Presentation on the Registration of Death and the Coronial System

Introduction 2

Registration and certification of deaths 2

Historical context of death registration in England and Wales 2

Current position re. death registration and certification in England and Wales 11

Death certification in Scotland 13

Death certification in Northern Ireland 14

Investigations into certain types of death 15

Coronial system in England and Wales 15

The Fatal Accident Inquiry System in Scotland 22

The Coronial System in Northern Ireland 27

Evidence relating to concerns about death reporting and investigations 28

Guidance provided to coroners 38

Information gathered by geographical area 38

Newcastle 39

Birmingham and Solihull 42

Oxfordshire 44

City of Manchester 48

Manchester North 49

Liverpool and Wirral 50

West Yorkshire (Leeds) 52

Inner South London 52

Cardiff 52

Northern Ireland 53

Scotland 54

Smaller coronial areas 54

Evidence relating to vCJD reporting 60

Appendix A: COPFS FAI Process Flowchart 62

Introduction

1. This presentation addresses the registration of death and the system for investigating the causes of certain types of death in each part of the UK. It also identifies various issues that have been raised in evidence to the Inquiry regarding death reporting and certification, and investigations into deaths. Finally, the presentation explores the evidence obtained by the Inquiry regarding the reporting of Hepatitis C and HIV deaths across a sample of geographical regions of the UK.

Registration and certification of deaths

Historical context of death registration in England and Wales

2. A national, statutory system of death registration was first enacted in the Births and Deaths Registration Act 1836 which established the General Register Office ("GRO"), although this did not require the cause of death to be certified by a medical practitioner. The Births and Deaths Registration Act 1874 ("the 1874 Act") required that the death and cause of death of every person dying in England and Wales be recorded by the registrar (s. 9 and s.51). Section 20(2) provided:

> "*In case of the death of any person who has been attended during his last illness by a registered medical practitioner, that practitioner shall sign and give to some person required by this Act to give information concerning the death a certificate stating to the best of his knowledge and belief the cause of death, and such person shall, upon giving information concerning the death, or giving notice of the death, deliver that certificate to the registrar, and the cause of death as stated in that certificate shall be entered in the register, together with the name of the certifying medical practitioner.*"

3. The Births and Deaths Registration Act 1926 stipulated that every certificate of cause of death under s. 20 of the 1874 Act be made on a prescribed form and delivered to the registrar (s. 6). Where there was no registered medical practitioner in attendance during the last illness, the registrar reported the death to the coroner.

4. In 1964, the British Medical Association ("BMA") published a report, "Medico-legal Investigations of Deaths in the Community", which raised concerns about the accuracy of information contained on death certificates and possible undetected homicides.[1]

5. A Home Office departmental committee of enquiry was established in 1965, led by Mr Norman Brodrick QC, to examine the coronial system and the system of death certification. Its terms of reference were to review: (i) the law and practice relating to the issue of medical certificates of the cause of death and for the disposal of dead bodies; and (ii) the law and practice relating to Coroners and Coroners Courts, the reporting of deaths to the Coroners and related matters, and to recommend what changes were desirable.

6. In 1968, the Registration of Births, Deaths and Marriages Regulations 1968 were passed to prescribe the forms to be used and particulars required for death registration. A report to the coroner was required where there was a gap of more than 14 days between the last doctor's visit and the death (regulation 51(1)(c)).

7. The Committee on Death Certification and Coroners reported in 1971 ("the Brodrick Report"). It made a variety of recommendations, including that:

> *"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 ...; and*
> >
> > *(ii) have attended the deceased person at least once during the seven days preceding death...*
>
> *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...; 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. ...*
>
> *4. A qualified doctor should issue a certificate of the fact and cause of death only if:*

[1] BMAL0000097. See also BMAL0000096 e-p.4, e-p.9

(i) he is confident on reasonable grounds that he can certify the medical cause of death with accuracy and precision;[2]

(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; ... "[3]

8. The Home Office established a Working Party to consider the Brodrick Report in 1977; the Working Party produced an interim report in 1977.[4] Some of the Brodrick Report's recommendations were implemented by way of amendments to the Coroners (Amendment) Rules 1977 and Coroners (Amendment) Rules 1980, consolidated in the Coroners Act 1980 and the Coroners Rules 1984. The recommendations which were implemented included:

   a. Coroners to have the power to transfer jurisdiction.

   b. Coroners to have the power to order exhumation.

   c. Coroners no longer required to view the body.

   d. Properly interested persons to be informed of inquest arrangements.

   e. Interim certificates of the fact of death to be provided.

   f. Abolition of mandatory juries. This was a partial implementation of the Committee's recommendation that coroners should have complete discretion on when to sit with a jury.

   g. Power to admit documentary evidence.[5]

9. On 25 February 1982 the Registrar General wrote to a number of medical bodies seeking their views on implementing the outstanding recommendations from the Brodrick Report.[6] The Registrar General wrote:

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[2] This was to replace the requirement that the doctor should state a cause of death which was true to the best of his knowledge and belief.
[3] RLIT0001844
[4] An interim report is at HOME0000258. The Inquiry has, at present, been unable to identify a final report.
[5] For a summary of the Brodrick Report recommendations, see RLIT0001844 pp.346-360.
[6] HOME0000058_100

"REPORT OF THE COMMITTEE ON DEATH CERTIFICATION AND CORONERS (BRODRICK REPORT) ...

The Committee reported in 1971 (Cmnd 4810) and although some of the recommendations involving the coroner have been implemented, the main proposals in Part 1 about the medical certification of the cause of death have yet to be brought into effect.

The passage through Parliament last year of a private member's Bill, now the Industrial Diseases (Notification) Act, re-awakened the general desire to implement the recommendations for improving the system of medical certification of the fact and cause of death. I have now been asked to consult the medical profession on whether a further Bill should be prepared to implement those recommendations which are concerned with the certification and registration of deaths and reports to coroners.

The relevant Brodrick recommendations are contained in Part 1 of the Report and can be described in general terms as follows:-

(a) The doctor would be obliged to inspect the body before completing the certificate. At present this is not a legal requirement. Before a doctor was allowed to certify the fact and cause of death for registration purposes he would have to be a fully registered medical practitioner (Recomm 1(i)) and must have attended the deceased person at least once during the seven days preceding death (Recomm 1(ii)).

(b) The doctor in attendance would have a duty either to certify the fact and cause of death to the Registrar or report the death to the coroner (Recomm 2 (ii)).

(c) The doctor completing the certificate, who at present states the cause of death "to the best of his knowledge and belief" would in future be required to issue a certificate only if he could state the cause with "accuracy and precision". (Recomm 4(i) and 13(i)). If he could not do this then he would be obliged to report the death to the coroner and leave the cause of death to be established by him.

(d) There would be a new category of "reportable" deaths which would include those which are at present reported to the coroner by the Registrar. In future these would have to be reported to the coroner by the doctor. (Recommit 3).

(e) A coroner to whom a death was reported would be required to certify the cause of death to the Registrar, not only as at present where a post mortem examination has been held by his direction or if he has held an inquest, but also in cases where he accepted a cause of death given to him by a doctor in the course of his enquiries.

These recommendations were made 10 years ago and it is time to consider whether they command support now. Although consultations are still at their very earliest stages, the members of my Medical Advisory Committee have considered these proposals and they came down in favour of the proposals numbered (b), (d) and (e) but were opposed to the recommendation (c). On (a) they were sympathetic to the proposal that in every case the doctor should be required to inspect the body before completing the certificate and that only a fully registered medical practitioner should be allowed to certify, though they considered this would involve a big change in hospital procedures. However, they did not agree with Brodrick's recommendation that the doctor should not be entitled to certify unless he had attended the patient during the last seven days of life. They thought this should be extended to 14 days.

My Advisory Committee were not in sympathy with proposal (c) because there was a belief that many doctors who, if told that they could only certify the cause of death if they could do so "with accuracy and precision", would react by refusing to sign the certificate at all. In examining this proposal I would ask that you bear in mind that the Brodrick Committee recognised that without the benefit of a post mortem examination it is impossible for the doctor to know the cause of death in the absolute sense and that the Committee was prepared to accept a standard of confidence which was expressed as follows:- "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". The actual wording proposed by the Brodrick Committee to be used on the medical certificate of cause of death was "I m confident that the cause of death was that recorded above". I should be particularly grateful for your views on whether this wording has the balance of advantage over the present phrase "to the best of my knowledge and belief".

In addition, it must be borne in mind that the Brodrick Committee in making these recommendations sought to encourage a doctor not to give a medical certificate of the fact and cause of death if he was in any doubt about the cause of death. It is

appreciated that these proposals, having the general aim of improving the accuracy with which the cause of death is determined, might lead to an increase in the number of post mortems. The effects on expenditure and on the work-load on coroners and pathologists as well as the possible reactions of the public will therefore need careful consideration. I should be very glad to receive any comments which you may wish to sake both on the Brodrick proposals and on the preliminary views as expressed by my Medical Advisory Committee."

10. The BMA agreed that the period in which a medical practitioner must have attended should not be shortened from 14 days to 7 days and that certification should not be restricted to fully registered medical practitioners.[7] The Royal College of Pathologists supported the Registrar General's recommendations with minor provisos, albeit noting that they would lead to an increase in work for pathologists.[8] The Royal College of Surgeons was largely in favour of the amended recommendations,[9] as was the Royal College of Radiologists,[10] the Royal College of Obstetricians and Gynaecologists,[11] and the Royal College of General Practitioners.[12] See also an individual response[13] and BMA article by an interested Home Office Pathologist.[14] In its statement to this Inquiry, the GRO states that a letter was also sent to the Royal College of Physicians, the British Association in Forensic Medicine, the Joint Consultation Committee and the Association of Clinical Pathologists.[15]

11. A similar letter was circulated by the Home Office on 25 February 1982 to stakeholders including the Coroners Society,[16] the Association of Metropolitan Authorities,[17] the Association of County Councils,[18] and the Greater London Council.[19]

12. In reply, Dr John Burton of the Coroners Society considered that the difference between 7 and 14 days was 'marginal', and there was no need to change the 'best of his knowledge

[7] HOME0000058_067
[8] HOME0000058_071
[9] HOME0000058_073
[10] HOME0000058_075
[11] HOME0000058_077
[12] HOME0000058_076
[13] HOME0000058_081
[14] HOME0000058_065
[15] WITN7591001
[16] HOME0000058_102
[17] HOME0000058_103
[18] HOME0000058_104
[19] HOME0000058_105

and belief' wording.[20] The Association of County Councils contended that requiring cases to be referred to a coroner where a doctor had not attended for 7 days or more, and where a doctor could not state the cause of death "*with accuracy and precision*", would increase caseloads between a quarter and a third, increasing the costs of the service, and the justification for such an increase in costs was questioned.[21] The Director General of the Greater London Council was similarly concerned about additional costs in relation to post mortems and charges for removal of bodies to mortuaries.[22]

13. On 20 May 1982, the Assistant Secretary of the BMA wrote to the Registrar General:

> "*The General Purposes Subcommittee of the CCHMS at a recent meeting considered the proposals contained in the Brodrick Report. The Subcommittee broadly supported the proposals contained in the Report subject to the following views:-*
>
> *(i)* *That it is wrong to withdraw from pre-registration house officers the right to sign death certificates*
>
> *(ii)* *That the Subcommittee is opposed to the Report's proposal that the death certificate should be signed by a medically qualified practitioner who had seen the patient within the last 7 days. The Subcommittee wanted the 7 day period extended to 14 days. Certificates should be signed by any medically qualified practitioner.*
>
> (iii) *The need to retain the wording "to the best of his knowledge and belief" for the doctor stating the cause of death.*" [23]

14. On 26 May 1982, the Private Practice Committee of the BMA wrote to the Registrar General:

> "*The Committee feels that it must be stated, since your letter does not, that the recommendations of the Brodrick Committee have never been accepted by the medical profession, or indeed adequately discussed. You will know from our recent meetings with the Home Office, at which your own Department has been represented, that the view of the profession ie that some amendment to the death certificate is desirable,*

[20] HOME0000058_096
[21] HOME0000058_089
[22] HOME0000058_088
[23] HOME0000058_079

and we believe that this commends widespread support amongst all interested parties. From a statistical point of view, there is no doubt that the present death certificate yields inadequate, and often incorrect, information to your Department, and that this in turn has consequences for Public Health which are of more direct concern to the medical profession. The Committee believes that for the desired improvement to be brought about, the doctor completing the death certificate should be required to inspect and examine the body before doing so. However, it is concerned at the proposed restriction that the doctor must have attended the deceased at least once during the seven days preceding death. This will prevent the general practitioner from completing the death certificate in many cases, when he is in a position to do so with the degree of confidence that we regard as necessary. We are concerned that the consequences of this would result in an increase in unnecessary post mortem examinations. Besides the consequences in terms of public expenditure, this would result in unnecessary distress for the relatives, particularly where the religious persuasions of those relatives gives a fundamental objection to the carrying out of autopsy."[24]

15. The responses were summarised by the General Register Office and provided to the Home Office.[25]

16. An internal Home Office memorandum dated 7 December 1982 summarised the consultation responses.[26] The memorandum noted that, in light of the consultation responses, the recommendations that a doctor should have seen the deceased within 7 days and should be required to certify the cause of death 'with accuracy and precision' should not be pursued. The memo proposed that a submission would be put up to Ministers, jointly with the General Register Office. However, this does not appear to have been pursued.[27]

17. In 1985, a Coroners Working Party was convened by the Home Office with membership drawn from various coroners and civil servants within the Home Office. The remit of the Working Group was "*To consider means of increasing the efficiency of the coroner*

[24] HOME0000058_080
[25] HOME0000058_069 and HOME0000058_064
[26] HOME0000058_011, see also HOME0000058_015
[27] RLIT0001826 e-p.102, p.88

system.[28] The group met on 21 January 1985 and circulated an update to coroners with an appendix of relevant recent Parliamentary Questions, including the Government's response that there was no immediate plan to implement a recommendation of the Brodrick Report to extend a right of appeal against coroners' decisions.[29]

18. It was also recognised in correspondence between the Crown Office and the Home Office in July 1985 that there was a need to update the Brodrick Report's recommendations in respect of Scotland given legislative and administrative changes there.[30]

19. In 1986, the BMA published an updated report, 'Deaths in the Community', with the purpose of informing medical practitioners of their statutory obligations and making recommendations for further reform.[31] This BMA report described the Brodrick report as 'placatory'.[32] The BMA report made a number of recommendations, including: a statutory requirement to notify the coroner in certain categories of death, improved funding for pathology services, consolidation of coronial districts into larger regions, and training for coroners.[33]

20. On 16 March 1988, a meeting was held between the BMA and the Office of Population Censuses.[34] At the meeting, it was acknowledged that *"nothing had happened by way of implementation with regard to registration of deaths"* since the Brodrick report. There was a discussion about how a statutory obligation on medical practitioners to report deaths to the coroner might be introduced.

