CHAPTER SEVENTEEN

The Inquiry's Consultation Process: Responses to the Discussion Paper, the Seminars and the Feasibility Study

Introduction

17.1 In October 2002, the Inquiry issued a Discussion Paper, 'Developing a New System for Death Certification', which presented a 'working model' for a revised death investigation and certification system. The working model, which represented the Inquiry's preliminary ideas, was based on a redesigned coroner service, with medically and legally qualified coroners working side by side, but fulfilling different functions. Under the working model, the medical coroner would be responsible for investigating and determining all issues relating to the medical cause of death. The judicial coroner would determine the more complex factual issues and disputes and, where appropriate, would conduct an inquest. Both coroners would be supported by a team of trained investigators. The system would have a defined leadership, providing training, continuing education, advice and audit. Within the Discussion Paper was a set of forms designed by the Inquiry for use during the process of death investigation and certification. Those forms would replace the current MCCD and the cremation forms.

17.2 The purpose of publishing the Discussion Paper was to provide a focus, both for written responses and for discussion at a series of seminars held by the Inquiry in January 2003. The Inquiry received written responses to the Discussion Paper from 154 individuals and organisations. A list of those who submitted responses ('respondents') appears at Appendix E of this Report.

17.3 The seminars were spread over a period of nine days and covered the following topics:

(1) Preliminary observations at the scene of death and certification of the fact of death.

(2) Certification of the cause of death and identification of those deaths which require investigation.

(3) Systems for the investigation and certification of death in other jurisdictions (held over two days).

(4) How a medical coroner system might work: interface with the judicial coroner, the police and other investigative agencies (held over three days).

(5) The role of post-mortem investigations and possible alternatives and/or adjuncts to the full invasive investigation.

(6) The new-style forms.

17.4 The Inquiry invited a number of organisations with a particular interest or involvement in post-death procedures to nominate representatives to take part in the seminars. Those organisations included the British Medical Association (BMA), the Royal College of General Practitioners (RCGP), the Royal College of Physicians (RCP), the Faculty of Public Health Medicine, Cruse Bereavement Care (Cruse), the Royal College of Pathologists

(RCPath), the British Association in Forensic Medicine, the Department of Health (DoH), the Office for National Statistics (ONS), the Coroners' Society of England and Wales (the Coroners' Society), the Coroner's Officers Association, the National Confidential Enquiry into Perioperative Deaths (NCEPOD), the Retained Organs Commission, the Board of Deputies of British Jews, the Association of Chief Police Officers (ACPO) and the ambulance services. In addition, the Inquiry extended invitations to a number of individuals with a particular knowledge of post-death procedures.

17.5 Participants in the seminars submitted written responses to the Discussion Paper in advance and expanded on those responses during the course of discussion at the seminars. The discussions were led by Leading Counsel to the Inquiry and covered a wide range of topics, including many of the issues which had been raised by respondents to the Discussion Paper. Persons attending the seminars as observers were able to raise points through Counsel for the consideration of seminar participants. I found the seminars of real value. Hearing the Stage Two evidence had already changed some of my preliminary views and, before the seminars began, my ideas were in a state of flux. In bringing together a range of opinions on each contentious issue, the seminars helped me to reach conclusions about the system I should recommend.

17.6 A list of the participants who attended the seminars appears at Appendix F of this Report. Further written responses have been received since the seminars and these too have been taken into account. Mr Tom Luce, Chair of the Coroners Review, attended for two days of the seminars and made a short statement, setting out the Review's provisional conclusions as at January 2003. It was extremely helpful to me to be made aware of those provisional conclusions at that stage.

17.7 In the course of this Chapter, I shall refer to some of the most significant points raised in the written responses received by the Inquiry and in the discussions that took place during the course of the seminars. I shall deal with the seminars relating to the systems in other jurisdictions in Chapter Eighteen. I have already referred in Chapter Ten to discussions which took place at the seminar on post-mortem investigations.

The Objectives of a Revised System for Death Investigation and Certification

17.8 The Discussion Paper suggested a number of objectives for a revised death certification system. Such a system must be effective in minimising any risk of the concealment of the fact that a death has been caused unlawfully. Given the background to the Inquiry and the findings contained in my First Report, that must be a primary objective. However, it cannot be the only one. The system should also, insofar as possible, provide reliable and accurate data about the cause of death. This is important because such data provides the statistical and epidemiological information necessary to plan health services and public health strategies, to evaluate their effectiveness and to identify and deal with threats to the health of the population or public safety. The Discussion Paper laid particular emphasis on the need to obtain full and accurate information about the circumstances in which the death occurred and about the deceased person's state of health before death. The better the quality of this information, the more accurate the diagnosis of cause of death is likely to be. Such information is also necessary in order to determine which deaths require

investigation. One objective of the system must be to ensure that information of the best possible quality is available for these purposes.

17.9 The Discussion Paper also suggested that there was a need for the system to be understood by those people (usually bereaved relatives) most closely affected by it. It was envisaged that relatives could and should be involved in the investigation and certification process to a much greater degree than under the existing system. The system must also be capable of meeting, wherever possible, the needs and expectations of the bereaved, including those who, for religious or cultural reasons, wish to bury or cremate their dead within a very short period after death.

17.10 In consultation, the suggested objectives met with broad approval. Some respondents drew attention to the obvious tension that exists between the objectives of collecting as full and accurate information as possible about the death and of meeting the needs and expectations of the bereaved. It was suggested that any revised system should not be so unwieldy as to cause distress to the bereaved relatives or undue delay in disposing of the dead. The need for independence on the part of those charged with the task of investigating deaths was also emphasised. A number of respondents stressed the need for the system to ensure that lessons were learned from deaths found to have been preventable. This is an aspect that is central to the systems operated in some of the other jurisdictions about which the Inquiry heard during the seminars. Professor Stephen Cordner, Professor of Forensic Medicine and Director of the Victorian Institute of Forensic Medicine, who attended the third seminar, suggested that the appropriate objectives in an effective system of death investigation and certification would be:

> **'... to accurately identify the deceased and to elicit the proper cause and circumstances of the death so that justice is advanced, that duties to the bereaved (and the deceased) ... are discharged and so that the community interest is served by learning for the purposes of death and injury prevention'**.

17.11 I shall refer to Professor Cordner's views, and those of the other international contributors, in Chapter Eighteen.

The Bereaved – Should They Be Involved in the Death Certification Process?

17.12 The Inquiry's Discussion Paper envisaged that, in any future system of death investigation and certification, there should be much closer involvement of the deceased's family in the post-death procedures, particularly in providing and receiving information about the circumstances of the death and in verifying information given by the treating doctor and others. This proposal received widespread support although some respondents suggested that relatives might be distressed by, and resent as intrusive, questions about the circumstances of the deceased's death. At the seminars, Mrs Anne Viney, representing Cruse, referred to the need of bereaved people for accurate information and honest explanation. She believed that most relatives would welcome an increased role in the post-death procedures and the opportunity of contributing any knowledge that they might have about the cause and circumstances of the death. She said that an impression

that information is being concealed could impair the grieving process. She believed that those working in the coroner system could be trained to deal sensitively with families. She stressed the need to treat bereaved families 'like grown-ups' and to be aware that people's imaginings, or lack of knowledge, are often more distressing than being informed of the true facts.

17.13 Some respondents to the Discussion Paper expressed concern that greater involvement of families could result in delay in the conclusion of post-death procedures. Mrs Viney suggested that 'delay' meant a period of time that is greater than some expectation on the part of the public. In the context of a new system, the public would have to be clearly informed of how long the certification process (with and without an autopsy) could be expected to take and the system would have to be carefully costed and appropriately staffed so as to meet the expectations produced by that information. Targets and time limits should be set, performance should be monitored and the results published. A response submitted by Cruse after the seminars expanded upon this topic. It suggested that, once the public understood that the main aim of the system proposed for the future was to prevent untimely deaths and improve public health and safety, people were likely to accept that the timescale between a death and the funeral might, in some cases, be longer than at present. The important thing was for relatives to know what to expect, so as to be able to make plans and feel in control of their situation to a greater extent than at present. Cruse suggested that there should be a maximum period of no more than ten days between death and release of the body for burial or cremation, with the expectation that, in most cases, bodies would be released within a shorter period. Within such a timescale, arrangements would have to be made, wherever possible, to meet the needs and expectations of those minority groups whose religion or culture demanded an early funeral. Cruse also drew attention to the change in attitude, which I referred to in Chapter Four, whereby families now wish to have the body of a deceased relative removed from the house as soon as possible. This is in contrast to the tradition in the past, which was to keep the body at home, where relatives and friends would visit to pay their respects. Cruse suggested that a return to such a tradition would have a number of advantages; in particular, it was said that it would assist the bereaved in the grieving process. It might also, it was suggested, reduce pressure on the death investigation and certification system. Whether the public would be amenable to this sort of change, however, must be open to doubt.

17.14 Although respondents broadly welcomed the proposal for greater involvement of the family in the post-death procedures, they were not entirely unanimous in their support. In its written response to the Coroners Review, the Coroners' Society referred to the risk that bereaved relatives might try to influence the certification process. The Society observed that:

> **'... it is difficult to see how the majority of the bereaved can play a meaningful part in the process of certification, other than to try and influence its outcome, possibly for dubious reasons'**.

Comment

17.15 In my view this attitude towards bereaved families is mistaken. It may be that a few families might seek to influence the outcome of the certification process. However, if that risk

exists, it must be taken. There are two powerful reasons why that is so. First, common humanity demands that bereaved relatives should be treated with due consideration. I accept the views expressed, which accord with my own experience, that the bereaved generally prefer to be involved than to be excluded and usually welcome open and honest explanations. Second, the relatives and friends of the deceased constitute a valuable source of information, which may be vital to the proper investigation of the death. That source must be used. I accept that there is a risk that consultation with families might delay the certification process. That risk can be minimised by the provision of adequate resources.

The Desirability and Feasibility of Creating a New Role of Medical Coroner

17.16 In general, as I have explained, no medical expertise is currently available within the office of a coroner who has only legal qualifications. Advice may be obtained from time to time from the pathologists regularly instructed by the coroner. However, most of the decisions made by the coroner and his/her staff are taken without the benefit of independent medical advice. There was almost universal agreement among respondents that the introduction of some medical expertise into the coroner's office would be desirable in a revised system. There was, however, a division of opinion as to how this should be achieved.

17.17 There was a considerable amount of support for the principle of creating a post of medical coroner. For the ONS, Dr Peter Goldblatt, Chief Medical Statistician, welcomed the idea of a locally operated service, independent of health care providers, that would supervise the certification and investigation of deaths. He enumerated the benefits of such a service, including the potential for the medical coroner to monitor, and thus to improve, the quality of death certification, to educate the public and the medical profession in the working of the system, to monitor local mortality trends and to provide good quality mortality data and other information for use by the ONS and other agencies. Dr Goldblatt pointed out that, if the role of medical coroner were to command the respect of the medical profession, it would have to be equal in status to that of a consultant or principal in general practice and to have recognised standards of postgraduate training and specialist accreditation. Many other respondents echoed the points made by Dr Goldblatt. Mrs Marcia Fry, representing the DoH, expressed the Department's view that the suggested system would promote public health, public safety and public confidence.

17.18 The BMA also expressed the view that the introduction of a medical coroner had much to commend it. The main concern of the Association was whether, given current workforce shortages, the medical profession could provide enough suitably qualified candidates to fulfil the role. This was a concern that was shared by many respondents from within the medical profession and it was a theme that recurred throughout the seminars. The response of Dr John Grenville, a general practitioner who attended one of the seminars, was typical of many others. He pointed to the shortage of doctors within the UK and doubted whether many doctors would be attracted to work as medical coroners. Plainly, recruitment is a real problem at present, particularly in the field of pathology and, to a lesser but significant extent, in general practice. However, Dr Anne Thorpe, representing the BMA, believed that there might be little difficulty in recruiting candidates who were 20 years or so into their careers and looking for a change. She observed that, in order for that

to be so, there would have to be a proper career structure, with appropriate professional support and terms and conditions (in particular, remuneration), commensurate with the importance of the position. For the DoH, Mrs Fry agreed with Dr Thorpe that there would be a pool of doctors wishing to leave clinical practice and seeking an alternative. Medical coroners could be recruited from that pool. The Department's view was that such people would leave clinical practice in any event. They would not, therefore, be 'lost' to front line clinical practice solely because of the creation of the new position of medical coroner.

17.19 Professor Richard Baker, Director, Clinical Governance Research and Development Unit at the University of Leicester and himself a general practitioner, understood and shared the concerns of his colleagues about manpower shortages. However, he believed the solution was to approach the introduction of the revised system slowly and carefully. Doctors would need to be identified and trained to operate the system. It was important that they fully understood exactly what the system was intended to achieve. Professor Baker suggested that they might benefit from having some exposure to the systems in other jurisdictions about which the Inquiry had heard. He felt that it was only by proceeding with caution that the opportunities for creating a really first class system would be realised.

17.20 A number of coroners who responded to the Discussion Paper were completely opposed to the idea of a medical coroner and expressed the strong view that the objectives identified by the Inquiry could be achieved under the existing coronial system. In general, however, coroners accepted the need for the introduction of medical expertise into the coronial service. They took the view that the role of the person providing the medical expertise should be very limited and should be of an advisory and audit nature only. The Law Society agreed with this view. It contended that the separate but parallel jurisdictions of the medical and judicial coroners suggested by the Inquiry would give rise to potential conflict between the two, as well as to confusion in the mind of the public. Mr Christopher Dorries, HM Coroner for South Yorkshire (West), observed in his written response that the proposals would be **'a breeding ground for professional rivalries'**. There was obvious concern about the impact of the introduction of medical coroners upon the existing legally qualified (or 'judicial') coroners. Mr Michael Rose, HM Coroner for the Western District of Somersetshire, expressed the fear that the medical coroner would **'usurp the functions'** of the existing coroner and **'consequently sever the close connection between him and the area he serves'**. He was afraid that the work of the judicial coroner would decline and thus what he termed **'one of the many counterbalances to the excesses of Government'** would be removed. A number of respondents expressed the hope that, if the Inquiry's suggestions were implemented, both medical and judicial coroners would be placed within the same agency.

Comment

17.21 In my view, there is an urgent need for coroners with medical qualification. Many of the decisions now taken by legally qualified coroners depend upon medical judgement. In my view, it will not be sufficient (nor would it be appropriate) for the medical 'person' in the coroner's office to be of a lower status to that of the legally qualified coroner. I do not share Mr Dorries' concern that a lawyer and a doctor could not work together without damaging professional rivalry. There might in some cases be a clash of personalities; that can

happen in any organisation. I see no reason why it should arise particularly in a coroner's office. If a judicial and medical coroner were to work as part of the same team, each would have his/her own functions to perform and, where any decision called for both medical and legal knowledge or judgement, each would benefit from the other's contribution.

17.22 Insofar as the proposals might result in a reduction in the amount of work done by judicial coroners, I can only see that as a benefit. I do not accept that a local population would be less well served by a medically qualified coroner than one with legal qualifications. Nor do I accept that the changes proposed would in any way diminish whatever effect, if any, coroners presently have on Government. The evidence I have heard suggests that some coroners are overworked and give insufficient time (and possibly attention) to those duties for which they are not well qualified personally.

17.23 I recognise that the creation of a number of medical coroner posts would place a strain on the resources of the medical profession. However, it seems to be generally accepted that some medical expertise must be employed on coronial work. I am encouraged by the view expressed by the representatives of the DoH and BMA that, provided that the terms and conditions provide a proper career structure, there will be a pool of suitable candidates for the post of medical coroner. Moreover, these doctors would be seeking a change of direction in their careers and would be likely to leave clinical practice in any event.

The Position of the Medical Coroner within the System

17.24 The Discussion Paper sought views as to the way in which the system should be structured. Views were also invited about how best to assure the independence of medical coroners from those parts of the NHS responsible for delivering patient care, whilst not causing them to become professionally isolated. The need for independence (certainly from local NHS Trusts with whom their duties might bring them into a conflict of interest) was widely understood and accepted and the tension between independence from the NHS and professional isolation well recognised among respondents. A range of solutions was offered.

Should the Medical Coroner Be Integrated within Existing National Health Service Structures?

