	5,018	3,531	1,032	206	1,665	2,221	14,538	8,458	55	
1910	483,247				19,509			35,417	4,686	3,314	953	183	1,717	2,255	14,212	8,013	84	
1911	527,810				20,742			37,612	4,700	3,494	883	226	1,887	2,495	15,062	8,793	74	
1912	486,939				20,932			37,098	4,507	3,366	880	179	1,856	2,243	14,961	9,006	100	
1913	504,975				21,594			36,801	4,363	3,204	971	194	1,855	2,331	14,778	9,042	63	
1914	516,742				23,618			38,129	4,399	3,246	929	174	1,963	2,482	15,596	9,237	103	
					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											363
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	31,656										
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	31,666										
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										353
1937	509,574	71,628	12,125	59,503	33,069	12,771	13,212	31,575										348
1938	478,996	70,635	11,250	59,385	32,381	13,180	13,764	31,505										345
					Pink Form A				Total		Under 1 year		1–13 years		14–20 years		21 years and over	
1946	492,090	72,664			23,219	13,655	22,895	26,550										333
1947	517,615	81,316			25,426	14,854	27,881	28,009										332

STATISTICS OF CORONERS WORK 1901-1969—*continued*

Source: Coroners' Returns to the Home Office

Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
	Total number of deaths in England and Wales	Deaths Reported *to Coroner*			Number of prelim. Inquiries not followed by Inquest			Number of Inquests										
		Total number	Lunatics and mental defectives	Other persons				Total 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
1948	469,898																	331
1949	510,736	75,844			22,538	13,897	28,865											330
1950	510,301	83,571																329
1951	549,380	89,587																327
1952	497,484	85,929																324
1953	503,529	88,128																321
1954	501,896	90,797			23,250	(17,304)	(41,564)											316
1955	518,864	94,914			24,761	(17,442)	(44,042)											313
1956	521,331	96,977			31,388	(15,086)	(39,399)		Total		Under 1 year		1–13 years		14–20 years		21 years and over	310
1957	514,870	10,671	10,671		28,654	(18,902)	(50,665)											309
1958	526,843	100,901	10,015		21,934	(19,759)	(53,031)		25,294		639		1,242		1,056		22,357	304
1959	527,651	102,182			21,012	20,982	54,788		25,499		622		1,300		1,026		22,551	303
1960	526,268	101,079			16,933	21,496	57,841		26,005		622		1,365		1,260		22,758	300
1961	551,752	101,667			13,162	22,229	62,329		25,620		538		1,295		1,445		22,342	300
1962	557,836	106,786			13,314	23,417	66,589		26,347		648		1,391		1,482		22,869	297
1963	572,868	113,001			13,245	24,179	72,443		26,585		689		1,364		1,507		23,025	299
1964	534,737	109,844			11,924	24,639	70,826		26,425		720		1,427		1,838		22,440	291
1965	549,379	116,267			12,639	24,914	76,604		26,053		726		1,497		1,790		22,050	286
1966	563,624	117,438			12,754	24,893	77,826		25,940		666		1,564		1,841		21,869	282
1967	542,519	117,935			12,964	23,918	79,364		24,654		604		1,549		1,741		20,760	270
1968	576,754	124,420			13,927	23,407	85,870		23,759		570		1,481		1,491		20,217	270
1969	579,378	131,639			14,506	24,101	92,003		24,172		609		1,486		1,482		20,595	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 (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
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.