21. In 2001, the Home Office established the 'Fundamental Review of Death Certification and the Coroner Services in England, Wales and Northern Ireland', led by Mr Tom Luce, which reported in May 2003.[35] The Report made a number of recommendations *"to deal with defects that we have identified – to create a service that has consistent and known national standards, that safeguards the public but makes good service to bereaved families a major priority, that is equipped with modern duties and powers, proper professional leadership, and the range of legal, medical and investigative and human*

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[28] HOME0000061_013
[29] HOME0000061_014
[30] HOME0000065_046, HOME0000063_010 and HOME0000065_051, HOME0000065_035
[31] BMAL0000096 e-p.4
[32] BMAL0000096 p.4, e-p.6
[33] BMAL0000096 e-p.21-22, p.33-35
[34] HOME0000067_010
[35] RLIT0001915

skills necessary for these purposes".[36] A subsequent Select Report committee noted that the Luce report had *"found the systems for the certification and investigation of deaths in England and Wales to be unfit for modern society".*[37]

22. In July 2003, the Shipman Inquiry chaired by Dame Janet Smith DBE published its Third Report, on 'Death Certification and the Investigation of Deaths by Coroners'.[38] It concluded there was: "*an urgent need for a more focussed, professional and consistent approach to coroners' investigations*" and recommended:[39]

a. Training for coroners;
b. Coroners to be legally qualified;
c. Training for coroner's officers;
d. The reporting doctor to provide a written account on a prescribed form;
e. Coroner's officers to seek information from relatives or those with knowledge of the deceased to verify and expand on information from health professionals;
f. Coroners to have the power to seize and compel the production of documents;
g. Coroners to have a discretion to certify the cause of death after investigation without an autopsy and / or without an inquest;
h. Pathologists to have access to the deceased's medical records;
i. Complex cases to have a team of investigators.

Current position re. death registration and certification in England and Wales

23. Section 15 of the Births and Deaths Registration Act 1953 ("the 1953 Act"), as amended by the Coroners Act 1988, provides:

> "*the death of every person dying in England or Wales and the cause thereof shall be registered by the registrar of births and deaths for the sub–district in which the death occurred by entering in a register kept for that sub–district such particulars concerning the death as may be prescribed.*"

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[36] At e-p.29.
[37] https://publications.parliament.uk/pa/cm200506/cmselect/cmconst/902/90204.htm#n2 See also the Home Office position paper published in response in 2004: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/251078/6159.pdf
[38] RLIT0001826
[39] RLIT0001826 p.211-212

24. Where there is no involvement of a coroner, which is addressed below, a relative, or an administrator from the hospital, will register the death with the registrar. They will provide the registrar with certification of the cause of death, completed by a registered medical practitioner. The registrar will then formally register the death and issue a certificate of registration of death (the death certificate).[40]

25. Section 22 of the 1953 Act sets out the requirements in relation to certifying the cause of death:

> *"(1) In the case of the death of any person who has been attended during his last illness by a registered medical practitioner, that practitioner shall sign a certificate in the prescribed form stating to the best of his knowledge and belief the cause of death and shall forthwith deliver that certificate to the registrar.*
>
> *(2) On signing a certificate of the cause of death under the foregoing subsection the medical practitioner shall give in the prescribed form to some qualified informant of the death notice in writing of the signing of the certificate, and that person shall, except where an inquest is held. . . touching the death of the deceased person, deliver the said notice to the registrar.*
>
> *(3) Except where an inquest is held into the death of the deceased person or a post–mortem examination of his body is made under section 19 of the Coroners Act 1988, a registrar to whom a certificate of cause of death is delivered under subsection (1) of this section shall enter in the register the cause of death as stated in the certificate, together with the name of the certifying medical practitioner.*
>
> *(4) The Registrar General shall from time to time furnish to every registrar printed forms of the certificates required to be signed by registered medical practitioners under subsection (1) of this section, and every registrar shall furnish such forms free of charge to any registered medical practitioner residing or practising in that registrar's sub–district."*

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[40] The CJA 2009 provides for a system of death certification under which all deaths in England and Wales that do not require investigation by a coroner will be subject to scrutiny by independent medical examiners. These provisions of the CJA 2009, ss. 19 and 20, are not yet in force. For further information, see: https://researchbriefings.files.parliament.uk/documents/CBP-9197/CBP-9197.pdf

26. The Registration of Births and Deaths Regulations 1987 (as amended by the Registration of Births and Deaths Regulations 1987 Amendment Regulations 2012) prescribe the relevant forms for the certificate of cause of death.

27. There is guidance for completing a medical certificate of the cause of death ("MCCD") for clinicians in England and Wales.[41] In 2019, the Chief Coroner also produced guidance on this subject.[42]

28. In Wales the Medical Examiner Service, hosted by the NHS Wales Shared Services Partnership, provides scrutiny for deaths that are not investigated by the coroner.[43] The service operates through four regional hubs. It commenced in 2021 and will scrutinise all deaths not referred directly to a coroner by a medical examiner from 2023. It is intended to ensure a review is undertaken into each death by a medical professional who is independent of the care provided to the deceased, allowing for (it is hoped) a more objective assessment and accurate recording of the cause of death.

29. As discussed below, in certain circumstances, the coroner must be notified of the death.

Death certification in Scotland

30. The position in Scotland is governed by the Registration of Births, Deaths and Marriages (Scotland) Act 1965 ("the 1965 Act"), as amended by the Certification of Death (Scotland) Act 2011. Under s. 22 of the 1965 Act, prescribed particulars are registered in relation to each death by the district registrar. Section 24, in relation to certificates of cause of death, provides:

> *"For the purpose of enabling information to be given... of the cause of death of, and any relevant medical information about, any person, any registered medical practitioner who was in attendance on the deceased during his last illness shall, within seven days, or such other period, not being less than two days, as may be*

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[41] See https://www.gov.uk/government/publications/guidance-notes-for-completing-a-medical-certificate-of-cause-of-death/guidance-for-doctors-completing-medical-certificates-of-cause-of-death-in-england-and-wales-accessible-version

[42] Guidance No. 31 Death Referrals and Medical Examiners: https://www.judiciary.uk/wp-content/uploads/2019/09/Guidance-No.-31-Death-Referrals-and-Medical-Examiners.pdf#page=5

[43] For further information, see https://nwssp.nhs.wales/ourservices/medical-examiner-service/

prescribed, after the death of the person, transmit to any person who is a qualified informant in relation to the death, or to the district registrar for a registration district, a certificate in the prescribed form attested, in the prescribed manner, by the medical practitioner stating to the best of his knowledge and belief the cause of death and such other medical information as may be prescribed…"

31. On 21 September 2018, the Chief Medical Officer for Scotland and the Acting Registrar General and Keeper of the Records of Scotland circulated 'Guidance for Doctors completing medical certificate of cause of death and its quality assurance' to doctors in Scotland.[44] This guidance explains the changes made by the Certification of Death (Scotland) Act 2011, including the introduction of independent reviews intended to monitor the accuracy of death certification. A randomised selection of the medical certificates of cause of death will be selected for review through the registration system and be scrutinised by a medical reviewer (s. 24(1A) and s.24A). This is done by the Death Certification Review Service, which is run by Healthcare Improvement Scotland.[45]

32. Enclosed with the same circular letter was Crown Office and Procurator Fiscal Service (COPFS) guidance for doctors to report certain deaths to the Procurator Fiscal.[46] In certain circumstances, addressed below, a death must be reported to the Procurator Fiscal.

Death certification in Northern Ireland

33. In Northern Ireland, the applicable legislation is the Births and Deaths Registration (Northern Ireland) Order 1976 ("the 1976 Order"), read together with the Coroners Act (Northern Ireland) 1959.

34. Section 21 of the 1976 Order provides that every death, the cause of the death and prescribed particulars must be registered by the registrar for the district where the body is found. Section 25, dealing with certificates of cause of death, provides that:

"*(1) The Registrar General shall furnish to every registrar forms of certificates of the cause of death for use by registered medical practitioners, and every registrar shall*

[44] RLIT0001096
[45] See https://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/death_certification.aspx. Also p. 6 of https://researchbriefings.files.parliament.uk/documents/CBP-9197/CBP-9197.pdf
[46] COPF0000107

furnish the forms free to any registered medical practitioner residing or practising in his district.

(2) Where any person dies as a result of any natural illness for which he has been treated by a registered medical practitioner within twenty-eight days prior to the date of his death, that practitioner shall sign and give forthwith to a qualified informant a certificate in the prescribed form stating to the best of his knowledge and belief the cause of death, together with such other particulars as may be prescribed.

(3) A registered medical practitioner shall not give an informant a certificate under paragraph (2) if—

(a) he or any other person has referred the death of the deceased person to the coroner under section 7 or 8 of the Coroners Act (Northern Ireland) 1959 [1959 c.15] or he intends so to refer the death; or

(b) he has reason to believe that the deceased person has died as the result of an industrial disease of the lungs.

(4) An informant shall, within five days from the date on which he receives it, deliver to the registrar a certificate given to him under paragraph (2), and the registrar shall enter in the register the cause of death as stated in the certificate."[47]

33. Certain deaths must be referred to the coroner, on which see below.

Investigations into certain types of death

35. In England, Wales and Northern Ireland, certain deaths are referred to the coroner to decide whether further investigation is required and whether an inquest should be held. In Scotland, the death is referred to the Procurator Fiscal who decides whether a fatal accident inquiry ("FAI") is required which will be carried out by a sheriff.

[47] Temporary modifications under the Coronavirus Act 2020 (c. 7), s. 87(2), Sch. 13 para. 28 are not reproduced here.

36. Inquests and FAIs are inquisitorial, investigative processes which seek to establish facts surrounding certain deaths. In contrast to litigation, inquests and FAIs are not adversarial processes with competing parties and the purpose is not to apportion blame.[48]

Coronial system in England and Wales

37. The coronial system in England and Wales has changed over time. There are currently 83 coroner areas and the Chief Coroner and Ministry of Justice plan to reduce this to around 75 by implementing mergers as senior coroners retire.[49] As at 1985, it appears that there were 159 coroner districts.[50]

38. Under the Coroners Act 1887 ("the 1887 Act") and previously, all inquests were conducted with a jury. Section 3 of the 1887 Act provided:

> "*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 a sudden death of which the cause is unknown, or that such person 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 within 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.*"

39. The 1887 Act was amended and supplemented by the following Acts, prior to consolidation under the Coroners Act 1988 ("the 1988 Act"):

    a. The Coroners (Amendment) Act 1926 required coroners to be legally or medically qualified (s. 1), made provision for the appointment of coroners (s. 2), introduced

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[48] However, some participants in inquests – particularly family members - would describe the process in practice as adversarial. See, for example, the 2009 Cullen Review into Fatal Accident Inquiries in Scotland which described the sheriff courts as *'intimidating and tend to have an adversarial atmosphere'*: see §3.3 of the Cullen Review.

[49] https://www.judiciary.uk/courts-and-tribunals/coroners-courts/coroners-appointments-contacts-and-areas/mergers-of-coroner-areas/#:~:text=There%20are%20currently%2083%20coroner%20areas%20in%20England%20and%20Wales.

[50] HOME0000060_006

the power to hold an inquest without a jury in certain cases (s. 13) and provided for post-mortem examination without an inquest where following the post-mortem the criteria for convening an inquest were not met (s. 21).

b. The Coroners Act 1954 made provisions for payment of fees and expenses to witnesses and doctors (s. 1).

c. The Coroners Act 1980 abolished the requirement for a coroner holding an inquest to view the body of the deceased (s. 1) and allowed for an inquest to be transferred to a different area (s. 2).

d. The Coroners' Juries Act 1983 and the Coroners (Amendment) Rules 1983 amended the procedure for summoning a jury.