17.25 Some respondents believed that it would be possible for medical coroners to be employed by the new Strategic Health Authorities (SHAs) and still retain their independence. In its written response to the Discussion Paper, the RCPath expressed that view. The College regarded that as appropriate in view of the responsibility that the medical coroner would have for the accuracy of epidemiological data and also because medical coroners were likely to be recruited from NHS personnel. However, during the seminars, Dr Peter Acland, representing the RCPath, acknowledged his personal view that problems might be caused, for example, when a medical coroner was investigating a death that might have been caused by clinical malpractice at a local hospital. The public might well not perceive an individual employed by an SHA as truly independent of the Trust responsible for operating the hospital. Dr Thorpe, for the BMA, could see arguments for and against medical coroners being placed within NHS structures. The position of the

medical coroner would be a new one and the career path as yet uncharted. There was an obvious danger of professional isolation. There were links with public health that made it attractive to locate medical coroners within the SHAs. On the other hand, that would give rise to a division of accountability between medical and judicial coroners (who plainly could not be placed within the NHS), which would be undesirable. Placing the medical coroner within a unified coronial system might be more appropriate. Dr Thorpe also stressed the need for the medical coroner to be seen as independent of all medical structures. This issue of public confidence in the independence of the system was emphasised in a number of responses to the Inquiry's Discussion Paper.

17.26 The DoH favoured the location of the medical coroner service within the Government Offices of the Regions. Medical coroners would be independent officers, accountable to regional directors of public health and, through them, to the Chief Medical Officer (CMO). The Department's view was that this would solve the potential problem of professional isolation and would provide leadership, stability and continuity. Mrs Fry, speaking on behalf of the Department, felt that the fact that the accountability of medical and judicial coroners would lie in different directions would not present an insurmountable problem. She made the point that regional directors of public health are not involved in the day-to-day management and performance management of the Health Service and are directly accountable to the CMO, whom the public sees as independent of individual doctors at local level.

Is There Any Alternative to Integration within Existing NHS Structures?

17.27 In its response to the Discussion Paper, the Retained Organs Commission suggested that a new 'arm's length' body should be established, along the lines of the Special Health Authorities. Examples of such Authorities are the National Clinical Assessment Authority (NCAA) and the Retained Organs Commission itself. The Commission's response suggested that the service could have a dual relationship with the DoH and the Lord Chancellor's Department (now part of the Department for Constitutional Affairs), thus balancing the need for quasi-judicial independence and a degree of integration into the public health system. The Commission recognised that practical problems might flow from responsibility resting with two Government Departments, but felt that the benefits of the scheme would outweigh the problems. Another consultee suggested that a new body should be set up under the joint auspices of the DoH and the Home Office, in order to provide national leadership and accountability. Others felt that the coroner service as a whole should be accountable to the Home Office.

17.28 In its written response to the Discussion Paper, the Coroners' Society said that, in order to achieve independence from clinicians, medical coroners should be employed by the ONS. However, by the time of the seminars, Mr Michael Burgess, Honorary Secretary of the Society, no longer favoured that solution. He supported the idea of a single integrated service, comprising both medical and judicial coroners and wholly independent from the NHS. He could see no reason why medical coroners, like existing coroners, should not be office-holders under the Crown. The Coroner's Officers Association strongly favoured independence from local authorities, health authorities, the police service and any other

organisation that might have an interest in the death. The Association regarded the Lord Chancellor's Department (now part of the Department for Constitutional Affairs) as one possible location for the service.

17.29 The Society of Registration Officers suggested that the office of medical coroner should be a statutory post, independent from the NHS, with accountability passing up to a Chief Medical Coroner (the Society favoured the term 'Medical Examiner') at the head of a free-standing national agency. The Tameside Families Support Group suggested the creation of a similar agency with the difference that, under the Group's model, the medical coroner would be accountable to the judicial coroner and, at the head of the agency, to the Chief Coroner. The Greater Manchester Police supported the creation of a statutory medical and judicial coroner service, accountable to an independent body which would be responsible for establishing and maintaining consistent procedures and standards nationwide. The police are particularly anxious to see uniformity of practice throughout the service. They, more than any other organisation, experience the problems caused by inconsistent practices and procedures operated by coroners in different districts.

17.30 Professor Baker emphasised the need for those employed in the medical coroner service not only to be seen to be independent, but also to be independent in their attitudes, behaviour and understanding. However, that independence must, he said, be coupled with membership of a wider network ensuring professional development, regulation and continuing education. On the evidence of what was being done in other countries, he felt that all this was possible with proper leadership and management, even within a free-standing service. There would, he thought, be a sufficient number and hierarchy of medical coroners to achieve a degree of professional vitality, if the service could be formally associated with one of the Royal Colleges, which would assume the leadership and educational roles. Professor Baker also saw a role for some sort of administrative link with an NHS organisation, possibly the Commission for Health Improvement (shortly to be subsumed into the new Commission for Healthcare Audit and Inspection). Many of the other respondents to the Discussion Paper and participants in the seminars spoke of the need for continuing professional links so that medical coroners would be able to avoid professional isolation and maintain an up-to-date knowledge of current clinical practice and procedures.

Comment

17.31 The focus of these discussions was what the position of the medical coroner should be within the system. However, on reflection, it seems to me that the real question is what the position of the new coroner service should be. A structure or 'home' must be found for the whole service, not just the medical coroners. The discussion was most useful nonetheless. It highlighted the need for independence from Government and from existing NHS structures, which I fully accept. It drew attention to the need for both medical and judicial coroners to be independent office-holders under the Crown. It brought home to me how difficult a question the 'placement' of the coroner service will be. As will become apparent, I find the suggestion made by the Retained Organs

Commission to be the most appropriate. I shall propose the creation of a special 'arm's length' body.

The Medical Coroner

What Qualifications Will Be Required?

17.32 In its Discussion Paper, the Inquiry suggested that the position of medical coroner might be suitable for clinicians from a range of different medical backgrounds, including forensic pathologists, public health doctors and police surgeons, as well as doctors with a background in general practice. Further categories were suggested by respondents to the Discussion Paper. These included senior hospital doctors, medically qualified coroners, doctors with medico-legal experience, general histopathologists with an interest in autopsy, epidemiologists, crematorium medical referees and forensic medical examiners.

17.33 There was general agreement that doctors from a variety of medical backgrounds would be suitable for the post. Dr Thorpe, representing the BMA, suggested that the ideal candidate for the post of medical coroner would be someone with a broad medical background and therefore with experience and understanding of many aspects of medicine, rather than an expert in a specialised area. However, there would be a necessity for specialist advice to be available when required.

17.34 Professor Baker originally suggested that the most suitably qualified doctors for the post would be public health doctors; they would be best placed to carry out a monitoring role and to use mortality data in determining the provision of local health services. At the seminars, however, Professor Baker agreed that the net could be cast wider. A number of respondents to the Discussion Paper suggested that public health doctors were unsuitable for the role because of their detachment from clinical practice. It was argued by some, including the NCEPOD, that public health doctors would not be appropriate candidates for the post unless they had substantial recent clinical experience. Professor Baker disagreed with that view. He acknowledged that some public health doctors were so distant from clinical practice that they would find it difficult to take on the role. However, many would be able to do so. He pointed out that public health physicians have a degree of detachment, together with the positive advantage of experience in evaluating the care given to patients. This view received some support, notably from Dr Gary Cook, of the Faculty of Public Health Medicine.

17.35 Some respondents thought that doctors currently working as crematorium medical referees would be ideal candidates for the job of medical coroner. A response from Dr W D S McLay, on behalf of the newly re-formed Association of Crematorium Medical Referees and the Association of Police Surgeons, suggested that, with appropriate resources and statutory authority, the existing role of the medical referee could be extended to cover many of the functions that the Discussion Paper envisaged being undertaken by the medical coroner.

17.36 It was generally acknowledged that, in order to function effectively, the medical coroner system would need to command the respect of the medical profession and that only

doctors of high standing and an appropriate level of experience should be eligible for the job.

Comment

17.37 In my view, doctors from a wide range of medical backgrounds should be capable, after appropriate training, of undertaking the work of a medical coroner. One aspect that was not mentioned by the contributors, which I regard as important, is that some administrative ability would be an asset.

What Sort of Training Would Be Required?

17.38 There was general agreement that, from whatever background a medical coroner came, an appropriate training programme would be essential. Ideas were put forward for a specific training course, leading to formal accreditation. Such a course would clearly need to cover a wide variety of the aspects of the work of the medical coroner. A number of key needs were identified, including training in forensic medicine, in the management of bereaved relatives and in the understanding of the needs of ethnic minority groups and, in particular, their religious and cultural requirements. The Royal College of Paediatrics and Child Health suggested that an understanding of child health and sudden unexpected death in infancy would be required. At the seminars, the possibility of having that kind of expertise available at a regional level was discussed. It was suggested a medical coroner would require some statistical and epidemiological knowledge. However, this would need to be at a basic level only. Every medical coroner would obviously have to possess an understanding of the legal and ethical issues surrounding death.

Comment

17.39 The contributors have identified the core requirements. It seems to me that the basic training of medical coroners should not present any great difficulty. In the longer term, a specific course leading to accreditation might be feasible and would, I think, promote the maintenance of high standards.

Would It Be Possible to Provide a Career Structure for Medical Coroners?

17.40 Under the current coronial system, there is no career structure beyond local level. Once a deputy coroner has been appointed to the post of coroner within a district, there is no further potential for promotion within the coronial system, save (for a part-timer) the possibility of moving to one of the few full-time positions.

17.41 There was broad support for the introduction of a regional and national structure within the coroner system. One of the advantages of such a structure is that it would provide a career structure for medical coroners, which would make the post more attractive to potential applicants. At the seminars, Dr Stephen Leadbeatter, Director of the Wales Institute of Forensic Medicine, suggested that doctors might occupy the post of medical coroner for a given period, as part of a wider career structure. The DoH also envisaged that some

medical coroners might spend only a few years in the service before moving on elsewhere.

17.42 A further perceived advantage of a regional and national structure is the ability to provide support for medical coroners acting at local level, offering expertise and guidance where required. It was suggested by a number of respondents that, insofar as possible, medical coroners should work in teams to encourage professional inclusion. It was thought desirable that such teams should incorporate, where possible, a range of different skills and backgrounds of expertise. Specialist skills should also be available for use as and when required.

Comment

17.43 I am unsure whether there will be a real need for a career structure for medical coroners, other than by the progression from work at a district level to work at regional level. However, I do recognise that, if a doctor becomes a medical coroner, s/he should not be trapped in the post and unable to return to mainstream medicine if, for example s/he did not enjoy the work. There are two aspects to this. First, the financial arrangements must be such that the medical coroner could return to the NHS without loss of pension rights. Second, medical coroners must not be isolated to the extent that they lose touch with developments in clinical practice and with the ethos of the profession. However, they will have to be quite independent of colleagues at a local level.

The Investigation of Individual Deaths

Should There Be a List of Reportable Deaths?

17.44 Under the current system, a number of categories of death are reportable to the coroner. There is no definitive list of reportable deaths, although the circumstances in which a registrar must report a death and a coroner must hold an inquest are set out in the Registration of Births and Deaths Regulations 1987 and the Coroners Act 1988 respectively.

17.45 The Discussion Paper set out a list of circumstances in which it was suggested that a death should be reportable to the medical coroner. Respondents to the Discussion Paper put forward a large number of suggested amendments and additions to the list. Many of the suggested additions were very sensible. If incorporated, they would result in a list containing more than 30 individual categories of death. There were differences of opinion about the merit of including some of the circumstances suggested by the Inquiry. In particular, there was a good deal of disquiet among members of the medical profession at the suggestion that a death should be reportable where there was reason to suspect that the death was or might have been caused by medical error or lack of treatment.

17.46 The responses illustrated the difficulties of compiling a complete and comprehensible list of every circumstance that should give rise to a report to the coroner. It also illustrated the impracticability of requiring every doctor to remember and apply such a list. There was general agreement that any such list should be reviewed and updated regularly, so as to keep pace with changing circumstances. Changes in the list would inevitably cause

further difficulties for the medical profession. In addition, the production of a list of reportable deaths would merely serve to perpetuate the existing system whereby, in general, the decision whether or not to report a death to the coroner lies with the treating doctor.

17.47 At the seminars, two alternative solutions to the list of reportable deaths were considered. The first was that all deaths should be reported to the medical coroner, except those within a narrowly defined category (e.g. where the death was expected). This would represent a complete reversal of the current system, under which a death is not reportable unless it falls within certain categories. The second solution was that every death should be referred to the medical coroner.

One Possible Solution – Should All Deaths Be Reportable Except for the Expected Death?

17.48 The Inquiry suggested that a death might not be reported to the medical coroner if it was expected and had occurred as a result of a natural disease process. The cause of such deaths would continue to be certified by the treating doctor, although there would be additional safeguards. In particular, the deceased's family would see the documentation and have an opportunity to voice any concerns they might have.

17.49 If there were no requirement to examine expected deaths, the workload of the medical coroner would obviously be significantly less than if all deaths were reported. Dr Christopher Evans, representing the RCP, thought that over half of all deaths that occurred on the general wards in hospital (as opposed to in the accident and emergency department) were expected. Dr David Pickersgill, for the BMA, estimated that well over half of all deaths occurring outside hospital (including deaths in community hospitals, care homes, etc.) fell into that category. Dr Pickersgill did not, however, support the proposal that only unexpected deaths should be referred to the medical coroner. He contended that all deaths should be referred and argued that, if this were done, the expected deaths could be dealt with very quickly.

17.50 A suggested definition of an **'expected death'** was set out in the Discussion Paper. This was:

> **'... a death where there was, prior to death, an expectation among those around the deceased and his/her health care team that the death was imminent'**.

17.51 A number of respondents expressed the view that a death might be **'expected'**, even if not **'imminent'**, and argued that the use of the word **'imminent'** severely restricted the range of deaths that would fall within the definition. Others were happy with the requirement for imminence. The Tameside Family Support Group, for example, suggested that a time limit should be set within which a death could properly be regarded as **'imminent'**. A period of three months was proposed. Others suggested that there should be a requirement that the fact that a death was imminent should have been formally recorded in the medical records prior to the death occurring.

17.52 The Royal College of Nursing (RCN) suggested that the definition contained in the Discussion Paper be qualified in the following way:

> **'... where a diagnosis of the illness leading to the death being expected has been confirmed and there has been no untoward incident in the period immediately prior to the death'**.

17.53 That form of words recognises the fact that, although a death may be 'expected' at the time it occurs, the condition that caused the death might have been precipitated by an event (e.g. an accident or adverse medical event) which makes an investigation into the death necessary. Dr Leadbeatter proposed the following definition, which encompasses both the element of 'expectedness' and the requirement that the death should be examined in the public interest:

> **'An 'expected death' is 'a death where there was, prior to death, an expectation among those about the deceased and his/her healthcare team that the death was imminent, and the underlying cause was known, and the cause was not violent or unnatural, and the person had not been 'deprived of liberty''.'**

17.54 The phrases 'natural death' and (to a lesser extent) 'violent death' cause considerable difficulty and are interpreted in different ways by different people. One example, which was the subject of discussion at the seminars, was the distinction to be drawn between the 'unnatural' death caused by lung cancer resulting from exposure to asbestos at work and the death (regarded under the existing system as 'natural') caused by lung cancer resulting from smoking cigarettes. It was agreed that the distinction is essentially one of social mores and is susceptible to change over time. Dr Ryk James, Senior Lecturer in Forensic Pathology at the University of Wales, suggested at the seminars that a 'natural' death was one that raised no issue of criminality, of civil liability or of public interest and was not attended by any complaint that might lead to any of those circumstances. There was, however, a general feeling that the concepts of the 'natural' and 'unnatural' death should be abandoned.

17.55 At the seminars, Dr Maureen Baker, representing the RCGP, suggested that, rather than having a positive requirement that death had been 'expected' before a death could be certified by a doctor, it might be easier to have a negative requirement that death was 'not unexpected'. This would cover, for example, a sudden death, apparently caused by a heart attack, in a patient with known ischaemic heart disease. This point had been raised by a number of respondents. During the course of discussion at the seminars, Dr Baker accepted that, in the example of the patient with ischaemic heart disease, the treating doctor would be able to offer only informed speculation as to the cause of death, particularly if the death was not witnessed by anyone and there was no report of the patient having exhibited the 'classic' signs of a heart attack. It is, after all, perfectly possible for a patient suffering from heart disease to die from some other, wholly unrelated, cause.

17.56 Both Dr Pickersgill and Dr Baker anticipated difficulties in determining whether or not a death had been 'expected' by the deceased's family. Family members may have been informed of the prognosis but may not have accepted it. Some may have been told but not

others. Mrs Viney was concerned that, if the fact that a death was 'expected' were to be a significant factor, this may have the effect of forcing discussions about topics that families might prefer to avoid.

17.57 Disquiet was expressed by some at the idea of treating expected deaths differently from other deaths. In a response sent to the Inquiry after the seminars, Cruse expressed concerns about the vulnerability of the terminally ill. The response pointed out that such people can be subject to inadequate care and treatment, even to criminal acts. Other respondents made similar points.