Coroners' Verdicts 1901–1969

Source: Coroners' Returns to the Home Office

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
		Death by wilful or criminal acts					Suicide			Death by negl			Exposure / excess							Open verdicts			Inquest on bodies of new-born children	
Year	Total	Murder	Manslaughter	Infanticide	Justifiable homicide	Executed	While insane	Felo de se	Attempted or self-induced abortion	Lack of care	Want, exposure etc.	Excessive drinking	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
1901		208	130		5	15	3,057	49		154	256	1,00		164		14,001	14,594	270	393	1,234	440	262	736	44
1902		173	127		1	22	3,197	42		153	230	98		189		14,202	14,305	264	354	1,159	408	279	834	38
1903		189	111		2	27	3,441	39		174	205	88		214		14,083	13,924	271	383	1,255	415	233	848	45
1904		191	126		1	16	3,252	75		166	217	81		193		14,419	14,338	250	339	1,139	523	213	873	49
1905		183	103		4	17	3,389	126		166	189	80		219		14,406	13,845	281	308	1,171	593	224	832	37
1906		155	110		3	8	3,337	97		156	220	78		233		14,805	14,293	223	360	1,061	502	210	888	43
1907		142	110		7	10	3,359	118		152	230	34		237		14,891	14,324	119	271	1,113	489	228	830	34
1908		182	109		8	12	3,362	119		143	255	69		219		14,939	14,184	306	336	1,165	511	243	851	43
1909		165	102		4	19	3,407	137		120	240	61		279		14,518	14,824	297	299	997	498	202	975	36
							Other cases of suicide																	
1910		171	88		4	16	3,400	129		135	227	58		248		14,175	14,016	290	247	1,025	475	195	880	46
1911		156	92		10	16	3,474	89		105	196	61		296		15,425	14,702	260	292	1,154	537	197	925	23
1912		192	97		5	10	3,490	115		97	231	58		275		15,118	14,458	255	322	1,125	502	220	901	41
1913		194	99		4	19	3,386	89		97	162	67		253		15,213	14,226	245	292	1,091	530	224	875	50
1914		170	76		16	15	3,590	107		83	168	68		288		16,305	14,330	258	397	1,024	434	181	936	34
1919	31,756	208	76		8		3,109	141		22	120	13		292		13,486	12,151	272	257	904	392	173		
1920	31,496	192	89		6		3,236	137		28	88	14		277		13,441	11,748	337	241	921	380	191		
1921	29,716	168	72		3		3,585	130		19	98	17		274		12,022	11,241	310	248	833	344	187		
1922	30,800	138	64		3	17	3,727	117		19	99	12		247		12,107	12,325	305	262	766	342	142		
1923	31,264	157	67	16	5	14	3,818	101		15	84	13		235		12,606	12,213	271	219	785	393	135		
1924	31,705	141	74	17	3	10	3,614	65		20	83	11		259		13,235	12,282	263	237	746	396	142		
1925	33,178	163	76	26	2	17	3,987	67		34	122	9		218		13,964	12,617	275	231	737	410	133		
1926	32,924	164	88	20	4	17	4,330	78		30	96	8		295		13,851	12,117	262	258	678	412	138		
1927	32,438	121	42	7	1	8	4,770	93		27	100	9		231		15,135	9,998	210	228	762	369	155		
1928	31,553	76	66	7	1	21	4,758	88		17	95	8		217		16,485	7,783	207	279	701	398	121		
1929	32,610	81	47	5	2	8	4,844	65		32	133	16	12	189		17,452	7,825	154	262	669	408	114		
1930	31,521	84	46	6	—	3	4,886	86		22	93	13	8	189		17,532	6,736	160	308	686	435	108		
1931	30,638	71	31	4	—	10	4,987	105		30	79	11	6	182		16,711	6,660	153	290	682	423	96		
1932	30,357	76	40	4	—	9	5,587	70	29	18	50	12	9	199		16,120	6,308	153	318	674	465	101		
1933	31,476	73	39	3	1	9	5,472	71	42	14	71	11	12	145		17,136	6,618	121	290	619	540	80		
1934	31,374	83	48	3	—	9	5,431	55	46	19	51	11	12	179		17,345	6,360	121	327	580	478	115		
1935	30,850	75	53	1	2	11	5,090	66	36	5	57	12	10	160		17,024	6,431	104	340	602	573	110		
1936	30,737	71	36	3	—	7	4,920	87	43	13	61	14	5	117		17,365	6,162	104	336	590	571	104		
1937	31,358	53	32	1	2	9	5,061	44	45	10	67	18	6	149		17,804	6,147	144	308	643	574	77		
1938	31,292	55	50	3	5	5	5,210	53	35	10	61	16	12	154		17,415	6,066	500	360	598	834	100		
												Chronic alcoholism								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
1957	25,294	76	17	4	1	2	5,313		15	40		7	4	42	874	15,088	2,440	21	1,290	497	95	60	10	332
1958	25,499	58	17	2	—	4	5,237		12	54		6	5	41	757	15,581	2,367	30	1,261	560	109	50	15	386
1959	26,003	71	21	4	1	6	5,206		7	66		9	4	40	737	16,042	2,279	36	1,365	596	94	75	18	409
1960	25,785	50	23	2	—	10	5,119		12	46		8	2	24	784	16,201	2,039	21	1,363	596	94	75	18	409
1961	25,620	53	27	3	—	7	5,212		15	39		7	1	35	954	16,878	1,860	19	1,392	688	111	68	14	495
1962	16,347	66	19	1	2	3	5,583		17	52		8	4	23	914	16,298	1,853	34	1,393	619	116	66	20	417
1963	26,627	60	25	2	2	2	5,727		13	67		7	5	39	1,012	16,522	1,501	40	1,490					
1964	26,425	62	21	3	2	2	5,565		8	53		8	8	26	853	16,651	1,575	22	1,507	707	122	59	14	512
1965	26,053	65	28	4	—	—	5,187		16	53		13	12	47	934	16,596	1,519	27	1,447	871	137	66	18	650
1966	25,940	55	26	3	—	—	5,013		8	75		10	11	31	882	16,670	1,541	25	1,491	933	173	84	15	661
1967	24,680	58	24	3	1	—	4,735		7	37		12	16	31	747	15,843	1,566	36	1,454	933	173	84	15	661
1968	23,759	59	28	1	—	—	4,569		9	47		12	19	29	771	15,111	1,517	23	1,450	998	175	85	14	724
1969	24,172	42	26	2	—	—	4,369		3	55		12	37	15	783	15,520	1,563	32	1,602	860	187	92	17	564