40. The 1988 Act consolidated the Coroners Acts 1887 to 1980 and came into force on 10 May 1988. Under s. 8 of the 1988 Act the coroner was under a duty to hold an inquest where a body was lying within his district and there was reasonable cause to suspect that the deceased:

"(a) has died a violent or an unnatural death;

(b) has died a sudden death of which the cause is unknown; or

(c) has died in prison or in such a place or in such circumstances as to require an inquest under any other Act ..."

41. The coroner had a power to request a post-mortem without an inquest taking place under s. 19 of the 1988 Act.[51] Where a coroner was satisfied that an inquest was unnecessary, he or she was obliged to send to the registrar of deaths a certificate stating the cause of death as confirmed by a medical practitioner: s. 19(3) of the 1988 Act.

42. The coroner was required, at the end of the Inquest, to answer the questions of who the deceased was, and how, when and where the deceased came by his death: s.11(5) of the 1988 Act. In addition, a verdict was given. The possible "short form" verdicts were:

- Accident or misadventure;

[51] Other than in cases of a violent or unnatural death, or a prison death.

- Dependence on drugs / non-dependent abuse of drugs;
- Industrial disease;
- Lawful / unlawful killing;
- Natural causes;
- Open verdict;
- Road traffic collision;
- Stillbirth;
- Suicide;
- Want of attention at birth;
- Attempted / self-induced abortion;
- Death in the [name] disaster;
- Execution of sentence of death.

43. While this was the "official" list of suggested verdicts, the conclusion as to death could be in any particular form and simply needed to be expressed in concise and ordinary language so as to indicate how the deceased came by their death.

44. A coroner had no power to charge any person with a crime (such as murder, manslaughter or infanticide): s.11(6) of the 1988 Act.

45. Within 5 days of the completion of the inquest, the coroner was obliged to send to the registrar of deaths a certificate setting out information concerning death, the particulars of death required by the Births and Deaths Registration Act 1953 and specifying the time and place at which the inquest was held: s.11(7) of the 1988 Act.

46. In addition, Rule 43 of the Coroners Rules 1988 provided:

> *A coroner who believes that action should be taken to prevent the recurrence of fatalities similar to that in respect of which the inquest is being held may announce at the inquest that he is reporting the matter in writing to the person or authority who may have power to take such action and he may report the matter accordingly.*

47. Of note, there was no unifying body overseeing the work of each individual coroner nor was there a judicial head of the coronial system who might provide guidance on specific issues.

48. In 2013 the Coroners and Justice Act 2009 ("CJA 2009") was implemented, bringing wide-scale reforms to the coronial system in England and Wales. The CJA 2009 was accompanied by secondary legislation, including the Coroners (Investigations) Regulations 2013 and the Coroners (Inquests) Rules 2013. More recently, the Notification of Deaths Regulations 2019 have also come into force.

49. One key change in 2013 was the creation of the role of Chief Coroner, as judicial head of the coronial system.[52] The role of the Chief Coroner includes providing support, leadership and guidance for coroners in England and Wales; keeping a register of coronial investigations lasting more than 12 months; publishing Prevention of Future Death reports and responses; and monitoring the system where recommendations from inquests are reported to the appropriate authorities in order to prevent further deaths.[53] The Chief Coroner has issued guidance, fact sheets and law sheets on a variety of matters.[54]

50. In relation to the requirement to notify the coroner of a death, Regulation 2 of the Notification of Deaths Regulations 2019 requires a registered medical practitioner to notify the relevant senior coroner of a death if any of the specified circumstances apply, namely:

> *"(a) the registered medical practitioner suspects that that the person's death was due to—*
>
> *(i) poisoning, including by an otherwise benign substance;*
>
> *(ii) exposure to or contact with a toxic substance;*
>
> *(iii) the use of a medicinal product, controlled drug or psychoactive substance;*
>
> *(iv) violence;*
>
> *(v) trauma or injury;*
>
> *(vi) self-harm;*

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[52] For more information about the Chief Coroner, see https://researchbriefings.files.parliament.uk/documents/SN05721/SN05721.pdf

[53] https://www.judiciary.uk/courts-and-tribunals/coroners-courts/office-chief-coroner/#:~:text=The%20current%20Chief%20Coroner%20is,KC%20(2016%20%E2%80%93%202020).

[54] https://www.judiciary.uk/related-offices-and-bodies/office-chief-coroner/guidance-law-sheets/coroners-guidance/

(vii) neglect, including self-neglect;

(viii) the person undergoing a treatment or procedure of a medical or similar nature; or

(ix) an injury or disease attributable to any employment held by the person during the person's lifetime;

(b) the registered medical practitioner suspects that the person's death was unnatural but does not fall within any of the circumstances listed in sub-paragraph (a);

(c) the registered medical practitioner—

(i) is an attending medical practitioner required to sign a certificate of cause of death in relation to the deceased person; but

(ii) despite taking reasonable steps to determine the cause of death, considers that the cause of death is unknown;

(d) the registered medical practitioner suspects that the person died while in custody or otherwise in state detention;

(e) the registered medical practitioner reasonably believes that there is no attending medical practitioner required to sign a certificate of cause of death in relation to the deceased person;

(f) the registered medical practitioner reasonably believes that—

(i) an attending medical practitioner is required to sign a certificate of cause of death in relation to the deceased person; but

(ii) the attending medical practitioner is not available within a reasonable time of the person's death to sign the certificate of cause of death;

(g) the registered medical practitioner, after taking reasonable steps to ascertain the identity of the deceased person, is unable to do so." (Regulation 3).

51. Regulation 4 of the 2019 Regulations sets out the precise information that must be given by the registered medical practitioner to the senior coroner.

52. In addition, Regulation 4(1) of the Registration of Births and Deaths Regulations 1987 (as amended by the Registration of Births and Deaths Regulations 1987 Amendment Regulations 2012) obliges the registrar to report to the coroner a death:

"*(a) in respect of which the deceased was not attended during his last illness by a registered medical practitioner; or*

(b) in respect of which the registrar–

(i) has been unable to obtain a duly completed certificate of cause of death, or

(ii) has received such a certificate with respect to which it appears to him, from the particulars contained in the certificate or otherwise, that the deceased was not seen by the certifying medical practitioner either after death or within 14 days before death; or

(c) the cause of which appears to be unknown; or

(d) which the registrar has reason to believe to have been unnatural or to have been caused by violence or neglect or by abortion or to have been attended by suspicious circumstances; or

(e) which appears to the registrar to have occurred during an operation or before recovery from the effect of an anaesthetic; or

(f) which appears to the registrar from the contents of any medical certificate of cause of death to have been due to industrial disease or industrial poisoning."

53. Annual statistics are published by the Ministry of Justice. The most recent statistics, published on 12 May 2022, show that 33% of all registered deaths in England and Wales were reported to the coroner in 2021.[55]

54. Section 1 of the CJA 2009 imposes a duty on a coroner to investigate a death in their coronial area if the coroner has reason to suspect:

"(a) the deceased died a violent or unnatural death;

(b) the cause of death is unknown; or

(c) the deceased died while in custody or otherwise in state detention."[56]

55. At the request of a coroner, or by direction of the Chief Coroner, the investigation may be carried out by a different coroner than one in whose area the body is lying: ss. 2-3 CJA 2009.

56. Where a death is reported to a coroner, the coroner will make preliminary enquiries and undertake an investigation. A senior coroner may require a post-mortem to be carried out: s. 14 CJA 2009. If a person informs the coroner that the death was caused, wholly or in

[55] https://www.gov.uk/government/statistics/coroners-statistics-2021/coroners-statistics-2021-england-and-wales
[56] S. 1 CJA 2009.

part, by the improper or negligent treatment of a registered medical practitioner, that clinician must not make or assist in the examination of the body. They, however, are entitled to be represented at such an examination.[57]

57. If the coroner is satisfied that the cause of death is clear, the coroner may decide that there is no need to carry out a post-mortem examination or to hold an investigation: s. 4(1) CJA 2009. However, this does not apply if the coroner has reason to suspect that the deceased died a violent or unnatural death or died while in custody or state detention: s. 4(2) CJA 2009.

58. An inquest without a jury can either be held at a hearing or, if the senior coroner decides a hearing is unnecessary, in writing: s. 9C CJA 2009. The senior coroner cannot decide that a hearing is unnecessary unless he or she has invited representations from each interested person, it appears to the coroner that there is no real prospect of disagreement among interested persons as to the determination or findings that the inquest could or should make and it appears to the coroner that no public interest would be served by a hearing: s. 9C(2) CJA 2009.

59. The purpose of an inquest is to determine the answer to the following questions:

    (a) Who the deceased was;

    (b) How, when and where the deceased came by his or her death; and

    (c) *The particulars of death to be registered.*[58]

60. Where article 2 of the European Convention on Human Rights (the right to life) is engaged, the question of '*how, when and where the deceased came by his or her death*' is broadened to also include the question of '*in what circumstances the deceased came by his or her death'*: s. 5(2) CJA 2009.[59] Under article 2 ECHR the State has a positive obligation to investigate deaths in certain circumstances. A full discussion on article 2 inquests is outside the scope of this presentation. In the context of medical/hospital deaths, article 2 is usually engaged in more limited circumstances, namely in cases that

[57] S. 14(4) CJA 2009.
[58] S. 5(1) CJA 2009.
[59] See *R v HM Coroner for the Western District of Somerset ex parte Middleton* [2004] AC 182.

demonstrate system or structural dysfunction rather than "mere" negligence, or in exceptional cases where there is a denial of life-saving treatment.[60]

61. A determination – in the old language, a verdict – cannot be framed in such a way to suggest either criminal liability on the part of a named person, or civil liability: s. 10(2) CJA 2009.[61] A coroner, or a jury,[62] are forbidden from expressing an opinion about any other matter other than the questions set out above[63]: s. 5(3) CJA 2009.

62. However, paragraph 7 of Schedule 5 of CJA 2009, provides that where *"anything revealed by the investigation [of the coroner] gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the coroner must report the matter to a person who the coroner believes may have power to take such action."* A Prevention of Future Deaths report ("PFD") will be issued to people or organisations and a report is required responding to a PFD explaining what actions have been taken to reduce that risk. There were 440 PFD reports issued in 2021.[64] These reports are published online.[65] The Chief Coroner has produced guidance about PFD reports.[66]

63. For completeness, it is worth noting the recently updated guidance provided to doctors on the completion of the medical certificate of the cause of death. On the certificate, the section marked I(a) addresses the disease or condition leading directly to death; I(b)

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[60] See *Lopes de Sousa Fernandez v Portugal (2018) 66 EHRR 28, Fernandez de Oliveria v Portugal* (2019) 69 EHRR 8; *Maguire v HM Senior Coroner for Blackpool & Fylde and ors* [2020] EWCA Civ 738. Article 2 may, however, be more widely engaged where the deceased is deprived of their liberty or is a vulnerable person for whom the state has assumed responsibility. This issue is currently under consideration by the Supreme Court, which heard the appeal in *Maguire* in November 2022.

[61] The 2013 changes also removed some short form verdicts, none of which are relevant to this Inquiry.

[62] An inquest is usually held without a jury unless the senior coroner has reason to suspect that the deceased died while in custody or otherwise in state detention, and the death was a violent or unnatural one, or the cause of death is unknown. A jury must be used where a death resulted from the act or omission of a police officer or a member of a service police force or where the death was caused by a notifiable accident, poisoning or disease: s 7 CJA 2009. An accident, poisoning or disease is notifiable if notice is required under an Act to a government department or under s. 19 of the Health and Safety at Work Act etc 1974: see s. 7(4). Covid is not a notifiable disease: s. 7(5) CJA 2009.

[63] I.e. Who the deceased was, and how, when and where the deceased came by his or her death.

[64] https://www.gov.uk/government/statistics/coroners-statistics-2021/coroners-statistics-2021-england-and-wales#prevention-of-future-death-reports

[65] See https://www.judiciary.uk/publication-jurisdiction/coroner/

[66] See Chief Coroner's Guidance No. 5: https://www.judiciary.uk/guidance-and-resources/revised-chief-coroners-guidance-no-5-reports-to-prevent-future-deathsi/

should contain any other disease or condition, if any, leading to I(a); and I(c) to any other disease or condition leading to I(b). Part II should include other significant conditions contributing to death but not related to the disease or condition causing it.[67]

The Fatal Accident Inquiry System in Scotland

64. Investigations into deaths in Scotland fall within the responsibility of the Crown Office and Procurator Fiscal Service ("COPFS"). Prior to 2013, the COPFS was organised into 11 areas, each of which was headed by an area procurator fiscal, who was responsible for the work of his or her area and accountable to the Lord Advocate.[68] Each of the 11 areas had a dedicated deaths unit or area deaths specialist and there was a senior member of legal staff assigned to supervise the investigations of deaths.[69] In 2013 the Scottish Fatalities Investigation Unit ("SFIU"), a specialist division of the Crown Office, was established to investigate all sudden, unexpected, and unexplained deaths in Scotland.[70]

65. The relevant statutory framework, prior to 2016, was the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 1976 ("the 1976 Act").[71] The Fatal Accidents and Sudden Deaths Procedure (Scotland) Rules 1977 were the governing procedural rules.

66. Under the 1976 Act it was mandatory to hold an inquiry where the death occurred in an occupational context or where the deceased was in custody at the time of death (s.1(1)(a) 1976 Act).[72] There was a discretion to hold a FAI when it appeared to the Lord Advocate that it was expedient in the public interest that an inquiry should be held on the ground that the death was sudden, suspicious or unexplained, or it had occurred in circumstances such as to give rise to serious public concern: s. 1(1)(b) 1976 Act.