Comment

17.58 For several reasons, I have concluded that the idea of seeking to identify 'expected deaths' for separate treatment at certification is unworkable. First, it has proved almost impossible to define an 'expected death' in a simple but comprehensible way. Second, I share the concern expressed by Cruse and others that such a system would increase the vulnerability of the terminally ill to neglect or worse. I also reject as unacceptable (in the light of the Shipman experience) the suggestion that all deaths save the 'not unexpected' should be referred to the coroner.

An Alternative Solution – Should All Deaths Be Reportable?

17.59 It was argued by a number of respondents that any system that relies upon the reporting of deaths to the coroner is flawed and that the medical coroner system could be effective only if it scrutinised every death. This argument was advanced with particular force by Dr James. He said that the proposal to retain a system of reportable deaths:

> **'... retains one of the major weaknesses of the current system creating potential loopholes for the future Shipman; will undermine the provision of quality mortality data and will create unnecessary complexity'**.

17.60 In Dr James' experience, doctors frequently make wrong decisions about whether to report a death, owing to a lack of understanding of the reporting requirements and the relevant issues to be considered, or out of a desire to avoid further investigation. If the present system of relying on third parties (mainly doctors) to report deaths to the coroner were retained, a future Shipman might be able to exploit the system. He or she could decide not to report a death and thereby to exclude the medical coroner's involvement. Dr James felt that the system would not enjoy public confidence. He pointed to the poor quality of death certification at present. I have referred previously (see paragraph 5.44) to research that he has conducted on this topic. His view was that the medical coroner should certify the cause of death (or approve the cause of death, where a doctor has given a provisional cause) in every case. Dr James' view was shared by a large number of respondents to the Discussion Paper, in particular coroners and pathologists. The suggestion that every death should be reported to the medical coroner also received a considerable amount of support from participants at the seminars.

17.61 On the other hand, there was a general recognition that a requirement that all deaths should be reported to the coroner service would have very significant workload and

resource implications. Doubts were expressed as to whether the service would be able to cope with the volume of work. The point was also made that, if all deaths were to be reported to the medical coroner, investigative resources might not be focussed on those cases where they were most needed. Concern was expressed about delays that might be caused by the coroner service becoming overloaded with work.

17.62 The issue of whether or not the service was able to cope with the reporting of all deaths would, of course, depend largely on the resources placed at its disposal. Plainly, the present infrastructure would not be equal to the task. Much would also depend on the extent to which the medical coroner and his/her staff undertook an investigation of the deaths reported to them and the way in which that investigation was organised.

17.63 Mr Thomas Hennell, senior analyst at Government Office for the North West, who participated in several of the seminars in his private capacity, said that the reporting of all deaths to the medical coroner would have a number of advantages. It would enable the medical coroner to co-ordinate all the post-death procedures. Such a system would also ensure that a public record of the death was made at the earliest possible time and that other agencies were informed promptly that the death had occurred. The medical coroner would also be a valuable source of advice to the relatives as to how they should proceed. Mr Hennell suggested that the medical coroner should not undertake a formal investigation in every case. He proposed that the doctor who certified the fact of death should send written notification of the death to the medical coroner (on the Inquiry's Form 1). The medical coroner would then discuss with the doctor whether or not the doctor was able to certify the cause of death. If it were concluded that the doctor was able to certify the cause of death and there was no reason for the death to be investigated, the doctor would be authorised to certify and the medical coroner would not conduct any investigation into the death. In those circumstances, copies of the Inquiry's Forms 1 and 2 (i.e. the forms used respectively to certify the fact and cause of death) would be delivered to the registrar and the medical coroner's office. With them would be the Inquiry's Form 3, which would contain a written account of events compiled by the deceased's family or carers. If any inconsistencies were noted, or if concern were expressed at the point of registration, the medical coroner could take matters further. Otherwise the death would be registered and disposal would follow.

Comment

17.64 I accept and agree with the concerns expressed by Dr James about the quality of decisions made by doctors when asked to recognise which deaths should be reported to the coroner. The alternative is that all deaths should be reported to the coroner. As Mr Hennell pointed out, there would be a number of consequential advantages. The resource implications would be considerable but, as Mr Hennell and Dr Pickersgill observed, not all deaths would require an in-depth investigation by the medical coroner. Much would depend upon how the deaths were handled in the coroner's office. Mr Hennell's suggestion (or something very like it) might be workable.

Is There a Need for a Second Doctor?

17.65 Under the Inquiry's working model, if a death were expected, the cause of death would be certified by the treating doctor alone. There would be no examination or enquiry by a

second doctor. The responses to the Inquiry's Discussion Paper revealed a strong feeling in many quarters that reliance on certification by one doctor was inadequate and did not afford sufficient protection, even within the limited category of expected deaths. Dr Grenville proposed an alternative model, by which a panel of doctors, practising in various fields of medicine, would be recruited to act as second certifiers on a part-time or sessional basis. Members of the panel would be specially trained and would need to demonstrate continuing competence in the field. They would have time to spend on the task of certification and would not have to fit it in between their other duties. Their work would be audited. The model would operate along broadly the same lines as the existing cremation certification procedure. The treating doctor would certify the cause of death, subject to confirmation by a member of the panel. The process of confirmation would include an examination of the medical records. The panel member would be wholly independent of the first doctor and would operate on a rota system, rather than, as now, being selected by the treating doctor to carry out the task. A limited number of medical coroners would be appointed and certain reportable categories of deaths would be referred to them. Medical coroners would also deal with deaths where the treating doctor and the second certifier were unable to agree about the cause of death. In other words, the system would remain the same as at present to the extent that the coroner would be dependent on others reporting deaths for investigation. However, death certification would be a two-tier process in every case.

17.66 The proposal for the creation of a panel of doctors approved to act as second certifiers was supported by the BMA and the DoH. Dr Pickersgill, representing the BMA, explained that he envisaged the panel operating under the auspices of the medical coroner. Every death would be reported to the medical coroner and members of the panel would carry out an investigation on his/her behalf. The view of the DoH was that there should never be certification of death by a single doctor. The DoH suggested that the second certifying doctor would speak to relatives, examine the forms completed as part of the certification process and, where considered necessary, would carry out a full examination of the body and consult the deceased's medical records. The Department would like to see the panel of second certifying doctors contracted to, and accredited by, the medical coroner. Dr Cook, on behalf of the Faculty of Public Health Medicine, supported the proposal in principle, but questioned the extent to which the panel would be perceived as independent of the local health service. Other participants emphasised the need for the second doctor to be of appropriate standing within the medical profession, so as to be able to question the judgement of the treating doctor, should that become necessary. As I have explained previously, Dr Grenville favoured retention of the existing system whereby certain categories of deaths only (rather than all deaths) are reported to the coroner. However, he observed that the two doctor system that he had described would work equally well if all deaths were reportable and the panel of doctors operated under the auspices of the medical coroner.

17.67 It will be appreciated that, if there were to be an examination and enquiry conducted by a second doctor in every case, this would go considerably further than Mr Hennell's suggestion of a discussion between the medical coroner and the treating doctor and would involve significantly greater medical resources. For the DoH, Mr Mann was

optimistic that the human resource implications were acceptable. Dr Baker, of the RCGP, was less confident that the necessary manpower would be available.

17.68 Mr Hennell's suggestion was supported by Professor Baker. He was concerned at the retention of a category of deaths that could be certified by only one doctor. On the other hand, he was worried that the medical coroner might be 'swamped' if s/he had the task of investigating all deaths.

Comment

17.69 In my view, the proposal that a panel of doctors should provide a second tier of certification is far from ideal. First, the system would depend on the doctors' identification of reportable deaths and the need for a published list. However, I accept that a panel doctor could be trained to identify reportable deaths satisfactorily. Second, I consider that it would be difficult to ensure that the panel doctor was truly independent of the first doctor. The panel doctor would be a member of the same local professional community as the first doctor. In rural areas particularly, there could be no true independence. Third, if the second certification were to be carried out thoroughly and were to include consultation with the deceased's family, it would be very heavy on medical resources. The proposal bears an uncomfortable resemblance to cremation certification. I have little confidence in the assurances that the second certification would be thorough. As I recorded in Chapter Three, the BMA used to give repeated assurances that the Form C procedure was thorough and effective and I am quite sure it was neither.

17.70 The proposal that all deaths should be reported to the medical coroner, who would use a panel of doctors for certification, would be more acceptable but I fear that the medical resource implications would be immense if the panel doctor considered each death thoroughly. I think that some other way must be found of handling deaths within the coroner's office.

Additional Safeguards

17.71 Professor Baker observed that one advantage of the process proposed by Mr Hennell was that it would enable a medical coroner to undertake prospective checks on certain deaths. This was in contrast to the Inquiry's original suggestion that retrospective checks could be made on the documentation relating to certain deaths. Such retrospective checks would take place after disposal of the body so that, if suspicion were aroused, it would (at least where the body had been cremated) be too late to conduct an autopsy or other examination of the body. Professor Baker suggested that, if a medical coroner were concerned at the pattern of deaths occurring at a care home, or among the patients of a particular doctor, s/he could elect to investigate a death falling within that pattern at the time it was reported. Then, there would still be the opportunity for all necessary examinations to be carried out and matters would still be fresh in the minds of the available witnesses.

17.72 Professor Baker supported general, as well as specifically targeted, checks. He believed that it would be helpful to ensure that the general checks covered deaths occurring under

the care of all general practitioners and clinical teams in hospital, and those occurring in a variety of institutions such as hospitals and care homes. He estimated, for example, that it might be feasible for the service to audit at least one death among the patients of every general practitioner, every two to three years, and up to 10% of deaths occurring in each institution. If a concern was identified, a greater number of deaths would be examined and Professor Baker said that there would then be a useful part to be played by retrospective audit.

Comment

17.73 I agree with Professor Baker's views on the need for audit. I accept that, if all deaths are reported to the medical coroner, prospective checks on a proportion of deaths would provide a useful form of audit of whatever handling system were to be adopted. If, for example, the medical coroner were to undertake a full investigation only into those cases which would now be regarded as 'reportable' and the remaining straightforward cases were to be certified by the medical coroner's staff, some form of audit of those cases would be required. Targeted checks into certain categories of deaths (e.g. deaths occurring in a particular nursing home) would also be of value.

The Imposition of a Statutory Duty to Report to the Coroner

17.74 Under the current system, a registrar has a statutory duty, in certain defined circumstances, to report to the coroner a death which falls within the definition of a 'reportable' death. A statutory duty also falls upon those responsible for certain types of institution (e.g. prisons) in respect of the deaths of persons in their custody. In its Discussion Paper, the Inquiry sought views about drawing up a list of other categories of persons who would have a statutory duty to report a reportable death to the coroner. If a system were adopted whereby all deaths were referred to the coroner, a duty might still exist to report concerns about a death. It was suggested that it might be a criminal offence knowingly to fail to report a reportable death and, for professionals, a disciplinary offence negligently to fail to report.

Doctors and Nurses in Hospital

17.75 Representing the RCP, Dr Evans said that, in the context of a death in hospital, doctors should be under a statutory duty to report concerns if, for example, they had reason to suspect that the death might have been caused by inappropriate treatment. He thought the duty could reasonably be extended to a doctor who had not treated the patient personally, but who was told about inappropriate treatment by another doctor. He believed that the duty to report concerns should extend to nurses. The example was used of a nurse who had concerns about the care a patient had received prior to death and who was not reassured by the explanation given to him/her by the treating consultant. If the consultant refused to take the nurse's concerns further, Dr Evans believed that the nurse should have a statutory duty to report those concerns to the coroner.

Hospital Managers

17.76 Both Dr Evans and Professor Baker took the view that any statutory duty to report to the coroner should be extended to hospital managers. Dr Baker, representing the RCGP, made the point that the various professional codes of conduct for nurses, doctors and other health professionals state that their primary duty is to protect patients. That means that there is a professional duty to raise concerns about care. She also observed that there were imminent plans to implement a professional code of conduct for NHS managers, which would have the effect of bringing them into line with their professional colleagues. Mrs Viney, representing Cruse, thought it appropriate to impose a duty on the manager of a nursing or residential home in relation to the deaths of residents at their premises.

Unqualified Hospital Staff

17.77 Dr Evans said that, if the duty were to be extended to non-qualified staff within a hospital, it should be limited to reporting the event to a qualified member of staff. Professor Baker agreed that a statutory duty to report to the coroner should not be extended to non-qualified staff, except those in a management role. It was agreed that the most important step, both inside and outside hospital, was to create easy and recognised routes through which unqualified staff could channel any concerns that they might have.

Paramedics

17.78 Professor Keith Mackway-Jones, representing the Greater Manchester Ambulance Service NHS Trust, suggested that any duty to report should attach to the ambulance service, rather than to individual paramedics. The duty on an individual paramedic should extend only to reporting any concerns to a superior or to ambulance control.

Doctors and Staff in General Practice

17.79 Dr Pickersgill, representing the BMA, did not see any difficulty in a member of a general practice being placed under a statutory duty to report concerns, even though this might result in him/her having to report concerns about the treatment provided by another member of the practice. He did not think that it would be reasonable to impose a statutory duty on the administrative and secretarial staff. Instead, he suggested that efforts should be made to ensure that staff were aware of the routes via which they could raise concerns, such as to another partner in a group practice or to the primary care trust. Dr William Holmes, the Group Medical Director of Nestor Healthcare Group plc, a commercial organisation which provides out of hours cover for general practitioners, thought that it would be reasonable to impose a duty to report concerns about a death on deputising doctors. The requirement to do so could be incorporated into the protocols produced by his own company (and no doubt those of other organisations) for guidance when dealing with unexpected deaths.

Members of the Public

17.80 A small number of respondents, including Cruse, supported the extension of the duty to members of the public. At the seminars, Mrs Viney, representing Cruse, said that it would

be reasonable to impose such a duty. Indeed, she felt the creation of a duty might make it easier for family members to report concerns. It would prevent them from having to make what would otherwise be a difficult decision. However, a further response, received from Cruse after the seminars, indicated a change of mind. Having learned that the imposition of a statutory duty would involve the imposition of legal sanctions for non-compliance, Cruse now believes that the imposition of a duty on members of the public would not be appropriate. Instead, a culture should be developed in which it is perceived as a citizen's duty to report a death about which s/he has concerns. The majority of respondents agreed that members of the public should be encouraged to report deaths to the coroner, but felt that the creation of a statutory duty would be neither desirable nor readily enforceable. The DoH and others said that, if such a duty were to be created, a considerable amount of public education would be required to make the system effective.

Funeral Directors, Embalmers and Mortuary Technicians

17.81 The British Institute of Funeral Directors thought that funeral directors and embalmers should have an obligation to report deaths to the coroner. The National Association of Funeral Directors suggested that both funeral directors and mortuary technicians should have a specific right to report any concerns to the coroner. Both regularly see bodies stripped and are in an excellent position to observe any signs of violence or neglect. They also have close contact with families.

Police Officers

17.82 Commander Andre Baker, representing ACPO, saw no problem in imposing a duty on police officers but thought that a duty should not necessarily be imposed on all civilian staff.

Comment

17.83 In my view, it would be reasonable to impose on a qualified or responsible person a duty to report to the coroner a concern about a death that arose in the course of that person's professional duties. I include, in the categories of the qualified and responsible, doctors, nurses, hospital managers, nursing and care home managers and owners, paramedics, police officers, funeral directors, embalmers and mortuary technicians. I can see no objection in principle to the suggestion that the duty should be imposed by statute and should carry criminal sanctions. I think it would be in only a very rare case that the police would prosecute. In any event, in my view, each professional body should impose an ethical duty to report concerns about a death to the coroner.

17.84 I do not think it appropriate that unqualified staff should be under any such duty. For them, there should be the opportunity to express their concerns, without fear of any form of reprisal.

Certifying the Fact of Death and Ascertaining the Circumstances of Death: Form 1

17.85 There is currently no statutory requirement for certification of the fact of death and procedures for diagnosing or confirming death vary from area to area. The fact of death

is often confirmed by a doctor. Increasingly, however, it is done by other professionals, including paramedics and nurses. In most areas of England and Wales, funeral directors will not move a body without death having been confirmed by a health professional. In some areas, however, funeral directors will take a body from the scene of death to their own premises without formal confirmation of the death having taken place. There is no statutory requirement for any record to be made of the fact that death has been confirmed or of the circumstances surrounding a death.

17.86 The Inquiry's Discussion Paper suggested that, in every case, there should be formal confirmation and certification of the fact of death. A form (Form 1) should be completed by the person who confirms the fact of death. Form 1 would require personal details of the deceased, together with details of the physical examination made in order to confirm the death and accounts of the circumstances of the death and of the medical condition of the deceased prior to death. A completed Form 1 would provide a snapshot of the information available very shortly after the death or the discovery of the death. There was unanimous agreement amongst the participants at the seminars that it was important to capture factual information about the circumstances of death at the earliest possible opportunity and to record it in a document such as Form 1.

