CHAPTER NINETEEN

Proposals for Change

Introduction – the Problems Summarised

19.1 The present systems of death and cremation certification failed to detect that Shipman had killed any of his 215 victims. Many of the deaths occurred suddenly and unexpectedly and, under the present procedures, should have been reported to the coroner. Yet Shipman managed to avoid any coronial investigation in all but two of the cases in which he had killed. He did this by claiming to be in a position to certify the cause of death and by persuading relatives that no autopsy (and therefore no referral to the coroner) was necessary.

19.2 The present system is almost completely dependent upon the professional integrity and competence of the medical profession. In general the profession can be relied upon, but not always. The Shipman case has shown that the present procedures fail to protect the public from the risk that, in certifying a death without reporting it to the coroner, a doctor might successfully conceal homicide, medical error or neglect leading to death. It is said by some that Shipman is unique; there will never be another like him. I hope that is so, but other, less prolific killers have been detected in the medical profession and it is not possible to determine how many killings or how many errors by a health professional have gone undetected. Certification of the cause of death by a single doctor is no longer acceptable. Cremation certification, as presently practised, is ineffective.

19.3 After many Shipman killings, relatives of the deceased were surprised and puzzled by the sudden death of their relatives. In Tameside, as would have been the case in most parts of the country, they were not consulted during the certification processes or given any specific opportunity to discuss the death. They never saw the cremation Form C doctor. They were not asked for their account of events. Those who were concerned about the death of their relative were too diffident to contact the coroner's office. Thus a source of information, which might have resulted in Shipman's detection, was not utilised. The relatives' concerns were unresolved. In future, the family of the deceased must play a full part in the processes of investigation and certification.

19.4 As I have said, only two of the deaths of Shipman's victims were investigated by the coroner. Most of these deaths were sudden and wholly unexpected by the relatives of the deceased. They should have been reported to the coroner but were not. For that reason alone, it is no longer acceptable that the decision on referral should be made by a single certifying doctor. In any event, research has shown that, even when acting honestly and making a genuine effort to recognise a death that should be reported to the coroner, many doctors fail to do so. Some means must be found to ensure that those deaths that require full investigation by the coroner receive it.

19.5 In the two concealed Shipman killings investigated by the coroner, the investigation failed to uncover the truth. Those investigations were inadequate. The Inquiry has found other examples of poor coronial investigation. If coronial investigation is not thorough, there is a danger that wrongdoing will go undetected. There are several possible explanations why coroners' investigations are not as thorough as they should be. One is that the coroner

may have insufficient time and inadequate resources to ensure that reported deaths are properly investigated. Often the coroner does not have medical knowledge or ready access to medical advice. He or she may therefore have an imperfect understanding of the issues. Many coroners lack the support of trained investigators.

19.6 In short, the present systems are failing to protect the public and to meet the reasonable expectations of society. There can be no doubt that change is needed. The changes that I shall propose are based upon the evidence I have heard and read, the responses to the Inquiry's Discussion Paper and the contributions made during the seminars. At times, in earlier Chapters of the Report, I have presaged some of my conclusions. In this Chapter, I shall describe my proposals for change and the new system that I recommend.

The Fundamental Review of Death Certification and the Coroner Services

19.7 The Terms of Reference of the Fundamental Review of Death Certification and the Coroner Services in England, Wales and Northern Ireland ('the Coroners Review') overlapped to some extent with those of this Inquiry. Mr Tom Luce, Chair of the Review, has been most helpful to the Inquiry. He provided the Inquiry with the responses to the Review's Consultation Paper. He agreed to make a public statement at one of the Inquiry's seminars, in which he outlined the Review's current thinking on a number of issues of common interest. Also, he has permitted me to read the Review's Report before publication. This has enabled me to identify those areas where the Review's conclusions coincide with mine and where we differ. I am pleased to report that there are many topics on which we are in agreement. Where we do not agree, I shall take the opportunity to explain why I differ from the Review's proposals. I hope that this approach will be of assistance to those whose task it will be to decide upon the form of change to be made.