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[67] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1062236/Guidance_for_Doctors_completing_medical_certificates_Mar_22.pdf
[68] §2.12 of the Cullen Review, RLIT0001836.
[69] §2.13 of the Cullen Review, RLIT0001836 .
[70] 1 September 2022 letter from SFIU,COPF0000105.
[71] The Fatal Accidents Inquiry (Scotland) Act 1895 first introduced mandatory public inquiries before a sheriff and jury into the causes and circumstances of fatal accidents in the course of industrial employment: see §2.1 of the Cullen Review. The Fatal Accidents Inquiry (Scotland) Act 1906 amended the 1895 Act to include issues of fault or negligence: see §2.2 of the Cullen Review. RLIT0001836
[72] Unless criminal proceedings were concluded and the Lord Advocate was satisfied the circumstances of the death had been sufficiently established in the course of those proceedings: §2.4 of the Cullen Review. RLIT0001836

67. Unlike its predecessor Acts, there was no requirement for a sheriff to sit with a jury.[73] At the conclusion of the evidence and submissions heard at the FAI, the sheriff had to make a determination:

> *"(a) where and when the death and any accident resulting in the death took place;*
>
> *(b) the cause or causes of such death and any accident resulting in the death;*
>
> *(c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;*
>
> *(d) the defects, if any, in any system of working which contributed to the death or any accident resulting in the death; and*
>
> *(e) any other facts which are relevant to the circumstances of the death."*[74]

68. At the conclusion of the FAI, the sheriff clerk had to send to the Lord Advocate a copy of the determination of the sheriff and, on a request being made to him, send to any Minister or Government Department or to the Health and Safety Commission a copy of key documents (such as the inquiry transcript, reports and the determination): s. 6(4) of the 1976 Act. However, the sheriff was not permitted to make any finding of fault or negligence.[75]

69. At the end of the FAI, the procurator fiscal had to send to the Registrar General of Births, Deaths and Marriages for Scotland the name and last known address of the person who had died and the date, place and cause of his death: s. 6(5) of the 1976 Act.

70. In 2009, the report of a review, chaired by Lord Cullen, was published considering the fatal accident inquiry legislation.[76] Lord Cullen noted that of the circa 14,000 deaths reported each year '*the need for a FAI arises in only a very small fraction of cases.*'[77] Lord Cullen described the '*wide discretion*' given to the Lord Advocate in a variety of situations:

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[73] §2.3 of the Cullen Review.
[74] S. 6(1) of the 1976 Act.
[75] See §2.9 of the Cullen Review.
[76] RLIT0001836
[77] See §2.14 of the Cullen Review.

"*such as an unexplained death in hospital or a death in circumstances suggesting a risk to public health or safety or a road accident on a bad stretch of road. Where there is a question of a discretionary FAI, the procurator fiscal has to report to the deaths unit which is part of the High Court Unit in Crown Office, with the views of the relatives of the deceased and his or her recommendations. It is for Crown Counsel, in consultation with the Law Officers where appropriate, to decide whether a discretionary FAI should be held, and for the procurator fiscal to apply for one if so instructed. A decision of the Lord Advocate to decline to apply for the holding of a discretionary FAI is open to challenge by judicial review.*"[78]

71. In his Review, Lord Cullen noted that there had been '*a considerable drop in the numbers of FAIs since the 1990s*'; from 141 FAIs in 1998/1999 to 57 in 2008/2009.[79] Lord Cullen recorded that COPFS attributed this to a reduction in road traffic collision deaths, deaths in custody and the workplace, and advances in medicine, rather than an underlying policy reason.[80]

72. One successful challenge to a refusal to hold an FAI was *Kennedy and Black v Lord Advocate* [2008] SLT 195. The judicial review was brought by the affected family members of people who died after being infected with HCV following NHS treatment.[81] Lord Mackay concluded that the Lord Advocate and the Scottish Ministers acted in a manner incompatible with their rights under Article 2, European Convention on Human Rights in deciding not to hold a FAI.

73. The Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 came into force on 14 January 2016 ("the 2016 Act"). The purpose of the legislation was to modernise the system of FAIs, largely accepting the recommendations of the Cullen Review.[82]

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[78] See §2.15 of the Cullen Review.
[79] See §2.18 of the Cullen Review.
[80] For a full consideration of the issues, see §2.18 of the Cullen Review.
[81] Mrs. Rosaleen Kennedy, the daughter of Mrs. Eileen O'Hara, who died on 7 May 2003, and Mrs Jean Black, the widow of the Reverend David Black, who died on 31 October 2003.
[82] See: https://www.webarchive.org.uk/wayback/archive/20150219113847/http://www.gov.scot/Publications/2009/11/02113726/14 The review made 36 recommendations, most of which were accepted by the Scottish government: https://www.gov.scot/publications/thematic-review-fatal-accident-inquiries/pages/3/

74. Under the 2016 Act there are several circumstances (that fall outside the remit of this Inquiry) where it is mandatory to hold a FAI.[83] Under s. 4 there is a discretion to hold an inquiry into a death which occurred in Scotland and the Lord Advocate considers that the death:

> *(a) ... (i) was sudden, suspicious or unexplained, or*
>
> *(ii) occurred in circumstances giving rise to serious public concern, and*
>
> *(b) decides that it is in the public interest for an inquiry to be held into the circumstances of the death.*[84]

75. Under s. 1 of the 2016 Act, the procurator fiscal must investigate the circumstances of a death and arrange for an inquiry to be held. An inquiry is conducted by a sheriff.[85] The purpose of an inquiry is to establish the circumstances of the death, and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances.[86]

76. In the context of medical deaths, in evidence to this Inquiry, the COPFS has stated that:

> "*the Procurator Fiscal will discuss with the reporting doctor the circumstances surrounding the death and any relevant medical history to determine whether a cause of death can be appropriately certified. In some cases, the doctor may be invited to seek further guidance on certification from a doctor based within the Death Certification Review Service (DCRS) (which is run by Healthcare Improvement Scotland). Following those discussions, where the reporting doctor is unable to issue an appropriate certificate of cause of death, the Procurator Fiscal will instruct a post mortem examination to enable a pathologist to determine the cause of death based on the autopsy findings and medical history.*"[87]

77. The sheriff must determine:

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[83] For example, it is mandatory for an inquiry to be held into the death of a person which occurred in Scotland and was the result of an accident while a person was acting in the course of their employment or occupation: s. 2(3) of the 2016 Act. It is also mandatory for an inquiry to be held where a person died in Scotland and they were in legal custody or were a child in secure accommodation: s. 2(3) of the 2016 Act. There are exceptions under s. 3 of the 2016 Act.

[84] Where the Lord Advocate decides not to hold an inquiry the Lord Advocate must give reasons, if reasons are requested to by the deceased's spouse, partner, "common-law" partner or relative: s. 9 of the 2016 Act.

[85] S. 1(2) of the 2016 Act.

[86] S. 1(3) of the 2016 Act.

[87] 1 September 2022 letter from SFIU, COPF0000105. See also Guidance for Doctors Completing Medical Certificates: RLIT0001096

"(a) when and where the death occurred

(b) when and where any accident resulting in the death occurred

(c) the cause or causes of the death

(d) the cause or causes of any accident resulting in the death

(e) any precautions which —

(i) could reasonably have been taken, and

(ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided

(f) any defects in any system of working which contributed to the death or any accident resulting in the death

(g) any other facts which are relevant to the circumstances of the death."[88]

78. It is not the purpose of an inquiry to establish civil or criminal liability: s. 1(3) of the 2016 Act. The sheriff has the power to make a recommendation which might realistically prevent other deaths in similar circumstances.[89] The recommendations are published by the Scottish Courts and Tribunals Service and a copy provided to the Lord Advocate, the participants in the inquiry, individuals to whom the recommendation is made and any other relevant person.[90] A response from the person to whom a recommendation is addressed is required in writing setting out what the respondent has done or proposed to do, or if no action has or will be taken, the reasons for that.[91]

79. After a determination is made, the Procurator Fiscal must give the name and last known address and the date, place and cause of death to the Registrar General of Births, Deaths and Marriages for Scotland.[92]

80. The overall FAI process is set out in a flow chart at Appendix A of this presentation. [93]

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[88] S. 26(2) of the 2016 Act.
[89] S. 26(1)(b) and (4) of the 2016 Act.
[90] S. 27 of the 2016 Act.
[91] S. 28 of the 2016 Act.
[92] S. 27(6) of the 2016 Act.
[93] From the Thematic Review of Fatal Accident Inquiries produced by the Inspectorate of Prosecution in Scotland, Annex A https://www.gov.scot/publications/thematic-review-fatal-accident-inquiries/pages/13/

The Coronial System in Northern Ireland

81. The governing legislation for inquests in Northern Ireland is the Coroners Act (Northern Ireland) 1959 ("the 1959 Act"). Section 7 provides that:

> "*Every medical practitioner, registrar of deaths or funeral undertaker and every occupier of a house or mobile dwelling and every person in charge of any institution or premises in which a deceased person was residing, who has reason to believe that the deceased person died, either directly or indirectly, as a result of violence or misadventure or by unfair means, or as a result of negligence or misconduct or malpractice on the part of others, or from any cause other than natural illness or disease for which he had been seen and treated by a registered medical practitioner within twenty-eight days prior to his death, or in such circumstances as may require investigation (including death as the result of the administration of an anaesthetic), shall immediately notify the coroner within whose district the body of such deceased person is of the facts and circumstances relating to the death.*"

82. Section 13 provides that a coroner may hold an inquest where a dead body is found or an unexpected or unexplained death, or a death in suspicious circumstances or in any of the circumstances mentioned in section seven, occurs. An inquest may be held without a jury, other than in certain stipulated circumstances, including where *"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"* (s. 18(1)).

83. The relevant procedural aspects of inquests and post-mortem examinations are set down in the Coroners (Practice and Procedure) Rules (Northern Ireland) 1963.

84. In 2006 the Coroners Service for Northern Ireland (CSNI) became a centralised body.[94] Prior to 2006, there were seven Coroner's districts with each district having a Coroner and deputy Coroner. Records of pre-2006 investigations are not searchable on the CSNI electronic database and so the information that is available is very limited.[95]

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[94] CSNI0000001
[95] CSNI0000001

Evidence relating to concerns about death reporting and investigations

85. The Inquiry has received evidence from a number of sources identifying a variety of issues relating to death reporting and subsequent investigations.

86. The Public Health & Administration Expert Group gave evidence to the Inquiry on 3 and 4 October 2022.[96] They were asked whether there are any systems or processes in place to ensure that death certificates accurately record the contribution of an infectious disease. Professor Vincent replied:

> "*Death certificates will record a number of different courses of death and which is given priority is up to the person who is filling that certificate. So everyone at the end of their life dies of cardiac arrest, that's the common theme, that might be the top, but what is underlying that is the question and I think that will vary from clinician to clinician what they put in. There probably are fashions with what goes on the death certificate. So I think for a broad brushstroke of one of the things killing people in the UK, they are very valuable but for very detailed work they are a bit too coarse.*"

87. He agreed that it was down to the individual clinician how the cause of death was recorded.

88. This is echoed by a study in 2000 by Roberts et al, which discusses the difficulty in achieving consistency in coronial decision-making in the 'grey area' between natural causes and accident / misadventure.[97]

89. Similarly, the guidance and training available to doctors during the relevant period on how to fill out death certificates may have contributed to a lack of consistency in overall reporting. An email from Mark Petrie (Golden Jubilee National Hospital) to Tracey Turnbull (NHS National Services Scotland)[98] dated 24 February 2011 regarding the Penrose Inquiry notes, on retrospective examination of a death certificate:

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[96] INQY1000251 p.108
[97] 'What is a natural cause of death? A survey of how coroners in England and Wales approach borderline cases', (2000) 57 Journal of Clinical Pathology 367-373: RLIT0001583, see also RLIT0001159
[98] PRSE0001247

"*Very little guidance was given with regards to how to fill in death certificates. Doctors have traditionally filled these important forms in with no formal training. I am not sure if this has now changed... The death certificate is important but given that these are usually filled in by junior doctors and the formal summary of admission by senior doctors most people would recognise that the discharge summary was preeminent*."

90. However, there is also evidence that on occasions the decision not to record HIV or Hepatitis C on a death certificate was a conscious one, as was the decision not to report deaths to the coroner.

91. One newspaper article dated 5 February 1987 titled "*Death Certificates hide AIDS truth*" stated that:

> "*DOCTORS are concealing the true number of deaths from AIDS to protect the feelings of bereaved relatives. Instead of recording AIDS on the death certificate, they are giving pneumonia 'or whatever comes to mind' as cause of death, according to a specialist in community medicine.*
>
> *'They don't want to upset relatives, so we may not have accurate figures about how many people are dying from AIDS,' explained Dr Marvin Schweiger, Leeds' medical officer for environmental health, who has predicted that 100,000 people in the city will be infected with AIDS by the year 2000.*
>
> *He called on doctors to ask themselves whether it was morally right to give misleading information when it was so important that accurate statistics were compiled in order to plan 'sensibly' for the growing AIDS epidemic.*
>
> *Dr Schweiger also questioned whether the overriding emphasis on confidentiality was obstructing the gathering of statistics and leading to 'double standards' in the medical profession.*
>
> *He said the need for confidentiality was stressed 'very vigorously' in all the DHSS guidelines on AIDS and as a result some doctors were reluctant even to record the AIDS diagnosis on hospital discharge notes.*

Doctors and nurses in the community were often left in the dark, he said.