Who Should Be Authorised to Certify the Fact of a Death Occurring in the Community?

17.87 Some respondents to the Inquiry's Discussion Paper had gained the mistaken impression that the Inquiry was suggesting that every death should be confirmed by a doctor and that other categories of health professional should be debarred from carrying out this function. Not surprisingly, this misunderstanding produced considerable concern about the potential burden that would be placed on doctors. In fact, the Inquiry was anxious to explore whether the categories of professionals trained to diagnose death might be extended, in order to relieve some of the pressure on doctors. Most respondents accepted that health professionals other than doctors should be authorised to confirm that death had occurred. However, in its written response to the Discussion Paper, Cruse argued that, in order for the system to have public confidence, every death should be confirmed by a doctor. At the seminars, Mrs Viney, Cruse's Chief Executive, recognised that such a requirement would present practical difficulties. In a further written response, submitted after the seminars, Cruse accepted that other qualified medical professionals, such as nurses and paramedics with relevant training, could properly be authorised to carry out the task of confirming death.

Doctors

17.88 Under the current system, if a patient dies in the community during surgery hours, the general practitioner or some other suitably qualified member of the practice team (such as a partner or the practice nurse) will usually attend and confirm the fact of death. If the person attending to confirm death is the deceased's usual doctor, s/he will certify the cause of death or, in an appropriate case, refer the death to the coroner.

17.89 Different procedures operate outside surgery hours. I have described these in Chapter Four. Given the increasing tendency of general practitioners to delegate out of hours care

to deputising services, general practitioner co-operatives and the like, it is likely that a doctor attending outside surgery hours will not be the deceased's own doctor and therefore will not be in a position to certify the cause (as opposed to the fact) of death. If the death occurs at a nursing or residential home and is expected, the BMA advises that there is little purpose to be served by the attendance of a doctor out of hours, unless there is some genuine concern as to whether the patient is dead. The obligation of the duty doctor or deputising service is merely to inform the deceased's general practitioner of the death early on the next working day. If a death occurs at the deceased's home, there may be distressed relatives who require the attention of a doctor. Mrs Viney observed that many people want the reassurance of having the death confirmed by a health professional. However, if the relatives are happy to arrange for funeral directors to remove the body without the attendance of a doctor, the BMA advises that there is no need for the duty doctor to attend.

17.90 Dr Holmes said that, in his experience, deputising doctors do generally attend to confirm the fact of death, despite the absence of a statutory requirement or professional obligation to do so. He stressed that this represents a considerable burden on the out of hours service. Dr Holmes estimated that attendance to confirm death accounted for approximately 4% of the home visits operated by his organisation and up to 10% of visits made after midnight. He said that there were already problems in recruiting suitable doctors to cover overnight shifts and that any additional workload would increase the burden on the out of hours service providers. He was concerned that the demands of gathering the information needed to complete the Inquiry's Form 1 would significantly increase the workload of the deputising services. Dr Pickersgill raised the same point and said that the resources of general practitioner co-operatives were already stretched. On an overnight shift, there might be one or two doctors covering the patients of up to 100 doctors.

17.91 The Inquiry had asked for views on whether a doctor should be permitted to certify the fact of death if s/he had a financial interest in the private hospital, clinic and/or care home in which the deceased resided at the time of his/her death. In their written responses to the Discussion Paper, the General Medical Council (GMC) and a number of other respondents suggested that a doctor should be permitted to certify the fact of death in those circumstances but that, as an additional safeguard, the death should then automatically be referred to the medical coroner. Others, including the DoH, took the view that no health professional with a financial interest should be able to certify the fact of death. Others expressed a similar view with regard to the certification of the cause of death. One respondent suggested that doctors should be required to declare such financial interests and that a register of interests should be maintained by the medical coroner.

17.92 The Royal College of Paediatrics and Child Health said in its written response to the Discussion Paper that, whilst other categories of person may be able to diagnose death in adults, only fully registered doctors should be permitted to certify the fact of death in children.

Nurses

17.93 The RCN told the Inquiry that it is current practice for registered nurses to confirm death in all NHS and independent sector settings, in accordance with locally established and

agreed protocols. It seems that different arrangements exist in different areas and hospitals. No problem arises with a suitably qualified nurse confirming the fact of death in a hospital setting. There was, however, some difference of opinion among respondents to the Discussion Paper as to whether a nurse employed in a nursing or other care home should be permitted to certify the fact that a resident in that home had died. Completion of Form 1 would involve the gathering and recording of information about the circumstances of the death and the deceased's medical history. If the death had occurred as a result of lack of care or some accident or ill-treatment in the home, there might be a temptation for a nurse employed there to seek to cover up the true facts surrounding the death, when completing Form 1.

17.94 Dr Pickersgill, representing the BMA, said that, in most areas of the country, agreements had been reached between doctors' practices and care homes as to who should confirm the fact of death. In the case of an expected death, this is done by a member of the nursing staff at the home concerned. Dr Holmes referred to the differences in the levels of experience of nursing staff (particularly agency staff) employed in care homes. Some were just not confident enough to confirm the fact of death. A number of participants at the seminars recognised the possibility of a conflict of interest for a nurse employed at the home. Professor Baker suggested that the solution to the potential conflict might be to permit nurses to certify the fact of death only in cases where the death was expected and the patient's general practitioner had indicated in advance that s/he was happy for a nurse to do so. He had experience of this being done in a nursing home or community hospital setting. Other respondents to the Discussion Paper also took the view that nurses should be permitted to certify the fact of death only where the death was truly 'expected'.

17.95 Not all respondents agreed that nurses should be authorised to confirm the fact of death. For example, the British Association in Forensic Medicine expressed the view that a nurse should not be able to certify the fact of death under any circumstances, without referral to a registered medical practitioner. The Nursing Midwifery Council (NMC) said that nurses should be able to confirm the fact of death, as they do under the current system, but that the decision whether or not to report the death to the medical coroner and the signing of a 'statement of professional opinion', as envisaged on the Inquiry's original Form 1, were outside the current remit of nursing practice. The NMC thought that it might be possible to extend the role of nurses with appropriate training and the use of agreed protocols, but that this would require careful consideration. In their written response to the Coroners Review, the Patients Association suggested that a solution might lie in limiting the function of certifying the fact of death to certain categories of nurse who could be provided with appropriate training.

Paramedics

17.96 In most parts of the country, paramedics are specifically trained to diagnose death, in accordance with protocols created by individual ambulance trusts. Those protocols are modelled on a protocol agreed by the Joint Royal Colleges Ambulance Liaison Committee. The circumstances in which paramedics are permitted to diagnose death vary from area to area. In general, they are restricted to cases in which an adult has

collapsed at least 15 minutes prior to the arrival of the paramedics, there has been no attempt at cardiopulmonary resuscitation and death has not occurred in a public place.

17.97 Professor Mackway-Jones said that paramedics undoubtedly had the requisite skills to certify the fact of death. However, in the case of an expected death, where there was no prospect of resuscitation, it was an inappropriate use of resources for a paramedic to attend. Professor Mackway-Jones was aware of instances of paramedics being called to deaths in the community because no doctor was prepared to attend. The family, or staff at a care home, had therefore turned to the ambulance service as the only agency available to confirm the fact of death. Professor Mackway-Jones accepted that, in a case where there was some prospect of resuscitation, attendance was clearly appropriate. However, the creation of a system that ensured that paramedics attended those cases, but not cases that simply involved confirming the fact of death, represented a real challenge to the ambulance service.

17.98 In cases where paramedics attend, but are not authorised to diagnose death (e.g. where the death occurs in a public place), they sometimes transport the body to the accident and emergency department of a local hospital so that a doctor can confirm the fact of death. Professor Mackway-Jones, who is the Medical Director of a busy accident and emergency department, said that this practice does not present a major problem at his hospital. He questioned whether paramedics should be permitted to certify the fact of death where that death had occurred after failed attempts by them at resuscitation. He pointed out that the situation gave rise to an obvious conflict of interests.

17.99 Professor Mackway-Jones said that, in principle, the ambulance service would be able to provide the sort of information required by Form 1, although he did have some specific observations about some of the questions contained on the version of the form which appeared in the Discussion Paper. Paramedics already complete their own forms after diagnosing death and Professor Mackway-Jones said that the completion of Form 1 would not increase the period of time that the paramedic spent at the scene of a death.

Police

17.100 There was support among some participants for police officers to be permitted to certify the fact of death in circumstances of obvious death, such as where the body has decomposed or decapitation has occurred. However, Commander Baker, representing ACPO, said at the seminars that he did not think that it was appropriate for police officers to certify death even in those circumstances, because of the other responsibilities they have at the scene. He was strongly opposed to officers certifying the fact of death in wider circumstances. He foresaw problems training officers to perform the diagnosis. He also recognised the potential for serious damage to public relations in the event that an officer mistakenly diagnosed death in a living person. Commander Baker also made the point that, although it is possible to certify the fact of death without any medical equipment, police officers would not have available to them the type of equipment available to a paramedic; therefore, the margin for error would be greater. Professor Mackway-Jones made the point that individual police officers would be called upon to exercise their skills in diagnosing death so infrequently that they would not develop the necessary confidence in performing the task.

Coroner's Investigators

17.101 Mrs Aline Warner, on behalf of the Coroner's Officers Association, suggested that coroner's investigators (who, in the Inquiry's working model, would replace coroner's officers) should be authorised to certify the fact of death. This would reduce the number of people having to attend the scene of the death and would thus limit the potential for contamination. That would be an important factor if the death turned out to be suspicious and the scene had to be subjected to forensic examination. The ability of a coroner's investigator to certify the fact of death would be particularly convenient in certain circumstances. She cited the example of deaths caused by falling from cliffs in the area where she operates. At present, the coastguard recovers the body and brings it to the top of the cliff where the coroner's officer is in attendance. Under the present arrangements, it is then necessary to bring a paramedic, doctor or police officer to the scene to confirm the fact of death. Obviously, if a coroner's investigator were able to perform this task, that would be far more convenient.

Comment

17.102 In my view, nurses, paramedics and coroner's investigators should be authorised to certify the fact of death, provided they have undergone a suitable training course. Doctors should do so, of course; police officers should not. I do not think that a doctor or nurse should be prevented from certifying the fact of death and completing Form 1 on account of a financial interest in the institution in which the death occurs. Such a person may well be the only suitably qualified person on duty at the time of the death. There would be little point in calling another qualified person as, if the person with the financial interest wished to lie about the circumstances of the death, s/he could give false information to the person who was to complete Form 1.

Certifying the Fact of a Death Occurring in Hospital

17.103 When a death occurs in hospital, the problem of obtaining the services of a doctor or other health professional to confirm the fact of death does not arise as it does when a death occurs in the community. Death is confirmed by a doctor working in the hospital, or by a nurse authorised to perform this task. Discussion at the seminars therefore centred on the issue of who should complete Form 1 and whether the obligation to complete such a form would place unreasonable demands on hospital staff.

17.104 In his written response to the Discussion Paper, Dr James suggested that the most effective way of certifying the fact of death in hospitals would be to set up a designated team with responsibility for certifying the fact of death in every case. He suggested that this role could become part of the responsibilities of a nurse practitioner. Dr James saw several advantages arising out of the scheme. The fact that fewer people were certifying death more frequently would encourage consistency and high standards, and would allow for audit. It was anticipated that a professional relationship would develop between the team and the medical coroner's staff, which would also facilitate the process. Dr James proposed that, as part of the process of certifying the fact of death, members of the team should consider a number of specific points that, if present, might indicate that

the death should be referred to the medical coroner. For example, he suggested that the team should consider whether there were any issues that might implicate the hospital in the death and whether the death fell outside the usual pattern of deaths.

17.105 Dr James suggested that the same arrangement would also work in hospices and larger nursing homes. At the seminars, Dr Pickersgill observed that he did not believe it would be possible for the arrangement to operate in community and cottage hospitals. He thought that deaths in those institutions should be treated as deaths in the community, rather than as deaths in hospital. There are around 400 community and cottage hospitals in England and Wales. They account for about 10% (or 20,000) of NHS hospital beds.

17.106 Professor Mackway-Jones thought that special considerations applied to deaths that occurred in hospital accident and emergency departments. He suggested that responsibility for confirming the fact of death should remain with the clinical team who had treated the patient but that the process of completing Form 1 could thereafter be carried out by the team envisaged by Dr James or another member of staff. He gave the example of a cardiac arrest, where death is confirmed at the point that a decision is taken to stop attempts at resuscitation. It was important that certification of the fact of death was not delayed so that the body had to remain for a long period in the department, where there is frequently considerable pressure on space. Professor Mackway-Jones welcomed the suggestion that someone from outside the department should attend at a later stage to carry out any necessary investigations relating to the circumstances of the death.

17.107 Ms Pamela Dawson, who is currently the Bereavement Co-ordinator for the Borough of Bromley as well as a former Chair of the National Association of Bereavement Services, attended one of the seminars. She welcomed Dr James' proposal in theory but thought that, in certain hospitals, the scheme would be very difficult to implement. By way of example, she said that the Bromley Hospital is split over three sites in three separate boroughs. She said that each site would require a separate team available 24 hours a day. On average, the hospital has 40 to 45 deaths a week and there would be obvious advantages in releasing other hospital staff from the task of certifying the fact of death. However, the resource implications were considerable. Ms Dawson did not think that it would be possible for a member of the nursing staff to be available to certify the fact of death whilst at the same time working on a ward because, each time that person had to go and deal with a death, the ward would be left understaffed. For a one-site hospital, the practical difficulties would not be as great.

17.108 On behalf of the RCP, Dr Evans welcomed the proposal and the standardisation that it would bring to post-death procedures. He agreed that the fact that the service would have to be available 24 hours a day would give rise to issues of manpower. Dr Evans and Ms Dawson both thought that, as an alternative to a dedicated team, it might be possible to have a member of staff who had been trained in the certification of the fact of death on duty on each ward. That member of staff would be responsible for the filling out of Form 1 for any death that occurred on the ward. The ward would not then be left understaffed when a death occurred. Training could be directed at a smaller number of staff members and those members of staff would be involved in the process of certification of the fact of death on a sufficiently regular basis to avoid becoming de-skilled.

Comment

17.109 In my view, the idea of having a person or team available to certify the fact of death and complete Form 1 is attractive. However, I think it would be feasible only in a large hospital. I accept Professor Mackway-Jones' point about deaths in accident and emergency departments.

Establishing the Fact of Death

17.110 The Inquiry invited views on the essential constituents of the examination required to confirm the fact of death. As a basis for discussion, it was suggested that, in order to certify that death had occurred, the person completing Form 1 should have observed the absence of heart sounds, carotid and femoral pulses, breathing and response to painful stimulus, together with tracking in the fundi (i.e. changes in the appearance of the veins at the back of the eye that occur after the blood ceases to circulate).

17.111 Respondents to the Discussion Paper broadly agreed with the constituents put forward by the Inquiry, with the exception of tracking in the fundi. This was thought too specialist an observation to be made by paramedics. The findings of the Feasibility Study commissioned by the Inquiry into use of the newly designed forms confirmed that the inclusion of a requirement to look for tracking in the fundi would present problems, even to doctors. Some respondents suggested that there should be prescribed time periods over which some of the observations (e.g. absence of breathing) should be made before death was confirmed.

17.112 At the seminars, Dr Paul Aylin, Clinical Senior Lecturer in Epidemiology and Public Health at Imperial College School of Medicine, Science and Technology, suggested that, in certain cases (e.g. where there was a devastating and obviously fatal injury), it might be appropriate to establish death by means other than the observations already referred to. He suggested that space should be made available on Form 1 for the certifier to record any alternative means by which the fact of death had been established.

17.113 Surprise was expressed at the seminars that no generally agreed protocol, setting out the minimum observations which must be made before a diagnosis of death can be made, appears to exist at present. Instead, different organisations work to different protocols. It does not appear that medical practitioners work to any protocol, except in special circumstances, such as the diagnosis of brain stem death. It would obviously be desirable if an appropriate protocol could be developed for agreement and adoption by all those concerned with the diagnosis of death.

Permission to Remove the Body

17.114 Initially, the Inquiry envisaged that the person completing Form 1 would be able, once satisfied that the death was expected and there was no other reason for the medical coroner to investigate, to give permission for the deceased's body to be moved to the premises of a funeral director. During the consultation process, some concern was expressed about the prospect of paramedics and nurses taking responsibility for giving that permission. At the seminars, a different system was canvassed whereby, having

completed Form 1, the person completing Form 1 would telephone the medical coroner's office and speak to the on-call investigator. Having heard the circumstances, the investigator would then give permission to move the body to the premises of a funeral director or would direct that it be moved to a mortuary.