19.8 It will be apparent to any reader of this Report and the Report of the Coroners Review that I have not covered several important issues that are covered by the Review. For example, I have not mentioned the special arrangements presently made for the certification and registration of stillbirths and neonatal deaths. I have not discussed whether special provision should be made for the investigation of the death of a child. I have not considered the procedures governing the disposal of bodies brought in from overseas or the granting of permission to remove a body for disposal overseas. I have not mentioned Northern Ireland. I have not touched upon these subjects because they have not arisen in my consideration of the deaths of Shipman's patients and the operation of the systems by which those deaths were investigated and certified. Those topics in effect fell outside the Inquiry's Terms of Reference.

19.9 There is one very important set of issues, covered fully by the Coroners Review, which I shall touch upon only briefly. This is the scope and conduct of inquests. As the Report of the Coroners Review makes plain, this is an area in which changes are necessary. I have not delved deeply into these issues for two reasons. First, they have not been prominent in the Inquiry's consideration of the deaths of Shipman's patients. No death of a victim of Shipman's was subject to an inquest until after his conviction. The deaths of very few of his patients were even reported to the coroner, let alone examined at inquest. For that reason, the Inquiry has received little evidence about inquests. The issues surrounding

the scope and conduct of inquests have arisen largely from consideration of the responses to the Coroners Review's Consultation Paper and the Inquiry's own consultation procedures. Second, as the results of the consultation have led me to form views similar to those expressed by the Coroners Review, it seems sensible that I should simply endorse the Review's conclusions, rather than explain my own at any length. In Chapter Nine (paragraph 9.76), I have listed those parts of the Coroners Review where I am in agreement with the views expressed.

Should a Coronial System Be Retained?

19.10 In any modern society, there must be a system for the investigation of the cause and circumstances of death. In England and Wales, for well over a century, coroners have been at the heart of the system of death certification and investigation. Although many deaths are certified by a single doctor, Parliament has provided that certain deaths requiring investigation are to be reported to the coroner with a view to an inquest being held unless the coroner decides, after an autopsy, that an inquest is not necessary. In earlier Chapters of this Report, I have been critical of the ways in which the coronial system operates at present. I have pointed to the poor quality of many coroners' decisions and the superficiality of investigation. Although I have not covered in depth the conduct of inquests, I am aware of many criticisms of them and I observe that the Coroners Review has concluded that they are unsatisfactory in many respects.

19.11 In the light of these deficiencies, ought I to recommend the abolition of the coronial system? Is there any need in the system for a hearing conducted by a judicial figure? Although some states and countries (e.g. Finland and Maryland, USA) complete death investigation and certification without any judicial involvement, many systems incorporate some form of judicial proceeding for the uncovering of uncertain facts. It seems to me that the availability of some form of judicial enquiry is highly desirable, if not absolutely essential. I think that the tradition of the coroner's inquest is so well rooted in this country that most members of the public would regret its loss, even though they are critical of the way it is operated at present.

19.12 I have concluded that the coronial system should be retained. In that, I am in agreement with the Coroners Review. However, in my view, there must be radical reform and a complete break with the past, as to organisation, philosophy, sense of purpose and mode of operation. The new Coroner Service that I shall recommend will be barely recognisable as the offspring of its parent.

The Aim and Purposes of the New Coroner Service

19.13 The aim of the Coroner Service should be to provide an independent, cohesive system of death investigation and certification, readily accessible to and understood by the public. For every death, it should seek to identify the deceased, to discover where, how and why the deceased died and should provide an explanation for the death to those associated with the deceased or having a proper interest in understanding the cause and circumstances of the death. It should seek to ensure that all the necessary formal details relating to the death are correctly and accurately recorded. Its procedures should be

designed to detect cases of homicide, medical error and neglect. It should seek to meet the needs and reasonable expectations of the bereaved, including those from minority groups who wish to dispose of their dead within a short time after the death. The Service should also provide a thorough and open investigation of all deaths giving rise to public concern. It should ensure that the knowledge gained and lessons learned from death investigation are applied for the prevention of avoidable death and injury. It should provide accurate information about causes of death for the purpose of maintaining mortality statistics and to assist in the planning of healthcare provision and public health strategies.