'We should have practices and policies not to spread the disease but we won't even tell our nursing colleagues in the community about diagnosis.

'I think the whole profession needs to think very hard about the consequences of not reporting the incidence of AIDS and AIDS deaths,' he added.

But he recognised the problems that arose when AIDS patients refused to allow even close relatives to know of their condition.

'Wives can be totally unaware of the diagnosis and lives can be put at risk. If the patient doesn't give permission you can't tell anyone else.'" [99]

92. On 13 February 1989, at the Haemophilia Reference Centre Directors Meeting, the minutes record:

"*The increased number of deaths related to HIV was noted. Professor Bloom felt that clear guidelines should be established regarding referrals to the coroner. In Wales all transfusion-related HIV cases must be referred to him. This action is not general throughout the UK. It was observed that there were more deaths from cancer in the HIV negative patients. Dr Rizza drew attention to his final paragraph of introduction to the report on the 1987 Annual Returns; he made the point that other causes of death could have been related to HIV infection, e.g. septicaemia, etc.*" [100]

93. In a memo dated 5 October 1989, Miss Harrison of the Home Office asked the General Register Office whether a confidential box should be added to death certificates to allow doctors to tick whether a death was related to AIDS. This was suggested as a compromise to respect the need for privacy for families but still ensure that investigation by the coroner was undertaken where necessary. [101] The Inquiry has been unable to identify the reply, nor has the GRO[102].

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[99] SHTM0000651
[100] HCDO0000432, item 5
[101] MOJU0000013_057.
[102] WITN7591001, para 4.2

94. Minutes of the 21st Meeting of the AIDS Group of Haemophilia Centre Directors on 4 February 1991 record:

> "*Professor Bloom said that he had a very good rapport with the local coroner who did not hold inquests but he had been dismayed to get a phone call from another part of Wales from a patient's widow when an inquest was being held. He thought that this matter should be discussed by the AIDS Group Members. Dr Swinburne said that in Leeds no inquests were held and there was no need to report AIDS deaths to the coroner. Dr Jones said things were satisfactory now but it used to be a horrendous situation. Professor Bloom said he was particularly concerned about the situation with small Haemophilia Centres. Dr Mayne said the Group should keep the situation under review and if a problem developed then further action could be taken.*" [103]

95. On 16 September 1991, at the Sixth Meeting of the UK Regional Haemophilia Centre Directors Committee, the minutes state:

> "*Dr. Rizza presented a short written report (Appendix E). Dr. Savidge asked how many deaths go to the coroners court; he had several enquiries about this from Centres in his Region and he thought that there should be a Regional Centre Directors policy. Dr. Jones said that there had been some problems with funeral directors and maybe it would be a good idea for the Directors to have a policy. Dr. Rizza pointed out that it depended on what was written on the death certificate as to whether or not there was necessity for the case to be referred to the Coroner.*
>
> *Death Certification*
>
> *Dr. Hay said that there had been some problems with bereaved relatives who were keen that HIV should not be mentioned on the death certificate even though the death was HIV-related and he would appreciate guidance about this. Dr. Wensley said that the Manchester Coroner wished to know if a death was HIV-related. He was strict on this point and as a consequence all of the Manchester cases had autopsies. The press was usually at the Inquest and it was reported in the local papers. Professor Bloom said that the Coroner in his region insisted on being told and on holding an Inquest but there was no publicity. Dr. Hill said he had no problems with the undertakers.*" [104]

[103] HCDO0000539, item 8
[104] HCDO0000441 pp.7-8

96. On 7 October 1991, Dr Hay, Liverpool Haemophilia Centre Director, wrote to Mr Barker at the Haemophilia Society regarding HCV and liver disease, in the course of which correspondence he stated:

> "*The number of deaths from liver disease is undoubtedly increasing but it is to some extent masked by the effect of HIV. Many patients dying of AIDS. Cirrhosis may not be the primary cause of death and will therefore not necessarily appear on the death certificate. It is also more difficult to obtain post mortem examinations in HIV seropositive patients, either because of lack of local facilities or because of resistance from the relatives, and many cases of cirrhosis may therefore be missed for this reason. The physical signs of cirrhosis are unreliable and only a proportion of patients with cirrhosis of the liver will be clinically diagnosable.*" [105]

97. On 10 February 1992 at the 8th meeting of the UK Regional Haemophilia Centre Directors Committee, the following discussion was minuted:

> "*Dr Mayne asked if an agreed formula of wording for death certificates should be considered. Dr Lucas said he would welcome the agreed policy; the Coroner always wanted an inquest in the Manchester area. Dr Hamilton said that there were good relationships with the Coroner in the Newcastle area; they never put HIV on the certificate but they made sure that the Coroner knew about it.*" [106]

98. On 1 November 1993 at the 25th meeting of UK Haemophilia Centre Directors, it was noted that:

> "*...Dr Jones said that he did not put AIDS etc on the death certificate. There was some discussion about this and about the way that Directors filled in death certificates. Dr Jones was concerned that the information used when analysing the deaths of people with haemophilia should be the information provided by the Directors and not just the information, as given, on the death certificate. He was reassured that it was the Director's information that was used when compiling the Annual Returns and other reports.*" [107]

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[105] HSOC0012308
[106] HCDO0000443, item 11
[107] HCDO0000493, item 8

99. One regional example is found in a West Sussex policy document, 'Paper on Control of Viral Hepatitis and Human Immunodeficiency Virus Infections' which was published in 1994. Under the subheading 'Last Offices' at page 12 it recites *"...confidentiality must be maintained as in life. It may be appropriate to complete the death certificate in more general diagnostic terms..."* [108]

100. On 31 October 1995, R J Clifford in the Home Office wrote to Mr G Skinner at the NHS Executive HQ regarding concerns Mr Skinner had raised[109] about the approach of the Exeter coroner, Mr GRO-D, in holding inquests into all AIDS-related deaths:

> *"As I think you are aware, the general position is that coroners are independent judicial officers, and, subject to any guidance or determination on the matter by a superior court, it is entirely a matter for an individual coroner to decide what an 'unnatural' death is for the purposes of section 8 of the Coroners Act 1988. (This provision requires a coroner to hold an inquest where there is reasonable cause to suspect that the death was unnatural.)*
>
> *Although it would be perfectly possible for this Department to hold a different view about the interpretation of 'unnatural' in this context (not that we have so far sought the views of our lawyers), I am afraid that, even if we did, we would have no powers to require the Exeter or any other coroner to take the same view. I appreciate, of course, that a lack of consistency in these matters can give rise to real problems, but, short of legislation, or a test case, our powers are limited.*
>
> *It seems to me that there are three issues here: the unwelcome publicity for the relatives; possible misclassification of the cause of death, with, presumably, statistical implications; and inconsistency by the coroner himself, leading to doubts about his competence.*
>
> *As regards unwelcome publicity, advice has already been given to coroners about the possibility of adding to the distress of relatives by the insensitive handling of inquests*

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[108] WSUS0000068

[109] The Inquiry has been unable to definitively identify Mr Skinner's original letter. However internal DH correspondence can be found at: DHSC0006199_026 and DHSC0006199_027. In addition, there is a letter from the BMA to Professor Calman, Chief Medical Officer, dated 7 September 1995 asking what action was being taken: DHSC0006199_030.

into AIDS victims, and suggesting, for example, that the cooperation of the press is sought in reporting the proceedings with due sensitivity.[110]

The second and third issues are more complex. Any misclassification of death, or misrepresentation of the incidence of a particular cause of death, are obviously a cause for concern, although given that the views of the Exeter coroner do not, as far as I am aware, seem to be widely shared by his colleagues, the statistical significance of his decisions appears limited. Perhaps you would say if you disagree.

I have, of course, noted the observations that Mr GRO-D *appears to display an inconsistency in his approach to the recording of AIDS in the completion of death certificates. Responsibility for appointing a coroner lies with the relevant county council. There is provision for a coroner to be removed from office on the grounds of, amongst other things, inability, but responsibility for taking such a step lies with the Lord Chancellor. As far as the Home Office is concerned, a practice has been agreed between LCD and us whereby we would investigate any allegations of conduct which might provide grounds for the dismissal of a coroner. Before instituting such enquiries we would need to be satisfied that a formal complaint was being made, and to be provided with sufficient details of the cases in question to enable them to be identified and to give Mr* GRO-D *an opportunity to comment on the complaints made. You will appreciate from this that the process is quite open and that allegations need to be well-founded and to relate to misconduct or inability which, if found to be true, would justify considering the coroner's dismissal. Whether that is the case here seems to be a matter in the first instance for local registrars and medical staff to consider, rather than for us. Furthermore, it would clearly be difficult to reach conclusions as to his ability on the evidence of a single case, and where the proper course for redress would be to challenge the inquest, or specific interlocutory decisions, through the courts.*

In considering any such course of action I think it would be right to mention also that Mr GRO-D *has recently been elected the president of the Coroners' Society, and you will appreciate the sensitivities that flow from this. That in itself would make it more difficult for the Home Office to raise the matter informally with Mr* GRO-D

[110] The Inquiry has been unable to identify this advice.

nor has the Coroners' Society shown itself disposed to do so, although the matter has been drawn to the attention of the Honorary Secretary of the Society.

I should say that the issue has been discussed with experienced coroners from within the service. They considered that Mr GRO-D *views did not reflect the view of the majority of coroners, although it might be shared by a small number of other coroners. They did not consider that it was necessary or appropriate to issue guidance to coroners on the matter since it concerned an issue of legal interpretation that could be subject to judicial review.*

In the circumstances, it seems to me that there are two courses open to local doctors and registrars. One is to raise the matter with the coroner directly (it would appear from the correspondence that this has not so far been done) with a view to reaching a common understanding. As a medical/death registration matter, I see no reason why they should not approach him; indeed, they would be best placed to do so. The second is to reject his interpretation of 'unnatural' death, if they disagree with it, and to refer to him only those cases which they believe they are required to refer under the relevant legislation. (After all, the coroner can no more impose his interpretation of 'unnatural' on them as they can on him). This will not, of course, prevent Mr GRO-D GRO-D *from holding inquests into AIDS- related deaths because there may be other grounds for requiring the death to be reported. But it may help to reduce the problem of an AIDS-related death being the subject of an inquest solely because Mr* GRO-D GRO-D *regards them as unnatural deaths."* [111]

101. A letter was published in the Lancet on 23 March 1996 in which it was noted that Professor Michael Coleman, deputy chief statistician at the Office of Population Censuses and Surveys, had received legal advice[112] and was proposing *"to issue revised guidance to doctors and registrars of deaths which makes it clear that HIV-related deaths must ordinarily be regarded as 'natural'".* [113]

102. The draft guidance concerned when referrals to the coroner should be made and stated: *"The phrase 'unnatural death' ... has been the subject of a recent ruling by the law lords in the Appeal Court. We have received legal advice, based in part on this ruling,*

[111] DHSC0006199_025. See also DHSC0006199_018.
[112] DHSC0006199_009
[113] DHSC0006199_002

that death from AIDS should normally be viewed as a death from natural causes. Therefore, unless there are other grounds for referral to the coroner, a death from AIDS or ni an HIV-positive individual should not be referred to the coroner."[114]

103. There is also evidence that in the 1980s there may have been some reluctance to conduct post-mortems in cases of AIDS due to a perceived risk to staff:

a. A letter from Dr G C Sutton, Deputy Medical Referee, City of Wakefield, to the Home Office on 4 July 1988 stated that "*Our Health and Local Authorities are drawing up policies for AIDS, which will cover, inter alia, advice on disposal of the dead and would discourage post mortems except at a Coroner's request.*"[115]

b. Minutes of the Coroner's Working Party Meeting on 20 November 1989 at item (iii) (Post-Mortems in AIDS cases) recorded that: "*Concealment of AIDS as the cause of death created a risk for those carrying out post-mortems and those handling bodies in mortuaries. Mr Gill said that limited screening of cases entering the Leeds Public Mortuary was carried out but there was pressure from mortuary staff to extend it to virtually all cases, even though this was not foolproof. Unnatural and sudden deaths referred to the public mortuary amounted to about one third. A full screening process would cost an estimated £10,000 per annum. Dr Burton pointed out that all deaths generated potential risk and that mortuary attendants cannot be immunised against AIDS as for hepatitis... Dr Burton considered that post-mortem examinations should not normally be carried out on AIDS victims. If a post-mortem was necessary, it should be possible to arrange for this to take place at a centre specialising in the treatment of AIDS or those provided with facilities for remote post-mortem examinations. Miss Harrison undertook to ask the Department of Health for details of pathologists willing to conduct post-mortem examinations in AIDS cases.*" [116]

104. The evidence that the Inquiry has received from family members indicates that there is not a universal view on whether the fact of Hepatitis C or HIV/AIDS should have been recorded on the death certificate. There are witnesses who considered that it should have

[114] DHSC0006199_004, DHSC0006199_006 and DHSC0006199_007. The Inquiry has been unable to identify the final guidance that was published.
[115] MOJU0000013_079, reply at MOJU0000013_078 and internal DoH comment at MOJU0000013_041
[116] MOJU0000013_053

been included and others who considered that it should not. For example, one witness to the Inquiry whose father was infected with HCV and HIV has said:

> "*We made sure when my father died that his death certificate did not mention HIV or hepatitis C. It just says liver failure and states the symptoms of death rather than the cause to stave off any stigma attached to the hepatitis C infection.*" [117]

105. Another witness states that her mother pleaded with the registrar to remove AIDS from the death certificate.[118] Another records that the family asked the doctors to keep HIV off the death certificate because of the stigma involved.[119]

106. On the other hand a witness whose father died following HIV and HCV infection wrote:

> "*The cause of his death was recorded as pneumocystis pneumonia. I am angry that this was recorded on his death certificate, and that there was no reference to HIV or contaminated blood products. At the time, the doctors suggested they were protecting me by not recording HIV, when I think they were protecting themselves. They said if they put this specific type of pneumonia, no one would ask any questions. I do not know why they said this.*" [120]

107. In her oral evidence to the Inquiry about the death of her two sons, Susan Hallwood addressed what was written on their death certificates:

> *"Q: There is a point -- I know you want to make about the death certificates for the boys, ... we have got on the left Brian's certificate and on the right Stephen's. When we look at the cause of death it is bronchopneumonia and then haemophilia on the left, and on the right it is pneumonia and haemophilia. And your point, as I understand it, Sue, and tell me if I've got it wrong, please, is it wasn't haemophilia that killed them?*
>
> *A. No.*
>
> *Q. It was AIDS.*

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[117] WITN2507001 §5.13
[118] WITN1644001 §36. See similarly WITN1104001 §21.
[119] WITN3316001 §25 and WITN2336001 §28.
[120] WITN3113001 §20

A. Yes.

Q. And that's not on their death certificates.

A. That should have been -- I don't know if there was a reason why it shouldn't have been on there but they've got no right to put haemophilia. God knows what they're putting haemophilia for. They didn't die of haemophilia."[121]

108. Another statement from a woman about her son, who died on 26 May 1995, states that there is no mention of HIV or HCV on his death certificate. She states:

"*The registry told me that they put a mark on the death certificate so that people of medical knowledge could understand what it meant. They said that they could not write down HIV as a cause of death. I was very upset at the time. It was a deliberate policy not to write down blood borne viruses.*"[122]

109. The death certificate lists the causes of death as 1a Meningitis, Ib chronic sinusitis and bronchopneumonia and II Haemophilia. There is no observable mark on the copy of the death certificate provided to the Inquiry.[123]

110. The inquest process itself has also raised issues. The Inquiry has heard evidence of one example where a coroner released a statement to the press resulting in unwelcome media coverage of the death of a child and also retained material for research without seeking the family's consent.[124] A further witness gave evidence to the inquiry about a coroner giving permission for samples to be retained for study without consent.[125]

Guidance provided to coroners

111. As noted above, until 2013 there was no role of Chief Coroner. Therefore, the scope for overseeing the practices of individual coroners was very limited. The Coroners' Society of England and Wales is an unincorporated association whose objectives include, *inter alia*, the promotion of the usefulness of the office of coroner to the public and the

[121] INQY1000249 pp.49 and 50
[122] WITN1616001
[123] WITN1616007
[124] INQY1000253 p.23. p.50
[125] INQY1000040 p.130

protection of the rights and interests of coroners.[126] However, the Society '*does not issue guidance but newsletters, law sheets, circulars and guidance have been issued from time to time by the government department with coroner policy*'.[127] The Society's (paper) archives have been searched by a retired coroner and it was noted that within the archives, *"there is nothing of interest to the Inquiry. In particular as far as I am aware the Society never issued any advice to members."*[128] Another retired coroner who had held coronial office for 37 years stated that "*I have no recollection of any death being referred which might possibly be within the scope of this inquiry and I do not recall it ever being raised by members or at Council meetings!*"[129]

Information gathered by geographical area

112. The Inquiry has gathered evidence from a sample of locations to identify any possible themes relating to the nature of deaths that were referred and when inquests were held. It appears from the information gathered that there are considerable disparities in approach in different locations, and the existence and content of records that are available are highly dependent on individual decision making by clinicians, registrars and coroners.

Newcastle

113. The Inquiry has identified records for 25 deaths in the Newcastle area involving HIV and HCV contracted through infected blood/blood products, of which 6 resulted in an inquest being held. [130] Of those:

a. One reached a narrative conclusion, that death was the consequence of transfusion with infected factor VIII blood products.[131]

b. Three reached a verdict of misadventure.[132]

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[126] §3 of WITN7210001
[127] §19 of WITN7210001
[128] §8 of WITN7210001
[129] §9 of WITN7210001
[130] This presentation focuses on the coronial process and GRO records. There may be evidence from witness statements and other sources of further deaths involving HIV and HCV contracted through infected blood/blood products which are not included in the records reviewed for the purposes of this presentation.
[131] DCDR0000018
[132] DCDR0000024, CRNC0000005_006, CRNC0000018

c. Two reached a verdict of natural causes.[133]

114. One further death certificate recorded *"Hep. C & H.I.V. contracted as a result of contaminated treatment for Haemophilia A"* as a cause of death.[134]

115. Non-inquest files including form A, B and post-mortem reports up until 1994-1995 have not been retained. Therefore, no data is available to the Inquiry regarding the other 19 deaths that were identified as potentially relevant.

116. One of the inquest files which resulted in a verdict of misadventure in 1985, includes a medical report by Dr Peter Jones, Director of the Newcastle Haemophilia Centre, which states that:

> "*....It is my opinion that my patient acquired the disease which was the cause of his death as a result of the transfusion of blood or blood products. It is not possible to say with accuracy which products might have contained the AIDS virus HTLV III. However, present evidence suggests that the virus was more likely to be present in the imported products obtained from donations than from...(products)... obtained from volunteer donors within the United Kingdom Blood Transfusion Service….*"[135]

117. A note of Dr Jones' evidence to the court records him saying:

> "*...It is of the utmost urgency that all blood donations in the United Kingdom be screened as it gives us one of the only ways that we know at present of preventing the spread of this disease. Effective steps are being taken to combat AIDS and I call for urgency in the making available of these tests ... The Aids was transmitted either by factor 8 or whole blood - far more probably factor 8, during the course of proper treatment and not through any natural agency….*"[136]

118. In early 1986, Dr Jones delivered a paper[137] in a conference in Newcastle, in which he opined that:

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[133] DCDR0000026, CRNC0000008_007
[134] DCDR0000105
[135] CRNC0000005_002
[136] CRNC0000005_009
[137] DHSC0002169

"*The final vestige of confidentiality, and because of an insensitive response by the media, the privacy and dignity of affected haemophilic families is stripped away shortly after death by the decision of the Coroners' Society*[138] *to submit all cases to public inquest. Whilst I cannot, especially as the prescribing doctor, argue against the fact that death from AIDS contracted via haemophilia treatment is misadventure, I do question the concurrent need for personal publicity.*"

119. Soon afterwards, Dr Jones gave evidence at an inquest in 1986 which reached a verdict of natural causes; [139] Dr Jones welcomed this as likely to reduce the need for inquests to be held in similar deaths in future.[140] He wrote to Reference Centre Directors following the inquest:

"*I thought that you would like to have some good news for a change. As a result of great help from the Medical Defence Union and discussion with the Coroners' Society, our local Coroner has now taken the decision that he will not need to hold an open inquest on every AIDS-related death. This week he returned a verdict of natural causes on a 62-year-old man who died as a result of AIDS and cirrhosis. We still have two further inquests (both lymphomas) which have already been opened and adjourned to get through, after that we should be able to preserve the anonymity of the families.*" [141]

120. Dr Peter Hamilton has given evidence to this Inquiry that:

"*Because of the considerable stigmatisation of patients with Haemophilia and acutely in those with HIV and its association in the public mind with homosexuality it is my recollection that Dr Jones had come to an accommodation with the Newcastle Coroner to refrain from writing HIV/AIDS on the Death Certificate ... Not all coroners allowed this practice without discussion. On one occasion it took some persuasion I remember not to open an inquest into the death.*" [142]

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[138] The Inquiry has been unable to identify any note of such a decision of the Coroners' Society.
[139] CRNC0000008_005
[140] HSOC0015461, HSOC0015477
[141] HCDO0000271_074
[142] WITN4197005 9th October 2020, §99.1

121. As noted above, at a Haemophilia Centre Directors meeting on 1 November 1993, Dr Jones stated that he did not put 'AIDS etc' on death certificates. [143] In his witness evidence to this Inquiry, he alluded to the practice of writing "lymphoma" and "haemophilia" on a death certificate, being sufficient information for a doctor to infer that AIDS was the causal link without including it on the public record.[144] However, he confirmed that each individual death involving HIV/AIDS was referred to the Coroner's Officer.

122. The evidence of affected persons to this Inquiry from this region includes the following:

a. Diana Elizabeth Middleton, the sister of Graham Edward Fox who died in 1996, recalls: "*We were advised that AIDS would not be on his death certificate. We were informed that this would protect us from harassment.*" [145]

b. Emma Louise Frame, the daughter of Jeffrey George Frame who died in 1991, states: "*My father's death certificate says he died of bronchial pneumonia and Haemophilia A. My mother recalls that she was told to put this as cause of death and that there would be no mention of HIV or AIDS*". [146]

c. A further anonymous witness wrote of her husband: *"[GRO-B] death certificate does not refer to the cause of death as HIV. I did not ask the Coroner or doctors to record another cause of death instead of HIV and was not aware that this was an option. [GRO-B]'s brother dealt with matters after he died so he may have asked, although it is unlikely. I understood that [GRO-B] died of AIDS and a liver disease.*"[147]

Birmingham and Solihull

123. The Inquiry is aware from the coronial records of 73 relevant deaths of people who received blood transfusions or blood products in this region, of which 28 deaths are known to have been investigated by means of an inquest. Of those:

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[143] HCDO0000493, item 8
[144] WITN0841005 §95
[145] WITN1392001 §30
[146] WITN1594001 §32
[147] WITN3133001 §26

a. Twelve reached a verdict of accident or misadventure.[148]

b. Four reached an open verdict.

c. Three reached a narrative conclusion referencing contaminated blood:

i. "*Died from hepatocellular carcinoma caused by Hepatitis C following Blood Transfusion prior to 1991*", where the cause of death was listed as 1(a) hepatocellular carcinoma, (b) hepatitis C cirrhosis, (c) blood transfusion.[149]

ii. "*Died as the result of receiving a contaminated blood transfusion*".[150]

iii. "*Death as a consequence of viral infection from blood products.*"[151]

d. Others were concluded by way of a narrative, such as "*died following necessary surgery*".[152]

124. One inquest, conducted in 1989 and reaching a verdict of accident, documented on the face of the inquisition that the bronchopneumonia which was the proximate cause of death was "*Sustained by the above who was admitted to the Queen Elizabeth Hospital about two weeks before his death with a serious chest infection. Some years before, tests had revealed that he had been exposed to the HIV virus and then a few months before his death, it appeared that he was suffering from Acquired Immune Deficiency Syndrome. He had been a sufferer of Haemophilia A since a small child and over a period of about fifteen years had been receiving injections of Factor 8 for the treatment of his Haemophilia. Initially these injections were all imported and were not heat treated.*" [153]

125. A statement made to the Coroner in that case stated that:

"*[The treating consultant] is aware that in the past H.M.C. had held Inquests into these death[s], to establish the cause, but that it is now recognised by the*

[148] E.g. DCDR0000001
[149] DCDR0000002
[150] CRBI0000031
[151] DCDR0000003
[152] CRBI0000002. See also: CRBI0000009, CRBI0000005, CRBI0000032 and CRBI0000007.
[153] DCDR0000195 and CRBI0000030

Government, and he believes that they make a payment to the relatives. The death and condition is recognised." [154]

126. In another case where a death from HIV was recorded under the verdict of 'accident' and linked to Factor 8 injections,[155] the coroner Dr R M Whittington subsequently expressed concern about the press attention suffered by the family. He wrote to the widow of the deceased on 8 December 1989:

> "*I was very disturbed to learn that following the inquest ... concerning the death of your husband that you and your family were subjected to intense press attention. In fact, it made me very angry since you know I appealed to the press to treat the matter with sensitivity by which I meant that there should be no undue attention drawn to the family concerned. As you appreciate, I do not have any powers though over editorial decisions.*
>
> *It was alleged that I had been insensitive in holding the inquest, but I believe that I was obliged to do so as I was informed that the death was not natural as the infection was acquired accidentally through his very necessary treatment.*
>
> *I have learnt this week that Mr. Justice Ognall of the Queen's Bench Division of the High Court in London is holding confidential enquiries on behalf of Plaintiffs concerning HIV/Haemophiliac litigation. For this reason, I will not be holding inquests in similar circumstances in future, now that I have this knowledge that a full enquiry will be held before a competent court.*
>
> *I would once more, like to offer my condolences to you and your family following the death of your husband and also my apologies for the quite unwarranted attention that you received which I had honestly hoped to prevent whilst carrying out what I believe to be my legal responsibilities.*" [156]

127. The same Coroner wrote on 19 December 1989 to an academic correspondent regarding the same inquest:

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[154] CRBI0000030 p.10
[155] CRBI0000001_021, CRBI0000045
[156] CRBI0000001_025

"Thank you for your letter which I received with sympathy for all concerned. I have in fact held about half a dozen such inquests in the last year or two and there has been no publicity though for some reason they took a contrary view following the inquest on [the deceased]. I wrote to [his widow] afterwards and I believe the letter I sent explains the action that I have taken. I enclose a copy for your interest.