17.115 Professor Baker and Dr Aylin supported the suggestion. Dr Baker, for the RCGP, and Dr Pickering, representing the BMA, were concerned about the practical difficulties that might arise. They foresaw problems with contacting the coroner's office, or the member of staff on call, particularly if a number of deaths were to occur during the same out of hours period. Dr Pickersgill spoke of the difficulties which can be encountered at present in reaching a coroner's officer, even during working hours.

Comment

17.116 I do not think the difficulties outlined by Dr Baker and Dr Pickersgill will arise, provided that the coroner's office is properly resourced. During the day, there should be sufficient officers to deal with all incoming calls. For deaths occurring out of hours, telephone calls to the on-duty investigator will have to be redirected to a second and possibly a third member of staff. Modern telephone technology can provide such a facility.

Responsibility for Coroners' Investigations

The Current Role of the Coroner's Officer

17.117 As I have explained in Chapter Eight, under the current system, the role performed by the coroner's officer varies from district to district. In some districts, coroner's officers are office-bound, answering the telephone and carrying out administrative duties. In others, coroner's officers (or coroner's liaison officers, as they are sometimes called) are based outside the office and spend much of their time visiting scenes of death, attending autopsies, taking witness statements and liaising with the police. In some districts, investigations are carried out on behalf of the coroner by serving police officers who have been specifically assigned to coroner's duties. Elsewhere, coroner's investigations are carried out by officers from the local police force, as part of their general policing duties.

17.118 Some coroner's officers are civilians, often former police officers, who may be employed by either the police force or the local authority. However, people from different employment backgrounds, such as former nurses, paramedics and social workers, have also been recruited in increasing numbers to fulfil the role of coroner's officer.

The Future Role of the Coroner's Investigator

17.119 The Inquiry's Discussion Paper suggested that, under the working model, the medical and judicial coroners would be supported by a team of trained civilian investigators. They would replace the existing coroner's officers and would be employed directly by the coroner service. Views were invited as to the qualifications, experience and type of training which would be appropriate for this new investigative post.

Experience and Training

17.120 Many respondents supported the idea of multi-disciplinary teams of investigators. Suggestions as to the type of employment backgrounds from which investigators might be drawn included existing coroner's officers, nurses, police officers, funeral directors, staff from local authority cremation and cemeteries departments, hospital bereavement officers, social workers, legal executives, mortuary technicians and personnel from the armed services. Particular emphasis was placed on the benefit of investigators having some medical knowledge. For example, in its written response to the Discussion Paper, the Faculty of Public Health Medicine suggested that all investigators should be trained at least to the level of a basic nursing degree, with some also having clinical experience.

17.121 A number of respondents suggested that the training should be complementary to the skills already possessed by the individual concerned. For example, it was suggested that a civilian would require greater training in investigative skills and forensic awareness in gathering evidence from the scene than would a former police officer. On the other hand, a former police officer would require training in the medical aspects of investigation. Some core areas, such as the legal and ethical aspects of post-death procedures, would need to be taught to all recruits.

17.122 Many respondents emphasised the fact that the investigators must have training in dealing appropriately with the recently bereaved. However, Mrs Warner, of the Coroner's Officers Association, stressed the value of previous experience in related fields in furnishing candidates with the skills and empathy necessary for speaking to bereaved families. In its response to the Coroners Review Consultation Paper, the Association suggested that a trainee coroner's officer should have at least ten years' **'life experience'** in a profession such as medicine, law, social work, teaching or the emergency services and, in addition, should undergo an entry examination.

Various Aspects of the Role of the Coroner's Investigator

17.123 In its Discussion Paper, the Inquiry envisaged a system whereby at least one coroner's investigator in each district would be on call 24 hours a day, seven days a week. The coroner's office in which Mrs Warner works provides such a service. She was asked whether any problems had been encountered in attracting staff prepared to work antisocial hours. Mrs Warner replied that there had been an average of 90 applicants for each of the last three jobs that had been advertised.

17.124 Mrs Warner described how, under the current system, coroner's officers (certainly those within her own district) take time to talk to bereaved relatives and to explain the post-death procedures. She pointed out that, quite apart from the needs of the relatives, interaction with the deceased's family can form a valuable part of the investigative process. Conversations with relatives can sometimes lead to information being volunteered that would not otherwise be available. Mrs Warner therefore believed that contact with families should continue to be made by those responsible for investigating the death, rather than by another member of the coroner's staff. Mrs Warner also observed that it is helpful for families to deal with the same person within the coroner's office throughout the whole process. Mr Burgess agreed.

17.125 There was discussion at one of the seminars about bereavement support and who should provide it. It had been suggested by some that the coroner service might be responsible for providing the support that some families so badly need. Mrs Warner pointed out that, at present, coroner's officers sometimes find themselves 'straying into the realms of' counselling (or at least offering support to the bereaved), however much they try not to do so. Both she and Mr Burgess, on behalf of the Coroners' Society, expressed the view that the coroner's office should not provide in-house bereavement counselling and support services, but should instead act as a facilitator, providing information about the availability of such services elsewhere. For the DoH, Mrs Fry acknowledged that bereavement services are not universally available, nor are they as effective as the Department would wish. She indicated that the Department was looking to support development of the services at present provided. However, the view is that these services should be located within the NHS, rather than within the coroner service, with the latter advising those in need of the services how and where they can be accessed.

17.126 At the seminars, Mrs Warner explained that the Coroner's Officers Association envisaged two distinct and separate roles for coroner's officers in the future. One would be a forensic investigative role. It was suggested that officers fulfilling that role would attend the scene of a death, determine whether there was any reason for suspicion about the death and, if so, arrange for the police to become involved. The second role would, Mrs Warner suggested, be linked to the work of the medical coroner. Officers fulfilling that role would take calls from general practitioners, liaise with families and inspect medical records. Mrs Warner could see, however, the potential for a combination of the two roles, provided that the individual concerned was willing to become involved in both types of work. For the RCPath, Dr Peter Acland expressed concern at the prospect of division of the two roles in the way suggested by the Coroner's Officers Association. He considered the role of the coroner's officer to be investigative and believed that coroner's investigators should be out and about, conducting interviews and gathering information, rather than performing duties of a purely administrative nature.

Comment

17.127 In my view, a trained corps of coroner's investigators will be crucial to the operation of the coroner service in future. They should come from varied backgrounds, although there will be a particular need for some with nursing or paramedic experience. I think they should have an investigative role and should liaise with bereaved relatives. I agree that they should not have to carry out purely administrative functions, as many do at present.

The Interface between the Coroner Service and the Police and Other Investigative Agencies

17.128 Under the current system, the police investigate all deaths where there is a suspicion of criminal involvement. Other types of death are subject to investigation by various bodies, including the Health and Safety Executive. The permission of the coroner is required in order for an autopsy to be carried out and, once the coroner is seized of a case, only s/he has power to order release of the body for disposal.

17.129 It was suggested in the Inquiry's Discussion Paper – and generally agreed by all – that the police must continue to be responsible for the investigation of deaths where there is any suspicion of criminal activity. The other responsible agencies too should retain their responsibility to investigate in certain types of case. However, in the case of the death with no suspicion of criminal involvement, trained investigators employed within the coroner service would carry out a far greater degree of investigative work than is at present undertaken by most civilian coroner's officers. In the future, as now, it would be necessary for the coroner service to co-operate with the other investigative agencies. The agency with which the coroner service would be working most frequently would inevitably be the police. The Discussion Paper therefore invited views about the interface between the investigative work carried out by the police (together with the other relevant agencies) and the coroner service, and about any potential conflicts that might arise.

The Role of the Coroner Service When There Is a Suspicion of Criminal Involvement

17.130 Commander Baker, representing ACPO, was asked about the contribution that a coroner under the current system is able to make to a police investigation. The Inquiry has heard that it is not unusual for coroners to attend murder scenes, to go to meetings of senior police officers who are investigating a case of homicide and (even when not medically qualified) to attend autopsies. It was not clear to me, when I heard this evidence, whether or not the involvement of the coroner was of any value in these cases. Commander Baker had no experience of coroners attending at the scene of a death. However, he did not see that a coroner could usefully contribute to the early part of a police investigation, save with procedural matters such as giving the necessary direction that an autopsy should be carried out. Dr Peter Acland, a forensic pathologist representing the RCPath, had experience of the presence of a coroner at the scene of a death actually hindering the police investigation. He said that the attendance of the coroner raised issues of contamination of evidence, that sometimes the investigation had to be delayed until the arrival of the coroner and, in certain cases in which he has been involved, the coroner has made decisions which complicated the investigation. He said that he had never known an investigation that had derived any benefit from the involvement of a coroner at an early stage.

17.131 Mr Burgess, representing the Coroners' Society, saw potential problems with a coroner being physically present at the scene of a death or at an autopsy. However, he supported the principle that a coroner, or at least someone separate from the police, should have the power to authorise examination and disposal of the body. He said that this provides a degree of independence and detached oversight. Mr Burgess agreed that, in some cases, the justification that has to be given by the police for examination of the body is a very straightforward matter. However, he said that, when asked by the police to direct an autopsy, he very often discusses with them who is the most appropriate pathologist and whether or not it is right to wait for that pathologist to become available in a case where, for example, the police are holding a suspect subject to custody time limits. Further issues can arise in relation to the disposal of the body. Mr Burgess said that the coroner plays an important role in cases where there is a conflict of interest between the police, who might

have an interest in retaining the body for as long as possible, and relatives, who usually want the body released quickly. He said that, in an appropriate case, it is possible for a coroner to apply pressure on the police by setting a limit as to when the body will be released for disposal. Mr Burgess agreed that decisions about directing autopsies and authorising disposal of a body could properly be performed by a medical coroner, provided those decisions were subject to challenge, possibly to the judicial coroner.

17.132 Commander Baker did not foresee any difficulties in the police liaising with the medical coroner in much the same way as the police liaise with the coroner under the current system. Mrs Warner, representing the Coroner's Officers Association, suggested that, since (under the current system at least) most deaths initially considered suspicious were likely to proceed to an inquest, liaison should not be with the medical coroner but with the judicial coroner who would ultimately be responsible for conducting the inquest.

No Suspicion of Criminal Involvement

17.133 The current policy as to the attendance of police at the scene of a death where there is no suspicion of criminal involvement varies from force to force. The police rarely attend the scene of a death occurring in hospital. In relation to deaths occurring in the community, the police are typically summoned by someone who has witnessed a sudden death or discovered a body. The police are often summoned by the ambulance service. There is often little that can be achieved by police attendance and it is widely thought that this represents an inappropriate use of police resources. Indeed, the police will often not attend the scene of a death if, in the period between the death being reported and the attendance of an officer at the scene, a doctor is identified who is able to certify the cause of death. Similarly, if an officer has actually reached the scene, in the absence of any obvious grounds for suspicion, s/he will leave once such a doctor has been identified.

17.134 Commander Baker said that, if the current practice of police officers routinely attending at deaths where there is no suggestion of criminal involvement were stopped, that could save police resources. In order for this to be achieved, the public would need to be educated to contact the coroner's office, rather than the police, in the event of a death. However, Commander Baker went on to say that, if a coroner's investigator attended at the scene and identified any suspicion of criminal involvement (e.g. evidence of suicide or death due to recreational drug taking), the scene must be 'frozen' and the police contacted immediately to take over the investigation. If, having attended, the police find no evidence of criminal involvement, the investigation could be handed back to the coroner's office unless and until there was any further suspicion of criminal involvement. Commander Baker thought that coroner's investigators could be trained to recognise when it was necessary to involve the police. Mrs Warner, for the Coroner's Officers Association, added that, to some extent, this happens already. In districts where coroner's officers attend scenes of death, they will assess whether or not the police should be involved.

17.135 Commander Baker agreed that the categories of cases that required police involvement could be set out in protocols. Those protocols could be refined and added to over time. Mrs Warner referred to a recent document, 'Report on the Provision of Coroners' Officers',

published in August 2002, to which I have referred in Chapter Eight. The document sets out appropriate standard operating procedures (or service level agreements) to manage the interface between coroner's officers and the police. This type of exercise would be necessary in any new system. Provision should also be made for liaison with the Health and Safety Executive and other investigative agencies, to avoid duplication of investigation or potential conflict.

17.136 In its written response to the Discussion Paper, the RCGP had expressed concern about possible conflicts that might arise between the police and the medical coroner. However, having heard the discussion at the seminars, the College's representative, Dr Baker, felt that any potential conflict would be capable of resolution by agreement.

The Provision of Mutual Assistance between the Police and the Coroner's Investigator

17.137 In cases that did not require investigation by the police, Commander Baker said that it would be possible for the police to offer assistance to coroner's investigators in a number of different ways. For example, police officers could assist coroner's investigators by exercising any powers that the coroner might be given to enter and search premises. The police could also take steps to prevent anyone from obstructing the investigators in their work and could assist in securing premises and in tracing next of kin.

17.138 Likewise, in relation to cases that are investigated by the police, it was said that coroner's officers are currently in a better position (certainly once an inquest has been ordered) to obtain medical records (particularly hospital records) than are the police. In future, coroner's investigators could continue to obtain records on behalf of the police. Mrs Warner said that, under the current system, there were a number of other ways in which some coroner's officers were able to offer support to the police: for example, in providing information about the capacity and workload of mortuaries in the area and about local and national toxicology services. They also act as a liaison for, and attend at, autopsies, where they can brief the pathologist about the circumstances of the death. Although the police have direct access to forensic services, Commander Baker said that they sometimes requested toxicological testing through the coroner in order to obtain the results more quickly.

Investigations on Behalf of the Coroner

Investigations at the Scene of Death

17.139 Under its working model, the Inquiry suggested that, in most cases to be investigated by the medical coroner (except where the death was being investigated by another agency, such as the police or the Health and Safety Executive), the coroner's investigator would attend the scene of the death. The investigator would record his/her observations of the scene and gather all available evidence, including as much information as possible from those with knowledge of the circumstance of the death. The investigation would be carried out in accordance with a protocol. Possible constituents of such a protocol were set out in the Discussion Paper and comments invited.

17.140 There was widespread support for the idea of developing a protocol, governing the way in which any investigation at the scene of a death should be carried out. Respondents to the Discussion Paper made helpful suggestions as to the possible content of such a protocol. At the seminars, it was suggested that minimum standards could be established; these could then be reviewed and added to over time. Commander Baker stressed the importance, from a police perspective, of having pictorial evidence of the scene, in the form of either a still photograph or a video. That would be valuable in the event of a criminal investigation becoming necessary in the future. Professor Baker agreed that the taking of photographs would provide a valuable record of the scene and made the point that the taking and storing of photographs would be much simpler with the advent of digital photography.

17.141 There was discussion at the seminars about whether it would be practical and desirable for a coroner's investigator to take a sample of blood from the deceased at the scene. It was suggested that this might be done for the purpose of random toxicological testing in a case that was not to be subjected to a full coroner's investigation. This is done, for example, in Maryland, USA, where toxicological testing is an important feature of the death investigation system. Dr Acland, on behalf of the RCPath, thought that, with proper training and in appropriate circumstances, it would be possible for a sample to be taken without problem. Dr Leadbeatter and a number of other pathologists expressed a contrary view. They felt that there would be real practical difficulties (such as inadequate lighting, lack of proper facilities and difficulty in finding an appropriate vein) in a large number of cases. In reply, Dr Acland said that, although there can be technical difficulties, these could be overcome with training. He pointed to the fact that, in cases where no crime is suspected, samples are often taken by mortuary technicians, rather than pathologists. He did, however, accept that there might be aesthetic problems, such as the spilling of blood at the scene, and an associated risk of disease. He said that the category of case where a sample could be taken by a coroner's investigator at the scene of death would necessarily be limited. Mrs Warner's view was that, although some coroner's officers might object to taking blood samples, the majority would not and, with adequate training, she did not see why it could not be done.

17.142 At the seminars, Professor Helen Whitwell, Professor of Forensic Medicine and Head of Department at the University of Sheffield, said that a full examination of the death scene was one of a number of investigative tools that the medical coroner could use to ascertain the cause of death. Other such investigative tools might include a thorough external examination of the body, examination of the medical records and toxicological testing. When conducted, they could provide sufficient evidence to avoid the necessity for an autopsy in certain cases.