19.14 It will be observed that I have not sought to draw any distinction between 'natural' and 'unnatural' deaths. This is a distinction that sometimes causes practical difficulty and results in decisions that are difficult to justify logically. The aim of the Coroner Service should be to investigate all deaths to an appropriate degree. With many, it will be sufficient to confirm and record uncontroversial basic information about the deceased and the medical cause of death. With others, there will be a need for investigation of the circumstances of the death and its medical cause. There should not be fixed categories of deaths that require and do not require in-depth investigation. Coroners should receive guidance about what types of death are likely to merit detailed investigation but the extent of the investigation in an individual case should depend upon the circumstances and any concerns expressed.

The Need for Leadership, Training and Expertise in the Coroner Service

19.15 As I described in Chapter Seven, coroners follow markedly differing practices and provide services of variable quality. In future, the Coroner Service should provide leadership, training and guidance for coroners, with the aim of achieving consistency of practice and a high quality of service throughout the country. This should be provided by means of a unified national Service, centrally governed and operating through regional and district offices.

19.16 In my view, the Coroner Service requires medical, legal and investigative expertise. A coroner should not, as now, carry out all coronial functions regardless of whether s/he is legally or medically qualified. In future, s/he should perform only those functions for which s/he is professionally qualified. Coroners should have the support of trained investigators. All coroners and investigators should be given initial and continuing education relevant to their functions and all must be trained in dealing with the bereaved and in the issues affecting minority groups. Such training should be compulsory.

19.17 Many times in this Report, I have drawn attention to the need for medical expertise in the coroner's office. At present, although most coroners are legally and not medically qualified, they carry out functions that require medical expertise. The conduct of inquests apart, the job of coroner requires medical knowledge far more often than legal knowledge, and entails a medical judgement far more often than a legal one. The coroner must decide whether a death falls within his/her jurisdiction. This is not usually a difficult legal issue but requires an assessment of the known facts, a process which often, although not always, depends upon medical knowledge and judgement. The coroner often has to decide whether to certify a cause of death, on the basis of an autopsy, without an inquest. The

interpretation of the autopsy results, in the light of other available evidence, is essentially a matter of medical rather than legal judgement. In any event, in my view, the identification of the cause of death in a case of uncertainty need not and should not always automatically entail the conduct of an autopsy. Consideration by a medically qualified person of other materials, such as medical records and information about the circumstances of death, should, in many cases, sufficiently identify the cause of death. Apart from the conduct of inquests and the investigation that precedes some of them, most of the coroner's functions call for medical expertise. In my view, there is a need, within the coroner system, for a medically qualified person to exercise many of the functions presently carried out by coroners who have, in the main, no medical expertise.

19.18 Sometimes, although not always, the task of directing an investigation into the circumstances of a death requires legal expertise. So, obviously, does the conduct of an inquest. My proposals in relation to the cases in which an inquest should be held would, if adopted, result in a substantial reduction in the number of public inquests. I envisage that many coroner's investigations would result in a written report rather than an inquest. At the present time, it appears to me that most such investigations and reports would not require the attention of a coroner with legal expertise. I shall discuss this topic in greater detail below. However, there would be other functions in the new system that I propose which would call for legal expertise. I envisage that a legally qualified coroner would be required in order to exercise a number of special powers, such as authorising the right to enter premises and seize property and documents relevant to the investigation of a death, which I am proposing should be available to coroners. A legally qualified coroner would also be required to exercise a number of appellate functions, which I am proposing should be introduced, particularly relating to issues affecting a citizen's rights. Plainly, there will be a need for legally qualified persons in the Coroner Service as well as for those with medical qualifications.