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	—

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 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	—

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	—

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	604	141	368	78	17
Western	971	188	664	119	—
Cardiff Borough	339	115	194	30	—
Merthyr Tydfil Borough	464	85	299	77	3
Swansea Borough					
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	113	(not available)	113
Boroughs		—	
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 or her and that he or she has no reason to doubt the truth of any of the information furnished by the applicant.

[1] Now the Secretary of State for the Environment.

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.

FORM F

AUTHORITY TO CREMATE

Whereas application has been made for the cremation of the remains of

(Name[1])

(Address)

(Occupation)

And whereas I have satisfied myself that all the requirements of the Cremation Act 1902, and of the Regulations made in pursuance of that Act, have been complied with, that the cause of death has been definitely ascertained, and that there exists no reason for any further inquiry or examination:

I hereby authorise the Superintendent of the Crematorium at to cremate the said remains.

(Signature)

(Date) Medical Referee to the

NOTE—This authority should be signed in duplicate—one copy to be retained with certificates and the other sent by the Medical Referee to the Superintendent of the Crematorium.

[1] In the case of a stillborn child, in place of the name, address and occupation, insert a description sufficient to identify the body, and in place of the words " that the cause of death has been definitely ascertained " insert the words " that the child was stillborn ".

FORM G

REGISTER OF CREMATIONS

carried out by

at the Crematorium at

No.	Date of crema-tion	Name, resi-dence, and occupa-tion of deceased	Age and sex	Whether married or un-married	Date of death	Name and address of person who applied for crema-tion	Names and ad-dresses of persons signing certi-ficates	District where death has been regis-tered	How ashes were dis-posed of

NOTE—Additional particulars may be added in the form of Register by the Crematorium Authority.

FORM H

CERTIFICATE OF ANATOMICAL EXAMINATION

I (full name in block capitals) .....

am licensed to practise anatomy under the Anatomy Act 1832.

I certify that the body of:—

Full name .....

Age..... Sex.....

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

has undergone anatomical examination pursuant to the Anatomy Act 1832 at

(address of medical school or other place).....

Signature .....

Date .....

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