17.143 In its written response to the Discussion Paper, the Coroner's Officers Association suggested that a coroner's investigator should attend the scene of a death only if there was likely to be an inquest into the death. That means that a judgement must be made at a very early stage as to whether an inquest is going to be required. In practice, this judgement is usually made by the police, who will inform the coroner's office about any 'inquestable death'. At the seminars, Mrs Warner said that attendance only when an inquest was expected was the practice in her district and that, although there would be

advantages in a coroner's investigator attending the scene of every death reported to the coroner service, the resource implications of attending at the scene of all those deaths would be enormous. If the resources could be made available, she said that attendance would have considerable benefits, especially for the deceased's family. The investigator would be able to inform the family about the post-death procedures and could give the information that the family needed at the time they needed it. The family would have seen a 'friendly face' to whom they could relate during their later dealings with the coroner's office. These advantages would be in addition to the opportunity afforded to the investigator of obtaining information to assist in the coroner's investigation.

17.144 Mr Burgess agreed that, ideally, every death scene should be visited but doubted that resources would allow for that. If they did not, a decision as to whether or not to attend would have to be made on a case by case basis, dependent upon the pressures placed on the coroner's office at any particular time. He estimated that, at present, his officers attend at the scene of approximately half the reported deaths that occur at home. Many of those deaths do not go to inquest.

Comment

17.145 In my view, there will be many deaths at which there is no need for the coroner's investigator to attend. I have in mind that an investigator will speak to someone at the scene in every case, usually by telephone, and will make a decision, on a case by case basis, as to whether or not there is any need to attend in person. This might arise if it appears advisable to inspect the scene of the death or if no one else is available to confirm the fact of death. Such a visit would, as Mrs Warner observed, provide an opportunity to make contact with a relative of the deceased.

Obtaining Information from Relatives and Others with Knowledge of the Circumstances of the Death

17.146 In the Inquiry's Discussion Paper, it was suggested that a near relative of the deceased, or another person who had been close to the deceased, should complete a form (Form 3), setting out information about the circumstances of the death and the deceased's state of health before death and confirming that s/he did not have any concerns about the death. This form would be submitted to the medical coroner, together with forms certifying the fact (Form 1) and cause (Form 2) of death. It was envisaged that the person completing Form 3 would have seen the completed Forms 1 and 2 and would confirm that their contents were true. The object was to involve relatives in the information-gathering process and to give them an opportunity to express any concerns that they might have about the death. In addition, completion of a form such as Form 3 would prevent the situation whereby the doctor certifying the cause of death could give false information to the authorities in the knowledge that it would never be checked with those who knew the truth. That was a situation that occurred time and time again with deaths certified by Shipman.

17.147 If a relative were to be required to complete a form, it was clear that someone would have to give him/her the form and provide any necessary assistance in completing it. The

question was who that 'someone' should be. It seemed to the Inquiry (and a number of respondents agreed) inappropriate that the certifying doctor should have any part in administering the form. Concern was expressed about the possibility that a doctor who was trying to conceal a negligent or criminal act might be able to influence relatives and convince them that their recollection of events was either incorrect or, in any event, compatible with a death due to natural causes.

17.148 It was suggested in the Discussion Paper that the funeral director might assist relatives in completing the form. However, respondents raised a number of potential problems with that arrangement. There was concern about the ability of the family member and funeral director to understand the medical information and terminology contained in the forms that had been completed by the doctor. In addition, it was suggested that funeral directors might put pressure on the family not to report concerns about a death, in order to avoid delay. It was also recognised that, in assisting the family in verifying the information provided by the doctor, funeral directors would be privy to the deceased's medical history, which would raise issues of confidentiality. There was concern that the funeral director would not be in a position to give informed advice. Doubts were also expressed about the willingness of families to commit any concerns that they might have to paper in an 'official' document. By the time of the seminars, the Inquiry had moved away from the idea of a form being presented to relatives by the funeral director and was canvassing other ideas for securing the involvement of the family.

17.149 At the seminars, it was suggested that a member of the medical coroner's investigative team should discuss the death with a family member, take him/her through Forms 1 and 2 and ask whether s/he had any concerns about the death. The idea received broad support, although there was doubt as to whether or not it would be practicable for every interview to take place in person. The possibility of a telephone interview was discussed. A number of participants felt strongly that the interview should be conducted in person, not least because several members of the family might wish to participate. Dr Pickersgill, on behalf of the BMA, supported the idea of a face to face interview in principle but pointed out the logistical difficulties in holding such an interview in every case, particularly in rural areas where there were large distances to cover. In response, Dr Aylin made the point that, under the current system, every death is registered in person, which requires the attendance of the informant at the register office. It was suggested that, in some cases, it would be appropriate for the interview to be held over the telephone. A question was raised about the amount of time the family would have to consider the information contained in the forms before giving their response. In practice, it seems likely that there would be greater flexibility in the timing if the contact with the coroner's office were to be by telephone or face to face interview than would be the case if the family were required to complete a form.

17.150 Another idea advanced at the seminars was that the interview with the family might be conducted by the second doctor if, as suggested by some, there were to be a system that involved certification by a second doctor in every case.

Comment

17.151 It seems clear to me that it will not be practicable or appropriate to ask relatives of the deceased to complete Form 3. Consultation with the family will have to be effected in some

other way. Ideally this should take place face to face but I can see that that might give rise to practical problems. It seems to me that the most appropriate person to consult with a family member would be a coroner's investigator.

Certifying the Cause of Death

17.152 Under the Inquiry's working model, it was envisaged that a doctor involved in the deceased's care would in every case complete a form (Form 2), either certifying the cause of death or, if the doctor took the view that s/he was unable to certify the cause of death, referring the death to the medical coroner and including on the form as much information as possible to assist in ascertaining the cause of death. The closest equivalent to Form 2 under the present system is the MCCD, which states the cause(s) of death, but contains minimal information about the surrounding circumstances. Currently, doctors report deaths to the coroner by telephone and, frequently, the reporting doctor provides no written information for the coroner's use. When the death occurs in the community, it is rare for the coroner's staff to obtain or examine the medical records.

17.153 There was almost unanimous agreement among respondents with the Inquiry's suggestion that the same certification procedures should apply to all deaths, regardless of whether the death is to be followed by burial or cremation.

Qualification to Certify the Cause of Death

Recent Contact with the Deceased

17.154 The existing statutory framework requires the doctor who attended a deceased during his/her last illness to issue an MCCD. The doctor might decide, however, that s/he cannot properly certify the cause of death, either because of uncertainty as to the cause, or because there is some other circumstance that makes the death reportable. One such circumstance will arise where the doctor has not seen the deceased either within 14 days before the death or after death (the 'either/or rule'). In Chapter Two, I explained the origin of the 'either/or rule' and its unsatisfactory effect. In the Discussion Paper, the Inquiry raised the question of whether, in any new system, there should be a requirement that a doctor must have seen the patient within a specified time before death in order to be able to certify the death.

17.155 There was a divergence of views on this issue. A number of respondents favoured a requirement that the certifying doctor should have seen the deceased after death and within 14 days before death. The BMA, however, was opposed to retaining any such restrictions. In its written response, the Association argued that: **'There are no logical grounds for requiring the certifying doctor (or a partner) to have had a consultation with the deceased within a specified period prior to the death'**. It stressed that knowledge of the patient and access to the medical records were the most important criteria. At the seminars, Dr Pickersgill, representing the BMA, said that, under the present system, if a patient of one member of a group practice dies while that member is away on holiday, a colleague at the practice will examine the medical notes to see if s/he is able to certify the cause of death. He said that, provided there is a well-documented history of

disease, which tallies with eye witness accounts of the death, the colleague will be able to give a cause of death. He or she will then contact the coroner's officer who, 'almost without exception', will give the colleague permission to certify. He pointed out that, even when a patient is terminally ill, a doctor who has been away on holiday might not have seen him/her within the fortnight before death and might therefore have to consult the coroner's officer before certifying.

17.156 Professor Baker disagreed with the stance taken by the BMA on the lack of need for there to have been a consultation within a specified period. He said that, if the only deaths to be certified were those which were truly 'expected', there should be a requirement for the certifying doctor to have had a consultation with the deceased within the 14 days before death. It should also be a requirement that the consultation was in connection with the condition that caused death. Where a death was believed to be imminent, he would expect the patient to be under fairly close medical supervision and to be visited regularly. He said that, if the condition said to have caused death had not formed part of the subject matter of the most recent consultation, that would suggest that the death had not been imminent at the time of the consultation. Professor Baker went on to observe that, if a death were expected and the usual doctor was going on holiday, he would expect responsibility for care of the patient to have been formally handed over to another member of the practice during the doctor's absence.

17.157 Dr Grenville supported the stance taken by the BMA. He pointed out that there is now a team approach to primary care, particularly in larger practices, so that the care of patients with chronic illness is a team responsibility. He gave the example of a patient with terminal cancer who might receive daily care from district and Macmillan nurses but less frequent visits from a general practitioner, particularly if the general practitioner the patient saw most regularly was away on holiday. Dr Grenville said that, in future, he would like to see the procedures simplified, so that a member of the team could certify the cause of death, based on the team's knowledge of the patient and the records kept by members of the team. He pointed out that it is not always the doctor (as opposed to other members of the team) who knows most about the patient. He would not welcome any change that made the certification process more difficult.

17.158 Dr Grenville expressed the view that the imposition of an arbitrary period within which the certifying doctor must have seen the patient may not be the right way to proceed. If a period were to be specified, it should be longer than 14 days. On behalf of the Faculty of Public Health Medicine, Dr Cook suggested that a limit of as much as six months would be appropriate for a patient known to be suffering from a chronic illness.

17.159 Dr James was opposed to the imposition of a specified period within which the certifying doctor must have seen the patient. He suggested that the focus should instead be on the underlying disease process, He favoured a system whereby a doctor was not excluded from completing Form 2 on the basis of the time which had elapsed since s/he last saw the deceased. Instead, the doctor should record on the form all the information relevant to the death (including the cause of death if s/he were able to give it) and the form should then be passed to someone independent who would speak to the family, review the contents of the form and make a final judgement as to whether there was sufficient

evidence to certify the cause of death. Dr Grenville supported this view. He observed that the independent person could be either a medical coroner or a member of a panel of second doctors, working on a sessional basis, as previously described. He observed that the imposition of an arbitrary time limit could preclude a doctor from giving a worthwhile opinion about cause of death. Such an opinion might, for example, be based on eye witness accounts of the death or contemporary diagnostic investigations. In its written response to the Discussion Paper, the GMC said that **'inflexible requirements'** about the circumstances in which doctors may or may not certify the cause of death would not be helpful. The Council's view was that what was important was that the doctor's knowledge of and involvement in the care of the patient was clearly detailed on the form that s/he was required to complete.

17.160 In its written response to the Discussion Paper, the RCP said that there should be different time limits for deaths in hospital and deaths in the community. It was suggested that, in hospital, the certifying doctor should have had a consultation with the patient within 48 hours before death. At the seminars, Dr Evans, representing the RCP, suggested that an appropriate period would be three, not two, days. He also said that the team approach described by Dr Grenville should apply in hospital because the doctor with whom the deceased had had the relevant consultation might not always be available to certify the cause of death.

Comment

17.161 I accept the views of those who suggest that there should not be an arbitrary time limit as a qualification for completing the proposed Form 2. What is important is not when the doctor last saw the patient but the quality of the doctor's knowledge about the patient. As the new system will not permit certification of the cause of death by a single doctor, there will be some check on the quality of the doctor's knowledge, either by a second doctor or by the medical coroner or a member of his/her staff. When the doctor last saw the patient will be only one aspect of that knowledge.

Period of Registration

17.162 The Inquiry's Discussion Paper invited views on the medical qualifications and experience that a doctor should have in order to qualify him/her to certify the cause of death. In particular, consultees were asked to consider whether the certifying doctor should have to be fully registered. Under the current system, all registered doctors – including first year hospital trainees with provisional registration – can complete an MCCD. The Inquiry has heard evidence of problems associated with junior doctors in hospitals certifying the cause of death, particularly just after the new intake of junior doctors take up their posts twice a year. Dr Evans said that, in hospital, the certification of the cause of death is, for the most part, left to junior doctors who are frequently left to carry out the task without any discussion with, or advice from, their seniors. Dr James agreed and expressed the view that the reason for this was that more senior doctors were not sufficiently interested to do it themselves. He said that what was required for good quality death certification was interest, familiarity with the task, training and accreditation. Attempting to create a system

whereby every doctor was fully capable of certifying the cause of death would, he suggested, involve a considerable amount of training and supervision, if indeed it were possible.

17.163 It was the view of the RCP, and the majority of consultees, that only doctors who have completed a year of post-qualification training, and have thus achieved the status of being fully registered, should be able to certify the cause of death. Dr Pickersgill, on behalf of the BMA, together with a number of other respondents, suggested a period of five years' post-registration experience, although Dr Pickersgill said it was not something about which the BMA felt strongly. The Tameside Families Support Group suggested that the appropriate period of experience should be seven years.

17.164 Professor Baker took the view that the certifying doctor should be fully registered but stressed that training in certification was more important than length of experience or qualification. There would be little benefit in delaying the time when a doctor was permitted to certify unless there was suitable training. On behalf of the ONS, Dr Cleone Rooney agreed that there was a need for training and assessment of competence in completion of death certification documentation if it were to be done properly. She said that consultants in a hospital should be responsible for supervising their junior staff. Research, to which I referred in Chapter Five, had shown that consultants were, if anything, rather less proficient in death certification than their junior colleagues. If they were required to exercise supervision over more junior doctors, Dr Rooney suggested that they might improve their own skills.

Comment

17.165 In my view, the completion of Form 2 is an important responsibility that should not be left to very junior doctors. The proposed Form 2 will require the doctor to provide a summary of the medical history and the chain of events leading to death. In my view, any general practitioner principal should be qualified to complete Form 2. Such doctors are usually at least four years post-qualification. A similar seniority would be appropriate for hospital doctors. This would result in the form being completed by a doctor with some seniority in the clinical team.

What Standard of Confidence Should Be Required to Certify the Cause of Death?

17.166 Under existing procedures, a doctor completing an MCCD certifies that the particulars set out on the certificate, and the cause of death, are correct to the best of his/her knowledge and belief. In its Discussion Paper, the Inquiry proposed that a doctor certifying the cause of death on Form 2 should state:

> **'I am satisfied that I am able to justify the diagnosis of the cause of death ... on the basis of the deceased's medical history and the circumstances of death.'**

17.167 There was general support for this form of words, both in the written responses to the Discussion Paper and at the seminars. It was suggested by the DoH, the RCP and a few others that the appropriate standard of confidence should be the balance of probabilities.

Whilst approving the Inquiry's suggested wording, Professor Baker drew a distinction between the decision as to whether or not the death should be referred to the coroner for investigation (about which, he suggested, the certifying doctor should be 'absolutely certain') and the decision as to which clinical condition was the direct cause of death.

Comment

17.168 I am pleased that the form of words proposed in the Discussion Paper received so much support, as I regard it as appropriate.

Old Age

17.169 Under the current system, it is open to a doctor to certify the cause of death just as 'old age'. The guidance provided to doctors completing an MCCD states that 'old age' should not be used as the only cause of death, unless a more specific cause of death cannot be given and the deceased was aged 70 or over. On behalf of the ONS, Dr Rooney said that, at the time of its introduction as an acceptable cause of death in 1985, it was intended that 'old age' should be used in the case of a frail, elderly person who gradually declined, was at home, being seen by his/her general practitioner, had no particular disease but just came to the end of his/her lifespan. However, following its introduction, the use of 'old age' increased and extended to deaths occurring in circumstances other than those for which it was intended. It began to be used where the death occurred in hospital, as well as in the community. Dr Rooney suggested that this was odd, since it was unlikely that a patient would get a bed in an NHS hospital if s/he had no identifiable disease. However, she reported that, in the recent past, the use of 'old age' as a cause of death had declined. Dr Rooney agreed with the suggestion that, if a system whereby doctors certified the cause of death were retained, it should not be open to a doctor to give 'old age' as the cause of death. Instead, where there was no specific diagnosis, the patient was sufficiently old and further medical investigations were deemed inappropriate, it should be open to a medical coroner to certify the cause of death as 'old age'. However, she added that there should be a positive element to the diagnosis, i.e. there should have been a very slow general decline preceding death. There was a significant amount of support for this view. In a written response to the Discussion Paper, the Death Certification Advisory Group of the ONS suggested that, rather than defining 'old age' by reference to arbitrary age limits, it might be better to define explicitly the circumstances in which it would be appropriate to use 'old age' as a cause of death.

17.170 Professor Baker said that, in his view, 'old age' was acceptable where it was put forward as a positive diagnosis. However, if it was merely put forward in the absence of any other diagnosis, because the deceased was elderly and to avoid the need for any further investigations, he did not regard that as appropriate. He pointed out that, in the case of many elderly people, there are other conditions present that might at least be part of the picture. He did not think that a 'guess' at 'old age' was acceptable.

17.171 The view was expressed by some participants that 'old age' should continue to be an acceptable cause of death as at present, but that the minimum age limit should be significantly increased, for example to 85 or 90.