19.19 What should these medically and legally qualified persons be called? In my view, they should both be coroners, as both would fulfil what have traditionally been regarded as coronial functions. In the Discussion Paper, the Inquiry team tentatively gave them the names of 'medical coroner' and 'judicial coroner'. The Coroners Review, which has also concluded that there is a need for medical expertise in the coroner's office, proposes that the coroner should be legally qualified and that the person with medical expertise should be called the 'statutory medical assessor (SMA)'. The differences between these two proposals are not merely of nomenclature. I envisage a different role for the 'medical coroner' from that which is proposed for the 'statutory medical assessor'. The 'medical coroner' would take many coronial decisions and would manage and be responsible for the operation of the district office. He or she should be an independent office-holder under the Crown with the status of the present coroner. The titles 'medical coroner' and 'judicial coroner' fit the functions that I propose. I shall therefore continue to use those expressions throughout the remainder of this Report. When referring to the proposals of the Coroners Review, I shall use their terminology. However, I stress that there is agreement between us that someone with medical expertise (whatever s/he is to be called and whatever the precise ambit of his/her role) is needed in the coroner's office.

19.20 At present, coroners depend for support on coroner's officers who are almost completely without training or management. In future, the coroner's support should come from a corps

of trained investigators, who would be the mainstays of the new system. The coroner's investigator would replace the coroner's officer but the role would be much enhanced and the coroner's officer's more routine functions would be performed by administrative staff. Investigators would come from different employment backgrounds and would bring a variety of skills and experience to the work. For example, some might have a background in criminal investigation. Others would have a paramedic or nursing background. The essential attributes would be an independent and enquiring mind, good interpersonal skills and particularly the ability to work with the bereaved. All investigators would be required to handle certification of deaths, in the way that I shall describe below, exercising powers delegated by the medical and judicial coroner. I envisage that some investigators (those with a medical background) would become accredited to certify the fact of death and would specialise in the investigation of the cause of death. Others would develop skills for the investigation of the circumstances of deaths, for example deaths in the workplace. All would be trained to approach every death with an open mind rather than a confident expectation that the death will be natural. In other words, like investigators in Ontario, they should be trained to 'think dirty'.

Proposals for the Structure and Operation of the Coroner Service

Central Organisation

19.21 The Terms of Reference of the Coroners Review required it to consider where departmental responsibility should lie for the provision of any new or changed arrangements for death certification and the role of coroners. The Inquiry's Terms of Reference contained no such specific requirement. The Inquiry has not heard evidence or received representations about the way in which the changes I am to recommend should be effected. However, I have formed some views about what should happen and why.

19.22 In my view, if coroners and the Coroner Service are to command the confidence of the public, they must be and must be seen to be independent of Government and of all other sectional interests. Although coroners investigate on behalf of the state, they might well reach verdicts and make recommendations unwelcome to Government and sectional interests. For example, coronial decisions critical of hospital practice might be unwelcome to the National Health Service. In the past, there has been no suggestion of interference by Government in the judicial independence of the coroners. They have, as I have observed, been left to their own devices. However, I now propose that coroners should have the benefit of leadership from a supervisory and supporting structure. The body which is to provide that leadership and support must be seen to be independent of Government. In my view, it would no longer be satisfactory for the coroner service to be administered from within a Government Department. Instead, the new Coroner Service should be a body at 'arm's length' from Government, that is an Executive Non-Departmental Public Body (ENDPB). Such bodies are formed in association with, but are independent of, the Government Department through which they are answerable to Parliament.

19.23 At present, responsibility for coroners lies with the Home Office, although the Lord Chancellor has the power to discipline them. It seems likely that the association with the Home Office arose because, historically, coroners were an adjunct to the criminal justice system. This is no longer the case. The Home Office is also responsible for cremation certification. Death certification is carried out either by coroners or by doctors. The doctor's duty arises under the Births and Deaths Registration Act 1953 and not from his/her employment within the National Health Service. Government responsibility for registration lies with the Office for National Statistics (ONS), which falls under the control of the Treasury. The Department of Health (DoH) (in Wales, the National Health Service Wales Department of the National Assembly for Wales) has an interest in death certification and in many aspects of the work of coroners (the use of pathologists is an example). This fragmentation of control and interest has led to difficulty in effecting reform in the past. As appears from the history I recounted in Chapter Three, one of the reasons why the recommendations of the Brodrick Report were not carried into effect was that there was insufficient political will; the interests and priorities of the various Departments pulled in different directions. That problem is likely to continue as, inevitably, several Government Departments will continue to have a policy interest in the various aspects of death certification, investigation and registration. However, I believe that the problems of fragmentation would be alleviated if the Coroner Service had the status and independence that enabled it to co-ordinate the various Departmental policies into a coherent overall policy.