Enquiries with coroner colleagues reveal that there is a varying attitude to these unfortunate cases and some coroners hold inquests and some do not. I have therefore written to Doctor John Burton[157] *who is the secretary of the Coroner's Society suggesting that he co-ordinates a policy now that Mr. Justice Ognall's tribunal has been set up to ensure that coroner's treat these cases as Death by Natural Causes and no inquest is held."* [158]

Oxfordshire

128. The Inquiry is aware of 47 relevant deaths recorded in this coronial area, of which four are known to have resulted in an inquest. Of these four:

a. One was noted to have suffered from HCV but the Coroner did *"not know how he contracted it to start with but no information that it was not natural"*[159]

b. In another case it was stated on the inquisition that the deceased contracted an HIV infection due to being given contaminated blood products. The verdict was accident.[160]

c. The third case also featured an accident verdict, with the medical cause of death recorded as *"1a Disseminated Lymphoma 1b Haemophilia and HIV infection."*[161]

d. The Inquiry does not have the records pertaining to the last case, but there is correspondence (referred to below) suggesting that the verdict was one of natural causes.[162]

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[157] The Inquiry has been unable to identify this letter.
[158] CRBI0000001_017
[159] CROS0000001
[160] WITN3377003
[161] CROS0000009
[162] OXUH0001262_003

129. In relation to the latter case, the Coroner N G Gardiner wrote to Dr Rizza, Director of the Oxford Haemophilia Centre, on 17 April 1989:

> "*Further to our telephone conversation I did write to the Secretary of the Coroner's Society and he confirms my own view that there is no easy answer to the problem.*[163] *I understand that the Registrar General has issued general instructions to Registrars of Death*[164] *that if the infection appears on the Doctor's certificate they should not enquire how it was caught. For this amongst other reasons only a very small number of cases are likely to be reported to me at all and cases that are reported to me will normally be where the H.I.V. status of the deceased has nothing to do with the cause of death, e.g. a road accident or even a suicide or where although the H.I.V. might be the reason for the act it has nothing to do with the actual cause of death.*
>
> *The above does not however help in cases such as [initials provided]. Under Section 8 of the Coroner's Act 1988 where a Coroner is informed that there is a body in his district and there is reasonable cause to suspect that the deceased died an unnatural death then he shall hold an Inquest. "Unnatural" is not capable of exact definition but certainly if a person is infected e.g. as a result of voluntary sexual activities I would not regard it as unnatural. However, it is difficult to regard a transfusion as a natural process and if as in these cases I am told that a person was infected with H.I.V. as a result of a transfusion with a contaminated product and dies as a result of the infection I think I am bound to fulfill my statutory function. In essence it is difficult to distinguish such a case from a case where a person for whatever reason is given the wrong drug and dies as a result.*
>
> *The case of [names provided] is particularly unfortunate in that probably under the Registrar General's directive it need not have been referred to me at all but it was and has to be investigated. I am of course very well aware of the distress these cases can cause relatives particularly if publicity results, and will always do my best to minimise such consequences. I had expected [his widow] to give a brief statement to my Officer on the day that the Inquest was opened but she did not in fact do so and has not so far forwarded a statement. I hope for her sake that this does not mean she has to be*

[163] The Inquiry has been unable to identify this correspondence.
[164] The Inquiry has been unable to identify these instructions and the GRO has also been unable to identify it: WITN7591001 at para 3.1.

called to give evidence in Court when it could have been avoided. I do have certain powers to accept evidence in written form in lieu of calling the witness in person and I can direct that the written evidence should not be read aloud in Court. The Pathologist has given the cause of death as;

1a Disseminated Lymphoma

1b Haemophilia and H.I.V. Infection

I have not yet been given the information in formal fashion but it is my understanding that [the deceased] as a haemophilia victim was under the care of your unit and that at sometime in the past contracted the H.I.V. infection from blood products given to him. If this is the case then a statement from you on the lines of the one you gave in the [name provided] case is probably all that is required and unless you actually wish to attend could probably be accepted in documentary form. I would however have to give you formal notice of the hearing under Rule 20(2)(D) copy attached. If in your statement you are able to confirm with reasonable certainty the source of the infection and assuming I have no other information to the contrary I would not feel bound to enquire into other possible sources of infection although such negative evidence could conveniently have been included in a statement from [the wife of the deceased] A sentence such as "I have no reason to think the infection was contracted in any other way" would be quite sufficient.

I do not wish to put words into your mouth but if it is the case I would certainly have no objection to your saying that although contamination was a problem in the past advances in knowledge and testing procedures have eliminated it." [165]

130. Dr Rizza in his response simply recorded that *"In view of the large amounts of Factor VIII received by Mr X in his life-time and the lack of evidence that his HIV was contracted any other way one must accept that his HIV infection was transmitted to him by Factor VIII transfusion given to him…"* [166]

[165] OXUH0001262_007
[166] OXUH0001262_004

131. There is evidence of one relevant case in which the cause of death was found to be different on post-mortem examination from that certified by the attending doctor. On 17 March 1989, the Coroner Mr N G Gardiner wrote to Dr Rizza:

> "*I thank you for your letter of the 14th March. The Inquest was actually concluded on Wednesday and I had not realised your report was on its way to me.*
>
> *I think you know that the matter was originally reported to me because the registrar was unable to accept the cause of death as given by Doctor Welch which was;*
>
> *1a Pneumonia 1b HIV Infection 1c Haemophilia; HIV contracted from blood products*
>
> *It was of course only the last phrase which caused the registrar to refer the matter to me. Doctor Millard carried out a post mortem examination for me and he gave the cause of death as;*
>
> *1a Pulmonary Oedema 1b Coronary Artery Atherosclerosis 2 Haemophilia*
>
> *He said that the HIV status of the deceased was quite irrelevant to these causes and accordingly I returned a verdict that he died from natural causes.*
>
> *I should perhaps add that the impression I received from Doctor Millard and from the relatives that I saw was not that they were surprised that he died but more that they were surprised that he lived so long. The relatives certainly seemed most appreciative of the care given to him at your centre.*
>
> *As I understand your report the contamination (if there was any) would have been from products four to five years ago and I assume that techniques now used avoid this problem.*"[167]

132. In 1992, Dr Rizza went on to forward this correspondence to Dr Mayne at the Northern Ireland Haemophilia Reference Centre.[168]

[167] OXUH0001262_003
[168] OXUH0001262_001

City of Manchester

133. The Inquiry is aware of 42 relevant deaths in this coronial area, of which 13 are known to have resulted in an inquest. Of these:

a. Five resulted in a verdict of misadventure. One listed "*Contaminated Factor VIII*" as a cause of death at 1c,[169] another *"Haemophilia A treated with Factor 8"*,[170] the third *"treatment with Factor VIII for severe haemophilia"*,[171] the fourth *"infected blood given for haemophilia"*,[172] and the fifth "*HIV infection due to clotting concentrate for treatment of haemophilia*".[173]

b. Two others had a misadventure verdict without reference on the record of inquest to contaminated blood.[174]

c. One resulted in a narrative verdict which referenced contracting HBV and HCV infections from Factor VIII therapy.[175]

d. Two were recorded as deaths from natural causes.[176]

134. The practice of the Coroner, Mr Leonard Gorodkin, appears to have been to hold an inquest in cases where infection via contaminated blood was suspected. In one of the misadventure cases referred to above, Dr Hay, Director of the Manchester Haemophilia Centre, wrote to the Coroner on 3 April 2000:

> "*I am informed that it is your intention to hold an inquest. The cause of death here, is not in doubt and we did not request a post mortem. I do not understand why an inquest is necessary. I don't think we are going to learn anything new from such a process and I am concerned that it would only serve to cause the bereaved further upset. I would welcome the opportunity to discuss this with you further.*"[177]

135. Mr Gorodkin replied on 22 My 2000:

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[169] DCDR0000078
[170] CRMA0000023 p.3
[171] DCDR0000188
[172] DCDR0000377
[173] CRMA0000012
[174] DCDR0000090, DCDR0000020
[175] DCDR0000081
[176] DCDR0000131, CRMA0000036
[177] CRMA0000023 p.13

"*It is correct that I will be holding an Inquest, not because there is any doubt about the cause of death. But because the underlying cause appears to be unnatural. Your opening sentence states that the reason for HIV was acquired from blood product treatment in the early 1980s. It is this that makes the death from an unnatural cause.*

I agree that nothing new will be learned from the process, and that the family may well be upset. Neither of those are reasons for not holding an Inquest and in due course when I have all the information I will proceed to Inquest." [178]

Manchester North

136. The Inquiry is aware of 12 relevant deaths in this coronial area of which 5 led to inquests being held. Of those inquests:

a. Three reached a narrative conclusion referencing infection via blood and blood products.[179]

b. One reached a narrative conclusion which did not mention infected blood.[180]

c. One reached an open verdict.[181]

137. One of the deceased was Mr Brian Ahearn. His son Mr Liam Ahearn, daughter Ms Paige Ahearn and wife Mrs Jackie Ahearn have given statements to the Inquiry referring to their experience of the inquest process. Mr Liam Ahearn stated that:

"*27.They said at the inquest that the hepatitis resulted from the haemophilia treatment and so it came back with what we all knew. However, it is good that now we are certain this is where it all stemmed from.*

28. But for me it is just a reason and doesn't change anything. Personally, I felt we had to go through it all again with the pain and anguish that brings and we didn't really need to. I do think the coroner was good though and any questions I had were answered that day.

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[178] CRMA0000023 p.41
[179] CRMN0000004, WITN3983002, DCDR0000396
[180] DCDR0000205
[181] CRMN0000025

29. Having been asked, I think that for us to have had legal representation at the inquest could have helped. The medical professionals have studied for years and been to university and although we were afforded the chance to ask questions, we didn't know enough about it all to challenge them.

30. They could tell us something and we wouldn't know if it was correct. You don't question what they say based solely on their title, you need an understanding of the subject and so I think a legal professional could have helped." [182]

138. Mrs Jackie Ahearn stated that "*it felt good that it came back with cancer as a result of contaminated blood from his haemophilia treatment.*" However, a delay of 7 months to the inquest meant "*it has been drawn out for us. The hurt remained and with no closure, the grieving process could not be properly concluded.*" [183]

Liverpool and Wirral

139. The Inquiry is aware of 31 relevant deaths in this coronial area, including two where an inquest was held. One of those was recorded as a death by misadventure with *"blood transfusion"* at 1c,[184] and in the other case the deceased was recorded to have died by his own hand.

140. The Inquiry has received statements from affected witnesses from this region, including one that deals with the recording of the cause of death. Alison Bennett has provided a statement regarding the death of her son Alistair which recorded:

"*In Alistair's case the immediate cause of death was acute renal failure due to septicaemia, due to immunosuppression caused by HIV/AIDS. This is not accurately reflected on his death certificate (WITN0553009). I think this was obfuscation really. I think it was left off because the authorities did not want to admit that my son acquired HIV from his NHS treatment. I am aware that some families did not want HIV mentioned because of stigma and difficulties with funeral arrangements etc. Maybe the hospital was influenced by this. I have no wish to criticise the medical and nursing staff who provided exemplary care in Alistair's final illness but I was surprised that the true cause of death was not certified. I do think there was some attempt to obscure*

[182] WITN3985001
[183] WITN3983001 §187-189
[184] DCDR0000246

the truth. I feel this is likely to have been due to Government, Regional or Hospital policy decisions and instructions to certifying junior hospital doctors. I cannot prove it, but it is my suspicion."[185]

West Yorkshire (Leeds)

141. The Inquiry has identified 28 relevant deaths in this coronial region, of which only 2 led to an inquest being held. One reached a verdict of natural causes, albeit with a causal link to "*Transfusion of blood and blood products for haemophilia*" at 1c,[186] the other death by misadventure.

Inner South London

142. The Inquiry is aware of 50 relevant deaths in this coronial area, of which 11 are known to have led to an inquest. Of these:

a. Four were recorded as accidental death or misadventure, with reference to infection by blood transfusion or blood products. In one misadventure verdict, the cause of death included chronic liver failure due to Factor VIII treatment.[187]

b. Three others were recorded as accidental death or misadventure without reference to infected blood.

c. One reached a narrative conclusion without reference to infected blood.

d. One was recorded as a death from natural causes.[188]

e. In one case there was an open verdict.

Cardiff

143. The Inquiry is aware of 45 relevant deaths in the South Wales Central coronial area. Of these, 14 are known to have resulted in an inquest.

a. Two reached a verdict of natural causes, with reference made to previous administration of contaminated blood products.

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[185] WITN0553009 and WITN0553003 §12
[186] DCDR0000110
[187] DCDR0000322
[188] WITN0349003

b. One was recorded as an accidental death with reference made to HIV contracted from contaminated pooled blood products;[189] another as misadventure with *"haemophilia therapy"* listed as a cause of death,[190] and two more as accidental deaths concerning a "*recipient of contaminated blood products.*"[191]

c. Four reached an open verdict.[192]

144. In another case where an inquest was not convened, the death in 1989 was certified to have been caused by, *"1a. Brochopneumonia. b. Acquired Immune Deficiency Syndrome. c. Treatment for haemophilia."*[193]

145. A witness to the Inquiry whose brother's death in 1982 following a contaminated transfusion was recorded as solely due to Hodgkins disease has stated that:

> "*Upon Glyn's passing medical staff told my Mother and Father that if they consented to the cause of death being Hodgkin's and not hepatitis C (HCV) then the family could avoid a post mortem and that ultimately 'nothing would bring him back.'*
>
> *My Mother was adamant that she did not want a post mortem carried out on my brother as he had already been through enough. As such my parents consented to the cause of death being Hodgkin's on the death certificate and not hepatitis C (HCV).*"[194]

146. Another witness recalls that her mother's request that a post-mortem be carried out to investigate her father's death was refused because he had hepatitis, and it would require the room to be fumigated. His cause of death was recorded solely as leukaemia.[195]

Northern Ireland

147. The Inquiry is aware of 36 relevant deaths in Northern Ireland, but has no evidence that inquests were conducted into any of them. None of the death certificates reviewed refer explicitly to contaminated blood or blood products. None listed HIV and only one referred to "*Immune Deficiency*" as a cause of death.