17.172 The suggestion that certification of the cause of death as 'old age' might be an automatic trigger for referral of a death to the medical coroner was supported by the BMA and the RCP, among others. However, the RCGP was concerned that, if 'old age' were not available to doctors as a cause of death, the number of autopsies might be increased. Concerns were also expressed that, in order to spare families the ordeal of an autopsy, doctors might cite other conditions as the cause of death. Those conditions might be no more specific than 'old age' (e.g. the use of 'bronchopneumonia' in a case where there is no convincing history or supporting histology) and might have the effect of rendering mortality statistics less accurate.

17.173 Some participants thought that, even with the additional safeguard of a referral to the medical coroner, the continued use of 'old age' would be unacceptable. This was the view expressed by the DoH in its written response to the Discussion Paper. However, at the seminars, Mr John Mann said that the Department recognised that, in the very elderly, it may be difficult to identify a cause of death other than 'old age', so that some flexibility might be required. Patient Concern, Age Concern and the Tameside Families Support Group were among the respondents who expressed the view that 'old age' should not be acceptable as a cause of death.

Comment

17.174 In my view, 'old age' should be an acceptable cause of death but only when it amounts to a positive diagnosis, as suggested by Professor Baker. If it were not acceptable, there might be an unwarranted increase in autopsies. I agree that 70 seems too low an age limit nowadays; 80 would be more suitable. I am attracted to the suggestion that only the medical coroner should be able to certify a death as due to 'old age'.

External Examination of the Deceased's Body

The Current Position

17.175 Under the existing system, there is no requirement for the doctor who issues the MCCD to see the deceased after death. Death may or may not have been confirmed by a doctor, paramedic or nurse. If it has, any examination conducted is likely to have been directed at ascertaining whether there are any signs of life, rather than checking for any marks suggestive of violence or neglect. When the deceased is buried, no second certificate is required, so that it is perfectly possible for the burial to take place without any examination of the body at all having taken place after death. If the deceased is cremated, the Forms B and C doctors should have seen and examined the body but the evidence given to the Inquiry suggests that such examinations are frequently very cursory, involving sight of the deceased's face and identity tag only. The likelihood is that the body will be buried or cremated, without any formal check having been made for marks of violence or neglect.

17.176 The Inquiry's Discussion Paper sought views about the value and practicability of an external examination of the body by the person completing Form 1 or by the Form 2 doctor. The object of such an examination would be to look for any marks suggestive of violence or neglect. The Inquiry also suggested that funeral directors might be required to complete a

form (Form 4), stating that they had carried out a visual examination of the deceased's body, recording any marks or injuries observed and stating whether they had any reason for suspicion about the death. Funeral directors are, of course, in a good position to observe any suspicious marks, since it is usual for them to see the naked body in the course of preparing the deceased for burial or cremation.

Examination at the Time When the Fact of Death Is Certified

17.177 It was suggested in the Inquiry's Discussion Paper that the person certifying the fact of death should examine the body and record on Form 1 any injection marks, sutured wounds, bruising, abrasions, petechiae, lacerations or other injuries. It was not contemplated that, when a death occurred in the community (especially at the deceased's home with family members present), it would be appropriate for the body to be stripped and subjected to a full examination. However, the Inquiry envisaged that a more limited examination might be carried out. In hospital, there would be no practical problems, as mortuary facilities would be readily available.

17.178 Many respondents expressed concern at the suggestion that there should be a full examination of the body at the time when the fact of death was confirmed. At the seminars Dr Maureen Baker, representing the RCGP, referred to practical difficulties, such as inadequate lighting and the possibility of infection, which might be encountered when carrying out an examination at a deceased's home. She emphasised the distress that might be caused to relatives by the conduct of a full examination and observed that some ethnic minority groups may require examination by a person of the same gender as the deceased. She said that the RCGP would support a limited examination at the scene of the death, with the proviso that the College's view was that a 'more comprehensive' examination of the body should take place at a later stage. In its written response to the Discussion Paper, the RCGP had said that there should be an examination of the whole body to exclude signs of violence, unless the certifier was present at death or death was due to a long-standing illness and the certifier did not suspect foul play. As to the extent of the 'limited examination', Dr Baker suggested that it should be confined to the head and neck. Such an examination would not be intrusive and, indeed, might be conducted without relatives being aware that the doctor was looking for possible signs of violence or neglect. For the RCP, Dr Evans pointed out that, in the context of the Shipman case, the examination should extend to the forearms, so that any signs of a recent injection could be noted. However, he expressed reservations about the requirement to record the suggested marks, particularly in respect of a patient dying in hospital. He pointed out that bruising of the arms is common among the elderly and those taking certain medication, while most patients dying in hospital will have skin puncture marks resulting from recent injections or the taking of blood samples. The BMA was also concerned about the practical difficulties of a full external examination and about the possible medico-legal implications for a doctor who failed to notice signs of violence and neglect that were subsequently discovered to be present.

17.179 Commander Baker suggested that, in practice, it might be possible to carry out an examination at the scene in a larger number of cases than was expected, so long as an explanation was given to relatives. He was concerned, however, that, if the death were to

be followed by a criminal trial, a response on Form 1 to the effect that there were no suspicious signs (when, in fact, there had been no opportunity to carry out a proper examination) might undermine any medical evidence subsequently obtained. He suggested that the extent of any examination carried out should be recorded on Form 1 and, if it had not been possible to carry out an examination, the form should reflect this.

Comment

17.180 In my view, for deaths in the community, there should be a limited examination when the fact of death is certified. For hospital deaths, the whole body should be examined at this stage.

Examination at the Point of Certifying the Cause of Death

17.181 The Discussion Paper invited views on the practical value of requiring the doctor completing Form 2 to undertake a physical examination of the body. A wide range of views was expressed on this issue. Some respondents believed that, in every case, the doctor completing Form 2 should perform a full external examination. Others thought that this would not be necessary so long as the person completing Form 1 had performed a full examination. One group of consultees felt that, in any event, an external examination was of little practical value and would lead to unnecessary delay.

17.182 At the seminars, Dr Evans, on behalf of the RCP, expressed the view that, if the doctor completing Form 2 had not also completed Form 1, s/he should be required to examine the body. He said that the doctor should be looking for signs of criminal involvement or a lack of care, such as bedsores. He said that, when he was asked to complete a cremation Form C, he would view both sides of the deceased's naked body and look for 'pressure sores and the like'. He would expect the examination carried out by the Form 2 doctor to be similar in nature. Dr Evans agreed that such an examination would be easier in a hospital than at the premises of funeral directors (where the facilities are not always ideal), but he thought that an examination of this kind should be possible, even so. He recognised that a requirement for an examination in every case would impose a greater burden on doctors because, at present, there is an examination only where the body is to be cremated. Nevertheless, he remained of the view that it was necessary for an examination to be undertaken in every case.

17.183 For the BMA, Dr Pickersgill thought that it would be possible, but in certain cases extremely difficult, to perform such an examination in the community. He said that bodies are often dressed and in a coffin by the time the doctor attends to examine before completing a cremation form. A doctor attending the premises of a small firm of funeral directors might have no assistance in moving or undressing the body and would not be able to carry out a full examination. He thought that the problem would not necessarily be solved by imposing a rule that the body should remain undressed until the time of the examination, because this would put great pressure on doctors to attend promptly. He referred to the difficulty of 'balancing the needs of the living population against the needs of dealing with the bureaucracy in relation to the dead' and suggested that a requirement for a full examination by the Form 2 doctor would lead to considerable delay, particularly

in rural areas where the body might be lying some distance from the doctor's surgery. Dr Pickersgill said that he was not convinced that a full examination of the body was necessary in every case. He said that an examination of the head, neck and arms would be likely to detect most problems. If there were a major feature (e.g. a pressure sore) on another part of the body, he would expect it to be drawn to his attention by the funeral director. He suggested that the doctor could assess the need for a fuller examination in each individual case, on the basis of the medical history and the account of the relatives.

17.184 Dr Grenville observed that a physical examination was rarely helpful in the diagnosis of (a natural) cause of death. He felt that it was important for the body to be examined by someone for signs of violence or lack of care. However, he did not believe that the examination need be carried out by a doctor. It could, for example, be undertaken by a funeral director or coroner's investigator. He said that the facilities and conditions at a funeral parlour might not be conducive to a doctor performing a thorough examination of a body. At the seminars, he gave a graphic account of the conditions that had prevailed at the premises of a busy funeral director when he had attended there on the previous day. The equipment ordinarily used to take bodies down from four-tier racks was not available and Dr Grenville had to examine a fully clothed body at shoulder height. Dr Baker agreed with Dr Grenville and said that requiring the examination to be carried out by a doctor would represent an inappropriate use of scarce medical resources. She thought that funeral directors could be trained to undertake the examination.

17.185 Professor Baker referred to the examinations currently undertaken by doctors completing cremation forms. His impression, like mine, is that such examinations are, in general, cursory in nature. They have not been accorded a high priority and doctors have not been properly trained in what to look for. As a result, the examinations have not been carried out well. Nevertheless, Professor Baker felt that, if properly carried out, such examinations might be of benefit. The main benefit that he envisaged was the opportunity to see whether there were any reasons (e.g. signs of possible neglect such as pressure sores or weight loss) that made it necessary to question the cause of death. He agreed that such an examination might be carried out by someone other than a doctor, provided that the person conducting it had the necessary skills.

17.186 Dr James was not in favour of a full examination in every case. He felt that it would be intrusive and unnecessary to conduct a full examination in a case where the death was expected and the condition causing the death well documented. In those cases where an examination would be of benefit, he said that it should take place in controlled conditions, with proper lighting and other facilities. The medical coroner should identify those cases in which an examination is to be carried out; they might include cases where the circumstances of the death are not completely known, where the death was unwitnessed or where the deceased has been entirely dependent on others for his/her care. The most appropriate person to carry out the examination, Dr James said, would be a pathologist, although, if a requirement for an investigation by a second doctor were introduced, the second doctor could be trained to carry out the task. However, Dr James emphasised that proper facilities would be required, together with a system of enforcement of a proper standard of examination. If no such system were in place, the current poor standard of many examinations for the purposes of cremation forms would persist. Dr James felt that

there might be public disquiet at the prospect of a coroner's investigator performing such an intimate examination. Dr Pickersgill thought that the type of examination described by Dr James would be outside the competence of general practitioners and would require specific training for those undertaking it. He suggested that the necessary training could be undertaken by a group of people other than doctors.

Comment

17.187 I do not consider that examination of the body by the doctor who is to complete Form 2 is either necessary or appropriate. Such an examination will not assist in identifying the cause of death. For community deaths, the requirement would place a substantial burden on the doctor, as the body may be some distance from the doctor's surgery. In hospital deaths, a full examination will have already taken place.

Examination by the Funeral Director or Mortuary Technician

17.188 The suggestion that funeral directors might be required to carry out a visual inspection of bodies passing through their premises, and to complete a form recording their findings, met with a mixed response from the different groups representing members of the profession. In written responses, the National Society of Allied and Independent Funeral Directors opposed the suggestion that an obligation might be placed on funeral directors to complete such a form, on the basis that they were not qualified to do so. However, the National Association of Funeral Directors did not envisage any problems in principle with completing a form such as Form 4, although the Association's response suggested that, if a statutory duty were imposed on funeral directors and hospital mortuary technicians to report to the coroner anything unusual or untoward, there would be no need for the form. The British Institute of Funeral Directors also gave broad support to the proposal. The Institute's response suggested that funeral directors could provide a further independent check in the system. It was also suggested that, in order to perform the examination, funeral directors would require specific training, which could be provided through the Institute.

17.189 A number of participants at the seminars supported the idea that an examination for signs of violence and neglect could be carried out by someone other than a doctor; some, including Dr Grenville and Dr Pickersgill, thought that funeral directors would be ideally placed to undertake the examination. Dr Evans expressed the view that such an obligation could also be placed on mortuary technicians and that a protocol or checklist could be devised to assist in the performance of the examination.

Comment

17.190 In my view, funeral directors and mortuary technicians are well placed to observe any sign of violence or neglect. I consider that if they are placed under a duty to report any physical signs giving cause for concern, there will be no need for a form to be completed.

The Interface between the Medical Coroner and the Judicial Coroner

17.191 Under the Inquiry's working model, it was envisaged that the coroner service would be a unified service. All deaths referred to the coroner system would go first to the medical

coroner, who would institute an investigation into the circumstances and cause of death. If the police or another agency were investigating the death, the medical coroner would be responsible for conducting, or assisting in the conduct of, any necessary medical investigations. The medical coroner would then review the evidence and certify the cause of death if able to do so. Alternatively, the medical coroner would order a medical examination, such as an autopsy, after which s/he would again review the evidence to see whether the cause of death could be certified. It was envisaged that the medical coroner would refer a death to the judicial coroner only in a case where the factual issues surrounding the death were uncertain, or in dispute, or might otherwise require resolution by way of a judicial hearing.

17.192 There was wide agreement among participants at the seminars that, whatever the internal arrangements within the coroner service, there should be a single service encompassing legal and medical expertise. The public should have a single point of entry to a unified coroner service.

17.193 There was less agreement about the more difficult question of internal division of responsibility for investigation and decision making between the two coroners. At the seminars, the discussion about the interface between the medical coroner and the judicial coroner, and their respective spheres of responsibility, was illustrated by reference to several different types and levels of investigation that might arise.

17.194 At the seminars, it was suggested by Leading Counsel to the Inquiry that a death might be investigated in the first instance by a coroner's investigator, under the direction of the medical coroner. If the investigation were concluded and the medical coroner decided that s/he was able to certify the cause of death without autopsy, and provided that there was no reason for the coroner service to be further involved (i.e. the family had no concerns, there were no public interest considerations, etc.), the medical coroner would certify the cause of death and the judicial coroner would not be involved. That approach was generally accepted. On behalf of the Coroners' Society, Mr Burgess said that a considerable number of deaths would fall into this category. In such cases, the investigations would be undertaken, and the decisions made, by the medical coroner and his/her staff, without any, or any substantial, input from the judicial coroner.

17.195 The discussion then moved on to the case where an autopsy would be required in order for the cause of death to be determined. Mr Burgess accepted that, if the medical coroner were an independent office-holder, it might be appropriate for him/her to make the decision as to whether an autopsy should or should not be held. That decision should, however, be subject to challenge by a properly interested party, usually a member or members of the deceased's family. It was suggested that the challenge, on an issue of fact or law, should be directed to and determined by the judicial coroner.

17.196 The third type of case discussed at the seminars had an additional element, namely that there was something about the circumstances or cause of death that required further investigation. Counsel gave an example that might arise. The deceased had apparently died after falling from a ladder whilst carrying out do-it-yourself work at home. Participants were asked to assume that an inquest in such a case was not mandatory, as it would be under the current system. They were asked for their views as to whether it might be

appropriate for the medical coroner to carry out or direct the investigation into the circumstances of the death, and then (provided that there was no public interest or other element making an inquest necessary) to write a report setting out his/her findings as to the circumstances and cause of death.

17.197 Mr Burgess felt that it would be appropriate for the judicial (rather than the medical) coroner to investigate the circumstances of the death and to reach conclusions thereon. Issues of fact which were essentially non-medical were outside the medical coroner's sphere of expertise and would be better understood by the judicial coroner. In the example given by Counsel, he pointed out that the ladder might have been defective or of poor design. Those possibilities would have to be investigated and it would be appropriate for that investigation to be done by the judicial coroner. It was suggested that protocols might be developed to assist in the 'standard' type of investigation. Such a protocol might, for example, provide that, in every case where the death was associated with use of a piece of equipment (such as a ladder), the coroner should arrange for that equipment to be tested for defects. Mr Burgess was asked whether, if that were done, straightforward investigations of this sort would really need the input of a judicial coroner. In reply, he questioned the usefulness of protocols and reiterated his belief that, if the investigation involved matters going beyond medical issues, it should be directed by the judicial coroner. Representing the Coroner's Officers Association, Mrs Warner agreed with the stance taken by Mr Burgess and said that, once a death had been classified as 'unnatural', according to the current understanding of the word (which would embrace the example referred to above), responsibility for the investigation should pass to the judicial coroner. Dr Leadbeatter agreed that, where there was any factual issue that might have a bearing on the death, the death should be referred to the judicial coroner.

17.198 On behalf of the RCPath, Dr Acland expressed a contrary view. Taking the example of the man falling from a ladder, he could not see why a medical coroner would not be able to participate in and lead such an investigation. The medical coroner could attend the scene if necessary, make an assessment of it and, 'just as anyone else is capable of doing', could arrange for the ladder to be inspected by an appropriate expert. He agreed that a case that appeared likely to be controversial or the subject of litigation should be referred to the judicial coroner. However, he envisaged that the medical coroner and the coroner's officers might have done a lot of the investigative work by the time the file went to the judicial coroner. The written response to the Discussion Paper by the Medical Protection Society expressed their view that the vast majority of cases would be capable of resolution by the medical coroner, without the need for legal expertise. The Society suggested that the duties of the judicial coroner might best be reserved to High Court Judges who, when the need arose, should direct those investigations requiring the input of legal expertise.