19.24 If the Coroner Service is to be an ENDPB, as I suggest, with which Government Department should it be associated? The Coroners Review has suggested that the Coroner Service should be administered directly by the Lord Chancellor's Department (LCD) and should have the benefit of a Coronial Council to monitor its performance. Since the Review's Report was published, the Government has announced the formation of a new Department for Constitutional Affairs, which will take over many of the functions of the LCD. At the time of writing, it seems likely that the new Department will be responsible for the administration of the courts and, in conjunction with a Judicial Appointments Commission, for the selection of the judiciary. I agree that the LCD would have been in many respects, a suitable Department to be associated with the Coroner Service. The Department was very experienced in the appointment of judges of all levels and well understood the need to protect judicial independence. However, there are some aspects of the work of the Coroner Service that would not have fitted comfortably with the functions of the LCD. The Coroner Service will have to recruit medical coroners or statutory medical assessors or some medically qualified persons, whatever title they are given. The LCD had no experience of such functions and no connection with the medical profession. The Coroner Service will also have an investigative function. The LCD would have been ill equipped to offer support in that respect also. In some respects, the DoH (and its equivalent in Wales) would be a more appropriate choice. It will be important for the Coroner Service to establish links with public health and to ensure that its medical coroners do not become isolated from current medical knowledge and practice. I cannot at present see any advantage in the Coroner Service being associated with the Home Office.

19.25 It seems to me that the ideal solution would be for the Coroner Service to be an ENDPB associated with both the new Department for Constitutional Affairs and the DoH or its

Welsh equivalent. It would in that way be able to draw upon the relevant expertise available in both Departments and would yet maintain a high degree of independence. I realise that an ENDPB is usually associated with only one Department. However, it appears to me that there are particular reasons why the usual practice should be abrogated in the case of the Coroner Service. Devolution issues may have to be addressed.

19.26 As an ENDPB, the Coroner Service would be governed by a Board. I have said that the Coroner Service requires three forms of expertise. I suggest that the Service should be managed by a Chief Judicial Coroner, a Chief Medical Coroner and a Chief Coroner's Investigator, who would be members of the Board and would provide the executive core of the Service. I suggest that the Board might have two or three other independent members with relevant knowledge and experience.

19.27 The Board would be responsible for the formulation of policy, the strategic direction of the Service and the provision of the necessary facilities, buildings and personnel. It should seek to secure adequate funding from Parliament. An important central function would be to promote the education of the public about the work of the Coroner Service. It is desirable that the Coroner Service should have a high public profile. I would suggest also that the Board should make provision for a national coronial information system, organised along the lines of that in Australia.

19.28 The Chief Judicial Coroner would provide leadership for the judicial coroners operating throughout the country. He or she would be responsible for the continuing education of judicial coroners and for the promotion of nationwide consistency of good practice. He or she would also exercise some judicial functions and might conduct some inquests. I suggest that the first appointee might be an existing judge or senior member of the legal profession, rather than an existing coroner, and the post should be of the status of a senior circuit judge. I consider it vital that there should be a complete break with the ethos of the existing coronial system.

19.29 The Chief Medical Coroner would provide leadership for medical coroners and regional medical coroners throughout the country. He or she would be responsible for the provision of the facilities necessary for the operation of the medical coroner service at regional and district level. He or she would be responsible for continuing education and the promotion of good practice. He or she would establish links at a high level with those concerned with public health and public safety. The position would call for a doctor with administrative ability and some knowledge of or experience in the fields of public health and forensic medicine.