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[189] DCDR0000197
[190] DCDR0000250
[191] Including DCDR0000329
[192] Including DCDR0000281
[193] DCDR0000338
[194] WITN2357001 §8.2-3
[195] WITN0695001 §2.9-12, §5.23

148. Dr Elizabeth Mayne, former Director of the Northern Ireland Haemophilia Reference Centre, has given evidence to the Inquiry. In answer to the question "*What was the Centre's policy as regards to recording information on death certificates when a patient had been infected with HIV or hepatitis?*" she stated:

> "*This question highlights a very difficult and thorny problem which affected all doctors in managing HIV deaths. I took the decision not to put HIV as a primary cause of death after a meeting of the HCDO at which the issue was discussed at considerable length and taking into account the great sensitivity surrounding the matter for families in Northern Ireland, especially in rural communities. ....*
>
> *There were a number of local religious reasons not to include HIV on the Death Certificate and there were also the paramilitaries who could use the information to exploit a family or individual. While HIV was not given as the primary cause of death, death certificates were filled in, in accordance with all rules and regulations. The primary cause of death, for example, pneumocystis pneumonia was stated. What was omitted was the secondary or tertiary cause of that pneumonia. However, all GPs and undertakers/funeral directors were personally informed that the death related to HIV so that all personnel involved with treating the body after death would be aware of the diagnosis.*"[196]

Scotland

149. The Inquiry is aware of 91 relevant deaths in Scotland of which at least 16 were reported to the Procurator Fiscal's Office. None appear to have resulted in a Fatal Accident Inquiry.

150. Judicial reviews were brought before the Scottish courts in respect of a failure of the Lord Advocate to apply for Fatal Accident Inquiries to be held into deaths caused by contaminated blood.[197] As noted above, the decision of Lord Mackay was delivered on 5 February 2008, upholding the claims.[198]

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[196] WITN0736009 §89
[197] COPF0000101
[198] https://www.scotcourts.gov.uk/search-judgments/judgment?id=7ea286a6-8980-69d2-b500-ff0000d74aa7

Smaller coronial areas

151. The Inquiry has also reviewed coronial records and death certificates in relation to smaller coronial districts.

152. In the Avon area, the Inquiry is aware of fourteen deaths involving HIV and/or HCV contracted through infected blood/blood products. Six deaths were reported to the coroner, inquests were held in three of those cases. Out of the fourteen deaths, nine of them did not record HIV or HCV among the cause(s) of death.

153. In Bedfordshire and Luton there were at least five deaths involving HIV and HCV contracted through infected blood/blood products. Three deaths were reported to the coroner, but there were no inquests. Three death certificates recorded HCV among the cause(s) of death, and one death certificate states the infection was "Transfusion Related".

154. In Berkshire there were at least seven relevant deaths, of which three were reported to the coroner. There were two post-mortems but no inquests were carried out. Only two death certificates recorded HIV and/or HCV as the cause(s) of death.

155. In the Black Country there were six relevant deaths, including two where there was a post-mortem, but no inquests. Three death certificates recorded HIV or HCV among the cause(s) of death.

156. In Blackpool and Fylde, the Inquiry has identified two relevant deaths, of which one resulted in an inquest. The verdict was misadventure, with reference made to transfusion-acquired hepatitis.[199]

157. The Inquiry is aware of 14 relevant deaths in the Brighton and Hove area, of which four were reported to the coroner and two resulted in an inquest. Four death certificates recorded HIV and/or Hepatitis as cause(s) of death, and two certificates referred to contaminated blood/blood products.

158. In Buckinghamshire the Inquiry has identified four relevant deaths and no inquests. The death certificates do not refer to HIV or contaminated blood.

[199] DHSC0100016_233

159. There were 18 relevant deaths in Cambridgeshire and Peterborough, none of which resulted in an inquest. One of the certificates refers to AIDS and Hepatitis C, 4 refer to HIV/AIDS, 5 refer to Hepatitis C only, 1 refers to Hepatitis B, 1 refers to Hepatitis C and Hepatitis B and 6 do not refer to the particular infection. None of the certificates refer to contaminated blood.

160. In Carmarthenshire and Pembrokeshire, four relevant deaths have been identified including one inquest, but with no reference to HIV/AIDS or no reference to infected blood.

161. There were also four relevant deaths in Central and South East Kent, two of which were investigated by way of an inquest. In one, a narrative conclusion was reached that death was the "*result of contracting the Hepatitis C infection. It is likely that the cause of the infection was from a blood transfusion given to him on 15/02/1991 during a coronary artery bypass graft*".[200]

162. The Inquiry is aware of nine deaths in the Cheshire area involving HIV and/or HCV contracted through infected blood/blood products. Inquests were held into five of those deaths. In one case the verdict referred to a blood transfusion contaminated with HCV.[201] In another, a verdict of misadventure was reached with reference to contaminated factor VIII.[202] In a third, a misadventure verdict was coupled with a finding that death was as a result of being given infected blood products.[203]

163. In Cornwall and Isles of Scilly, the Inquiry has identified 15 relevant deaths, and one inquest in 2002 which concluded the deceased died of infected blood products.[204]

164. The Inquiry is aware of two deaths in the County Durham and Darlington area involving HIV and/or HCV contracted through infected blood/blood products. An inquest was held for one of those deaths, and cause of death was recorded as liver cirrhosis and opiate toxicity; the post-mortem report referred to HCV acquired from a blood transfusion.[205]

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[200] DCDR0000010
[201] CRCH0000003
[202] CRCH0000002_001
[203] CRCH0000006
[204] The documents dealing with this inquest will be disclosed shortly.
[205] CRDD0000001

165. In Coventry the Inquiry has identified seven relevant deaths, none of which led to an inquest. None of the death certificates referred to infected blood.

166. Seven relevant deaths have been identified in Cumbria; there was one inquest, which followed a road traffic accident, and none of the death certificates made reference to contaminated blood.

167. In Derby and Derbyshire, nine relevant deaths have been identified. Five were reported to the coroner and there was one inquest which reached a verdict of accident.[206]

168. Ten relevant deaths have been identified in the Dorset area, resulting in three inquests; one verdict of misadventure[207] and two narrative verdicts explicitly referring to a causal link with infected blood.[208]

169. A further 11 relevant deaths have been identified in East Riding and Hull; only one, a drug-related death following an HCV infection, was investigated by an inquest.[209]

170. There were, to the Inquiry's knowledge, 17 relevant deaths in East Sussex, with four inquests resulting in one suicide verdict,[210] one verdict of accidental death[211] and two misadventure verdicts.[212]

171. In Exeter and Greater Devon, the Inquiry has identified seven relevant deaths none of which resulted in an inquest.

172. In Gateshead and South Tyneside there were two relevant deaths and no inquests.

173. The Inquiry is aware of four relevant deaths in Gloucestershire, and no inquests.

174. In Gwent there were eight relevant deaths, and no inquests.

175. In Herefordshire there were two relevant deaths and no inquests.

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[206] CRDS0000002. See also CRDS0000001 and CRDS0000003.
[207] CRDO0000021. See also CRDO0000020.
[208] CRDO0000003 and CRDO0000019. See also CRDO0000017, CRDO0000018_002 and CRDO0000002.
[209] CRER0000002
[210] DCDR0000030
[211] SKIP0000062_216
[212] DCDR0000013, DCDR0000014

176. The Inquiry is aware of eleven individuals in the Hertfordshire area. Only three deaths were reported to the coroner, and inquests were held in all three cases, with one verdict of suicide and two verdicts of accidental death.[213] Five death certificates list either Hepatitis or HIV as cause(s) of death, and one death certificate also includes "*treatment for haemophilia*".

177. The Inquiry has identified 46 individuals in the Inner North London area whose deaths involved HIV and HCV contracted through infected blood/blood products. Approximately one sixth of those had HIV or AIDS (or similar) listed on their death certificates. Approximately two fifths mentioned HCV or Hepatitis explicitly on their death certificates. A minority of those individuals had both. Only three individuals included the source of infection on their death certificates. Inquests were held in all three cases.[214] In two of the inquests, verdicts of misadventure were recorded. In relation to the third, a narrative verdict was given, that the deceased *"died of the consequences of Hepatitis C infection which resulted from repeated blood transfusions necessary for the treatment of Beta Thalassaemia Major".*

178. In Inner West London, on the evidence gathered by the Inquiry to date, there were no relevant inquests.

179. On the Isle of Wight one inquest resulted in a verdict of accidental death referring to transfusion of contaminated blood.[215]

180. The Inquiry is aware of eleven deaths in the Lancashire with Blackburn and Darwen area involving HIV and HCV contracted through infected blood/blood products. Four death certificates record HIV or HCV as a cause of death, and three of those certificates also include "haemophilia". Six deaths were reported to the coroner. An inquest was held into the death of one individual in 1998, after which the coroner recorded a verdict of "natural causes".[216]

181. In Manchester South, four relevant deaths have been identified, one of which resulted in an inquest which reaches a verdict of misadventure, recording at 1b: "*HIV infection*

[213] CRHE0000001, DCDR0000433 and DCDR0000434
[214] CRIL0000001, CRIL0000003 and DCDR0000022. In addition there was a further inquest where the record notes that the Deceased died from a fractured skull with a verdict of accidental death.
[215] NHBT0030291_106
[216] The Inquiry has been unable to obtain the inquest files.

due to clotting concentrate for treatment of haemophilia".[217] In Manchester West, there were 11 relevant deaths and one inquest, which reached a narrative verdict recording that liver disease had been caused by a contaminated blood transfusion.[218]

182. In Mid Kent and Medway, five relevant deaths have been identified, and no inquests.

183. The Inquiry has identified 12 relevant deaths in the Norfolk coronial area, but no inquests.

184. In North East Kent there were seven relevant deaths, and three inquests, one of which reached a verdict of misadventure,[219] one gave a narrative verdict[220] and another of natural causes.[221]

185. The Inquiry has identified 3 relevant deaths in North Lincolnshire and Grimsby and no inquests.

186. In North London, the Inquiry has identified 13 relevant deaths and one inquest, which reached a verdict of misadventure.[222]

187. The Inquiry is aware of seven relevant deaths in the North Wales (East and Central) area; three of these resulted in inquests which reached verdicts of accident.[223]In North West Wales, two relevant deaths have been identified, one of which led to an inquest. The verdict was natural causes, and infection with HIV due to haemophilia treatment was listed as a cause of death.[224]

188. In the North Yorkshire (Eastern) region, two relevant deaths have been identified, neither of which led to an inquest. In one case, infection due to factor VIII injections was listed as a cause of death on the death certificate.

189. In the North Yorkshire (Western) region, the Inquiry is aware of four relevant deaths but no inquests.

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[217] CRMA0000012
[218] CRMW0000001
[219] DCDR0000104, see also WITN1595001
[220] The document will be disclosed on Relativity in due course.
[221] DCDR0000015
[222] CRNL0000002_003
[223] DCDR0000008, DCDR0000009 and CRNW0000001. Further documents will be disclosed in due course.
[224] DCDR0000007 and CRNW0000002

190. In Northumberland, one relevant death has been identified, which was not reported to the coroner.

191. The Inquiry is aware of eight relevant deaths in Somerset; four led to inquests, one of which reached a conclusion of misadventure with an explicit reference to HIV due to infected blood products.[225]

192. Nine relevant deaths have been identified in South London; one resulted in an inquest and that was a death by suicide.[226]

193. In Suffolk four relevant deaths have been identified; one resulted in an inquest and that was a death by drowning.[227]

194. The Inquiry is aware of 14 relevant deaths in Surrey. An inquest was held in one case in 2017 which reached a narrative conclusion that the deceased died from medical complications to which he was susceptible due to Hepatitis C, which he contracted from an historic blood transfusion.[228]

195. Ten relevant deaths have been identified in the Swansea and Port Talbot coronial areas. There were two inquests, one resulting in a verdict of natural causes. In the other inquest, it was recorded that the deceased died from primary hepatocellular carcinoma following the development of cirrhosis of the liver caused by infection from the Hepatitis C virus; that the source of which was likely to have been from contaminated blood or blood products given to him by way of transfusion while undergoing surgery in June 1990.

Evidence relating to vCJD reporting

196. Peter Buckland has given evidence to the Inquiry about the death of his son, Mark Buckland, from vCJD.[229] An inquest into the death in August 2006 reached a narrative

[225] CRSO0000004
[226] CRSL0000011
[227] CRSU0000003
[228] DCDR0000413
[229] WITN0694001

verdict noting that he died as the result of infection with vCJD transmitted by an infected blood transfusion.[230]

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[230] WITN0694002, WITN0694006, WITN0694009

Appendix A: COPFS FAI Process Flowchart