17.199 Professor Baker's view was that the appropriate division of responsibility would depend on the structure of the coroner's office and the extent to which individual cases were discussed between the medical and judicial coroner. He thought that it would be ideal if such discussions could take place and joint decisions could be taken on the investigative steps required. On the basis that the judicial coroner and medical coroner would work separately, with a process of formal referral from the medical to the judicial coroner, Professor Baker said he would 'verge on the side of caution' and go along with the view

that cases involving a factual element should at least be notified to the judicial coroner. Having considered the matter further, Professor Baker referred to the need to avoid a situation whereby the medical coroner dealt only with the straightforward cases and all the more difficult cases were passed to the judicial coroner. He said that this would have the effect of making the post of medical coroner 'fairly low level' and, consequently, unattractive and unrewarding. It might also reduce the ability of the medical coroner to identify those cases about which s/he should be concerned. Dr Leadbeatter pointed out that the medical coroner's involvement would not necessarily cease once the case had been referred to the judicial coroner. He had experience of some inquests where witnesses relevant to the medical issues had not been called to give evidence. The medical coroner should be able to offer advice and assistance to the judicial coroner so as to ensure that all relevant evidence would be available.

17.200 The final type of case discussed was one in which it was obvious from an early stage that it had a public interest or public safety element, such that it was likely that a public hearing (or, at least, the determination of a factual issue by the judicial coroner) would be required. The examples given were an apparent case of suicide where there was an issue as to the provision of proper psychiatric services and the death of a young person apparently caused by inhaling solvents. Mr Burgess felt that the judicial coroner should be involved from the beginning of the investigation of such cases. He advocated that judicial coroners (but not medical coroners) should have available to them powers of entry, search and seizure of property and documents. If valuable evidence were not to be lost, the judicial coroner should be notified of the death immediately. The scene should be examined in the name of the judicial coroner and any necessary exhibits seized. At first, Mr Burgess seemed to be suggesting that the judicial coroner would have his/her own team of investigators who would collect evidence on his/her behalf. However, he later accepted that, if there were a team of investigators at district level which undertook both medical and circumstantial investigations, the judicial coroner would be able to request a member or members of that team to carry out any investigations that s/he deemed necessary over and above those already directed by the medical coroner.

17.201 Mr Burgess was asked about the desirability of the current arrangement whereby the coroner is responsible for directing the process of evidence gathering in a case in which s/he is later to assume a judicial role. He could see no alternative to that arrangement. He described how, under the existing system, a coroner often has a detailed involvement in the evaluation and preparation of the evidence. He saw no tension between that degree of involvement and the coroner's judicial role. It was suggested that, in those cases which proceeded to a public hearing, evidence gathering might be directed by a solicitor based, with the judicial coroner, in the regional coroner's office. The solicitor would be responsible for taking statements in more complex cases and for preparation of cases for hearing. Mr Burgess observed that, in his view, a properly trained coroner's investigator would be able to produce sufficient evidence to enable an inquest to proceed without the need for a solicitor. For the Coroner's Officers Association, Mrs Warner agreed that she would expect coroner's officers to fulfil this role, with the coroner being the ultimate arbiter as to the adequacy of the evidence gathered.

Comment

17.202 In my view, the medical coroner should be able to complete the investigation into a large proportion of deaths. I do not think it should be necessary for the judicial coroner to be involved just because some factual aspect of the circumstances requires investigation. I agree with Professor Baker and Dr Leadbeatter that in some cases the medical and judicial coroners should both contribute to the investigation. Plainly, the judicial coroner will take a leading role in the investigation of any death where the circumstances are complex or where the weight of the investigation relates to factual rather than medical matters.

17.203 Although Mr Burgess did not feel that there was any tension between his role as manager of the investigation and his judicial function at an inquest, I consider that there can be such tension. I would experience it myself if I had to play an active role in directing the investigations carried out for this Inquiry. I give only general directions. In my view, in any inquest case which is likely to be complex or controversial, the judicial coroner should be able to distance him/herself from the practicalities of investigation.

Registration of Death

17.204 In order to register a death under the present system, an informant, usually the nearest relative of the deceased, must attend at a register office and provide certain details to the registrar. The registrar will then create an entry in the register of deaths and provide the informant with a certified copy of the entry, generally known as the 'death certificate'. At the seminars, there was discussion as to whether or not the registration of death should continue to be performed outside the coronial system, or whether there might be some way of integrating the function of registration into the coroner service. The point was made that, if relatives were to attend the coroner's office in certain cases to discuss the circumstances of the death, it would be desirable for them to be able to register the death at the same time and thus to avoid attendance at the register office.

17.205 I referred in Chapter Six to the recent proposals for the remote registration of deaths on the Internet or by telephone. At the seminars, it was suggested that, if such a system were in operation, the information required to register the death could be obtained by the coroner's staff and passed electronically to the registrar, who could then register the death. This would remove the necessity for two personal attendances. On behalf of the ONS, Miss Ceinwen Lloyd did not welcome the proposal. She stressed the important role of the registrar in providing information to relatives about administrative issues such as obtaining state benefits, closing bank accounts and taking out probate. She felt that, even if the cause of death were to be registered on-line, the families should still have contact with the registration service in order for such practical advice to be given. Miss Lloyd also made the point that there are practical advantages in the location for the registration of both births and deaths being the same. She gave the example of the multiple birth, following which a family might need to register a stillbirth on the same occasion as a live birth. Miss Lloyd thought that only a minority of informants would use remote facilities if they were made available. Most would prefer face to face registration, which constitutes a formal recognition of the fact of the death and brings a sense of 'closure'. She suggested that it was likely to be only people such as executors dealing with deaths where there were

no relatives who would avail themselves of the facilities for remote registration. Miss Lloyd acknowledged that the ONS had examined registration procedures in other jurisdictions where there was no requirement for a face to face interview. No problems seemed to arise with the procedures in those jurisdictions. However, she said that people in this country expect to attend the register office following a death, whereas it is not the culture to do so in other jurisdictions.

17.206 The Inquiry's Forms 1 and 2 would contain far more information about the deceased's medical history and the circumstances surrounding the death than does the present MCCD. Miss Lloyd did not think it appropriate for registrars to be given the task of analysing that information at the point of registration and of determining whether or not the death should be registered or referred to the medical coroner. She said that registrars do not have the necessary medical knowledge to fulfil this role.

17.207 Miss Lloyd thought that it might be possible for a registrar to be seconded to a coroner's office, as occurs in hospitals under the current system, so that families could register the death at the same time as attending the coroner's office for interview. Dr Leadbeatter supported the idea of the 'one-stop shop', with all the post-death processes dealt with at one physical location. Miss Lloyd mentioned a number of practical difficulties that might be associated with locating registrars in coroner's offices. These included the effects on staffing levels and possible inconvenience to the public if coroner's offices were based less locally than register offices. At the present time, coroners and registrars operate out of the same building in some areas. In his written response to the Coroners Review, Mr M J F Sheffield, HM Coroner for Teesside, said that he had found it advantageous having the registrars located in the same building as his own office.

17.208 In its written response to the Discussion Paper, the Death Certification Advisory Group of the ONS expressed concern that, under the current system, the ONS is not informed of deaths which are the subject of inquests until the conclusion of the inquest proceedings. That can be months, even years, after the death. This has an impact on mortality data which is used for public surveillance and monitoring standards of healthcare. At the seminars, Miss Lloyd said that she hoped that this matter could be addressed. The ONS would like to be informed promptly of the fact that a death had occurred and, if possible, of the cause of death. For the Coroners' Society, Mr Burgess thought that there was no reason why, under a revised system, that information could not be provided to the registrar soon after the death. He drew a parallel with the current system whereby, if an inquest is adjourned under the provisions of section 16 of the Coroners Act 1988, the coroner must provide to the registrar a certificate stating, so far as they have been ascertained at that time, the particulars required to be registered concerning the death.

17.209 There was support for the idea that information about the cause of death should not be released into the public domain and should be capable of being accessed by limited categories of person only.

The Inquiry's New Forms

Before the Seminars

17.210 In its Discussion Paper, the Inquiry proposed that four new forms should be introduced. The person certifying the fact of death should record the circumstances of death on

Form 1. The existing MCCD and cremation forms would be replaced by Form 2, to be completed by the treating doctor. A family member or other responsible person would complete Form 3, confirming the deceased's medical history and the accuracy of the accounts put forward by those completing Forms 1 and 2. Finally, having carried out an examination of the body, the funeral director would complete Form 4, confirming whether or not there were any external injuries on the body which might give rise to suspicion. I have already referred to discussion about these forms in the course of this Chapter.

17.211 Views were sought as to the desirability of introducing the forms, as to their content and as to any practical problems which might arise from their completion. Respondents to the Discussion Paper expressed a number of concerns about the content of the forms, as then drafted. By the time of the seminars, the Inquiry had moved away from its original suggestion that relatives should be required to complete a form such as Form 3. The Inquiry had also realised that Forms 1 and 2 would have to be greatly simplified if they were not going to be unacceptably burdensome to complete.

Discussion at the Seminars

17.212 With those factors in mind, a detailed discussion of the content of the forms took place at the last seminar, which was dedicated to a discussion of the forms. One of the issues canvassed was how new technology might be used to assist in the completion and transmission of the forms. The hope was shared by all that both Forms 1 and 2 might be completed electronically. Participants at an earlier seminar had pointed out that it is not unusual for employees of utility companies, for example, to visit householders to inspect boilers and other equipment and to record and transmit their findings, using a handheld computer. If that were to be done in the case of Form 1, it would enable the form to be transmitted (by the ambulance service, for example, or a deputising doctor service) straight to the coroner's office. Dr Baker, for the RCGP, suggested that Form 2, which would usually be completed by the treating doctor, might have self-populating fields linked to a patient's electronic records so that some details could be inserted on the form automatically without the need to key them in manually. That would save valuable time. Dr Evans, for the RCGP, had previously observed at a seminar that the task of completing Form 2 and sending it to the medical coroner using a computer on a hospital ward would be a great deal easier for a doctor than having to make his/her way to the hospital bereavement office to complete an MCCD or a Form B. Electronic transmission of forms would obviously speed up the whole process of getting information to the medical coroner. The possibility of sending to the medical coroner, with Form 2, a small bundle of the most significant medical records was also discussed. This is likely to become relatively easy in the near future when the categories of computerised record to be sent could be identified and selected in advance. Dr Evans suggested that, in hospital, the drug cardex could be photocopied and sent with Form 2.

17.213 One point which emerged clearly from the seminar was that the forms (in particular, Form 1) would require adaptation for use in hospital. The Inquiry has therefore designed new Forms 1 and 2 for hospital use, as well as a third version of Form 1, to be used when death occurs in, or is confirmed upon arrival at, a hospital accident and emergency department.

17.214 At the seminar, there was discussion of the Inquiry's ideas for simplified versions of the questions on Forms 1 and 2. To a large extent, these appeared to meet the concerns which had been expressed by organisations such as the RCGP, the BMA and the RCP. Discussion also centred around the time which it would take to complete the forms. Respondents to the Discussion Paper had been very concerned about the length of time that would be required to complete the forms, particularly in the case of a patient who had suffered from a long and complex illness.

17.215 In the light of the proposed simplification of the forms, participants at the seminar expressed less concern about the time which completion of the forms was likely to take. Dr Baker, representing the RCGP, held the most pessimistic view as to the likely time required. In the light of the simplification of the forms which was proposed, she reduced her estimate to an additional one hour over and above the time at present taken to complete the MCCD and cremation Form B. She made the point, however, that she was only able to offer an estimate and that undertaking a pilot study would be the best way of establishing the time that would be required. Dr Pickersgill suggested that the completion of the forms would take, on average, an hour in total and not, as Dr Baker believed, an additional hour. He said that it would take a similar time to the process of consulting the medical records, writing the MCCD, travelling to the funeral director's premises to examine the body, completing the Form B and consulting with the Form C doctor. The latter steps, of course, assume that the deceased is to be cremated. He pointed out, that under the new system, the doctor completing Form 2 would have to speak to the medical coroner. But the total time taken would be approximately the same. The point was also made at the seminars that only one doctor would be involved in completing the proposed forms, unlike the current cremation procedures which require forms to be completed by two doctors.

17.216 At the seminars, Dr Evans, for the RCP, said that, in the context of a hospital death, the completion of Form B, on a worst case scenario, could take up to an hour. He thought that a doctor familiar with the case would be able to complete the form more quickly and suggested that the best person to complete the form would be the treating senior house officer or registrar. Dr Aylin suggested that time and resources could be saved in hospital by the forms having a dual purpose. He suggested that a copy of Form 1 could go into the patient's notes and become the final entry in the notes. A copy of Form 2 could be sent to the patient's general practitioner in place of a discharge letter, thereby removing the need for a separate discharge letter to be composed and sent. Dr Aylin's suggestion received broad support at the seminars and a number of further practical benefits flowing from it were identified. Dr Pickersgill thought that Form 2 would greatly assist general practitioners in dealing with the needs of the bereaved family members following a death. They would receive the information quickly and in far greater detail than at present. Dr Baker also agreed that Form 2 would be an invaluable tool for internal audit in general practice.

The Feasibility Study

17.217 The Inquiry commissioned a small feasibility study to be undertaken by the Department of General Practice and Primary Health Care at the University of Leicester. The Report of that study was submitted in March 2003. The aims of the study were:

- to assess the feasibility of using the new death certification forms for deaths in hospital and in the community
- to assess the views of doctors and relatives on the practical aspects of filling in the forms, information requested, ease of interpreting the questions, and usefulness of the information
- to identify any problems with the proposed forms.

17.218 The study team was provided by the ONS with details of recent deaths registered at the Leicester register office. A sample of general practitioners and hospital doctors named as having certified the deaths were invited to take part. They were asked to complete the new Forms 1 and 2 (in the form in which they appeared in the Discussion Paper) as though they were certifying the fact and cause of death. Where the doctors were able to contact a relative, the relative was invited to complete Form 3. In cases where the fact of death had been confirmed by an out of hours doctor, s/he was invited to pilot Form 1. Participating doctors and relatives were interviewed by a member of the research team to elicit their views on the proposals in general and explore any problems encountered with specific questions on the forms.

17.219 Nineteen general practitioners, ten hospital doctors, two 'out of hours' doctors and six relatives participated in the study. The study team reported that there was general support for the view that the current death and certification processes should be overhauled. However, there was less agreement about the desirability of involving relatives to the extent suggested. The relatives interviewed had had difficulty in understanding and completing the forms and several of them felt that a requirement to do so would be too emotionally traumatising. That served to confirm the view already formed by the Inquiry that it would be inappropriate to require relatives to complete a form such as Form 3.

17.220 The Report prepared by the study team made a number of specific points about the forms. It was suggested that it might be preferable to have different forms for community and hospital deaths and the need for training and supporting materials for doctors implementing any new system of certification was emphasised. There was concern about the complexity of the forms and the amount of information which was required in order to complete them. Many of those concerns have been met by the changes which have been made to the proposed forms.

17.221 The study showed that, in practice, it appeared to take less time than had been estimated for the forms to be completed, despite the fact that the original version of the forms was used. The doctors participating in the study took varying amounts of time to complete the forms. The shortest time taken to complete both forms was 20 minutes and the longest one hour, with an average of something in the region of half an hour. A number of doctors said that they thought that the time taken would reduce with familiarity. The study team concluded that the time taken to complete the forms was mainly determined by the knowledge that the doctor had of the deceased as a patient. In the study, forms were completed retrospectively, on average six to eight weeks after the death and the point was made by some participating doctors that the process would be quicker if the forms were completed immediately after the death.

17.222 Concerns were expressed about the impact on minority groups in the event that the new system proved to be slower than the old one. Doctors participating in the study also raised the issue of payment to doctors for completion of forms. At present, doctors receive payments from relatives for completion of cremation Forms B and C but no payment for completion of an MCCD.

The Result of the Consultation Process

17.223 The exercise of publishing the Discussion Paper prior to the Stage Two hearings had the effect of crystallising the Inquiry's thinking on the detailed arrangements for a new system at that stage. That thinking underwent significant changes as I heard the oral evidence relating to Stage Two. It underwent further change as I became aware of the responses to the Discussion Paper and participated in the discussions at the seminars. The consultation process produced many ideas that had a significant effect on my thinking and, as will be evident from this Report, it has had a considerable influence upon my final recommendations.