19.30 The Chief Coroner's Investigator would be responsible for the provision of a corps of suitably trained and experienced coroner's investigators for deployment in the regional and district offices. He or she would devise and arrange training courses. He or she would also devise and promulgate protocols for the conduct of investigations. He or she would be responsible for the maintenance of high standards of investigative work. The position might suit a former senior detective police officer or a solicitor with experience of investigative work. I shall describe the operation of these officers and the central, regional and district offices in greater detail at Appendix L.

19.31 The Service should have the benefit of an Advisory Council, which should provide policy advice on all issues. This might comprise, in addition to the members of the Board, representatives of the DoH, its Welsh equivalent, the Department for Constitutional Affairs, the Home Office, the General Register Office, the ONS, organisations representing doctors, nurses and those providing pathology services, the Association of Chief Police Officers, an Ambulance Trust and an organisation such as Cruse Bereavement Care.

Regional and District Organisation

19.32 The Coroner Service should be administered through a regional and district structure, with a regional medical coroner and at least one judicial coroner assigned to each region. I envisage that there would be ten regions in England and Wales (coinciding with the ten administrative regions). The Coroner Service should have jurisdiction over every death that occurs in England and Wales and over every dead body brought within the boundaries. Jurisdiction should not depend upon a report being made or upon the need for an inquest. A death should be investigated in the district office most convenient in all the circumstances.

19.33 The principal functions of the judicial coroner would be the conduct of inquests and the direction of more complex investigations. The main functions of the regional medical coroner would be the provision of regional services of a specialist nature such as forensic pathology, paediatric pathology and toxicology. He or she would also undertake investigations into the more difficult or complex medical cases, where appropriate, in conjunction with the judicial coroner. I suggest that there might also be a regional investigator who would supervise the investigative teams within the region and would manage a small team of investigators at the regional office.

19.34 Each region would be divided into districts. I have in mind that each region would have between three and seven districts and each district would have a population of about a million. I suggest that districts should be coterminous with the boundaries of the 42 police areas (excluding the City of London), although where a police force covers a wide area or serves a large population, there would be more than one coronial district within that police area. In all, I envisage between 50 and 60 district offices. Each district office would have a medical coroner, one (or possibly more than one) deputy medical coroner (who might work part-time), a team of coroner's investigators and a small administrative staff. The service would operate for 24 hours, seven days a week, although the 'out of hours' service would be limited to the necessary minimum.

19.35 It will, in my view, be important to ensure that the medical coroner is and is seen to be independent of the medical community within the district. He or she will, in many respects, be required to 'police' the local doctors. It may well be necessary to appoint a medical coroner from an area distant from the district in which s/he is to serve.

Death Certification and the Reporting of Deaths to the Coroner

A Unified System

19.36 All the evidence received by the Inquiry and virtually all the opinions expressed during consultation suggest that the separate system of certification prior to cremation should be

abolished. It was universally recognised that we must have an improved system of death certification applicable to all deaths, whatever mode of disposal is to follow.

The Proposal in the Discussion Paper

19.37 In the Discussion Paper, the Inquiry suggested a dual system of death certification, in which a single medical practitioner would be permitted to certify the cause of death in a limited class of cases, namely 'expected deaths' that were not in any other respect reportable to the coroner. All deaths other than 'expected deaths' and all reportable deaths were to be fully investigated by the coroner. There was to be a more comprehensive list of circumstances in which a death was to be reported. Certification by a doctor would be subject to safeguards that would operate through the completion of a new set of forms. Form 1 was to record the fact of death and the circumstances in which it occurred. It was to be completed by the health professional who examined the body and ascertained that death had occurred. Form 2 was to replace the existing MCCD and was to provide additional information about the deceased's medical history. It was to be completed by a doctor who had treated the deceased during the last illness. Form 3 was to be completed by a member of the deceased's family who had had the opportunity to examine what had been said on Forms 1 and 2. It was to provide an opportunity to raise any concerns about the death, including those caused by any perceived inaccuracy in the information recorded on Forms 1 and 2. Form 4 was to be completed by the funeral director who prepared the body for disposal and who was to draw attention to any signs of violence or neglect observed. All the forms were to go to the register office; it was hoped that the detail on the form would be such that any indication of the need for a referral to the coroner would be readily apparent to the registrar. In the event, the registration service did not agree that it would, for reasons that, having heard the evidence given in Stage Two, I fully understand.

19.38 The thinking behind the Inquiry's proposal was as follows. Although I was attracted to the idea that all deaths should automatically be reported to the coroner's office (because of the difficulty doctors have in recognising reportable deaths), I feared that such an arrangement might lead to delay in the granting of permission for disposal. I thought that there would be many 'expected deaths' which could be certified quickly, simply and safely by a single doctor; there would be a sufficient safeguard against the 'Shipman factor' if the family were to have the opportunity to see what the doctor had written and to raise their concerns.

19.39 However, as a result of the consultation exercise and the feasibility study carried out on the Inquiry's behalf, this proposal has been abandoned. First, it became obvious that it was not easy to define an 'expected death'; the suggested definitions were far from simple. At the moment, most doctors apply the term to any death for which they are able to issue an MCCD. The converse, the 'sudden' or 'unexpected' death, has to be reported to the coroner. Not only was it difficult to define an 'expected death', it seemed to me that it would be extremely difficult to wean doctors from their present understanding of the term. Second, there was an unexpected degree of support for the idea that all deaths should be considered by the coroner rather than only those falling within the reporting criteria. Third, and perhaps most important, it became quite clear that, as a means of involving the family of the deceased and providing a cross-check on the certifying doctor's account, the use

of Form 3 would be unacceptable. Families would find the form difficult and possibly distressing to complete; they would need help and could not be asked to deal with it quickly. Some means of personal contact with the bereaved family would be required.

Identifying the Basic Requirements of the System

19.40 Although the consultation exercise led to the abandonment of the suggested system of certification advanced in the Discussion Paper, it confirmed the suitability of some of the Inquiry's ideas. In particular, I became convinced that modified versions of Forms 1 and 2 should be the basis of the certification system. Before turning to the more difficult question of who should be responsible for the decision on certification, I shall explain the operation of the two new proposed forms. They are reproduced, together with explanatory notes and sample completed forms, at Appendices G–K. The purpose of the explanatory notes is to describe what each question is driving at and the type of information that should be provided. The notes are not intended to be a blueprint for the explanatory notes that would have to be provided for the doctors and health professionals who would complete the forms. The completed sample forms have been prepared to illustrate the type of information that should be provided. These forms contain the Inquiry's ideas about what is required. They will almost certainly have to be redesigned by experts. However, I strongly recommend that the information sought in the forms eventually used should be substantially the same as is suggested in the Inquiry's Forms 1 and 2. The Inquiry has not attempted to design forms for special circumstances (such as stillbirths and neonatal deaths), which would clearly be required.

Form 1

19.41 In my view, there should be a requirement that the fact that a death has occurred should be confirmed and certified. At the seminars, there was unanimous support for the proposal that there should be an official record of the fact and circumstances of death. The Coroners Review makes a similar proposal. For this purpose, the Inquiry proposes Form 1, which would be completed by the health professional or coroner's investigator who confirms the fact of death. I recommend that, in addition to doctors, accredited nurses and paramedics should be authorised to confirm the fact of death and to complete Form 1. Coroner's investigators should also be trained and accredited for the purpose of certifying the fact of death. The Coroners Review has suggested that a nurse employed in a care home should not be permitted to certify the fact of a death occurring at that home. The Review proposes that a nurse should be provided by the local Primary Care Trust for that purpose. I do not think that such a limitation is necessary, provided that the nurse is properly accredited.

19.42 Different versions of Form 1 are suggested for deaths in the community, in hospitals and in accident and emergency departments. All versions of Form 1 require a description of the circumstances of death, including a statement as to who was present, together with contact details. All require that some external examination of the body should take place and the findings be recorded. For deaths in hospital, the whole body should be examined for signs which might be indicative of violence or neglect. For deaths in the community,

where conditions for examination are often difficult, there should be an examination of the head, neck and arms to the elbow. A special form is suggested for use in accident and emergency departments because of the particular pressures of work in such places. A patient might be dead on arrival or die very soon after admission. The fact of death might be certified by a doctor and the body moved from the department to make way for other patients. It seemed sensible that the examination of the body and the provision of information about the circumstances of death and the contact details should be made later, by someone other than the doctor who has certified the fact of death. Also, the circumstances of a death in an accident and emergency department are likely to be different from those of a death on the ward, in that the events leading to admission to the department are likely to be more relevant than those which took place in the department itself.

19.43 An issue arises as to whether a doctor or nurse who owns or has a financial interest in a care home or private hospital in which the death occurred should be permitted to complete Form 1. The concern was raised that such a person might be tempted to conceal some form of wrongdoing by him/herself or a member of staff. It appears to me that a doctor or nurse in that position ought to be allowed to complete Form 1. The main purpose of this form is to certify that the patient has in fact died. That is purely a question of medical fact and there is no reason to suppose that anyone would lie about it. It is possible that the person completing the form might tell lies about the circumstances of death. However, if the owner of the care home is not permitted to complete Form 1, some other health professional will have to attend to do so. That person will be dependent on the member of staff, probably the owner of the care home, for information about the circumstances of death. If the owner intends to deceive, s/he will be able to do so. The only way in which such deception might be uncovered would be by checking the information with some other person (if there is one) with relevant information.

19.44 It should be possible for Form 1 to be transmitted promptly to the district coroner's office on-line or by fax.

Form 2

19.45 It seems to me clear that the certification process should include the preparation of a brief summary of the deceased's recent medical history and the chain of events leading to the death. That would be provided on Form 2, which would be completed by a doctor who had treated the deceased during the last illness or, if no doctor had treated the deceased in the recent past, by the deceased's usual medical practitioner. It might well be completed by the doctor who had completed Form 1. The forms for hospital and community use are substantially the same, although the form for use in the community requires the doctor to describe any nursing or other care the deceased had been receiving before death. I suggest that it should become usual practice for the doctor to attach to Form 2 any important extracts from the medical records (e.g. the result of a test or a consultant's opinion). In future, with the increased use of computerised records, it should be possible for such extracts to be sent on-line, with Form 2, to the district coroner's office. Form 2 also provides a box in which the doctor can draw any relevant matter to the attention of the coroner.

19.46 The form also contains a box where the doctor has the option to express an opinion as to the cause of death. This should be done only if the doctor is able to express an opinion with a high degree of confidence. The declaration relating to that part of the form requires the doctor to say that s/he is **'able to justify the cause of death specified** [*above*] **on the basis of the deceased's medical history and circumstances of death'**. The doctor giving an opinion as to the cause of death should be capable of justifying the diagnosis to the medical coroner, by reference to the medical history and circumstances of the death, in the same way that s/he would expect to have to justify a diagnosis relating to a live patient in discussion with his/her peers. Even if the doctor cannot give such an opinion, s/he must still complete the remainder of the form. If the doctor is uncertain of the cause of death, it would be plain that the death required full investigation by the coroner. I should point out that Form 2 is not a certificate of cause of death. It provides only information and possibly the doctor's opinion. Certification would take place at the coroner's office.

19.47 Form 2 does not specifically require the doctor to state when s/he last saw the deceased alive, although the date of the last consultation with a doctor is almost bound to appear as part of the medical history. It is not intended that a doctor should be disqualified from expressing a professional opinion as to the cause of death simply on account of the lapse of time since the last consultation. However, when the doctor's opinion comes under scrutiny, as it must, the length of time since the last consultation would be a material factor for the person considering whether the diagnosis was reliable.

19.48 In my view, the completion of Form 2 is a very important function and should not be carried out by junior or inexperienced doctors. I have referred to the problems presently experienced when newly qualified house officers are given the task of completing an MCCD. It seems to me that the doctor who describes the medical history, expresses an opinion as to the cause of death and gives any other information to the coroner should have some experience and authority. A doctor will not usually become a principal in general practice until s/he has been qualified for about four years. In my view, any principal in general practice (but not a trainee) should be eligible to complete Form 2. In the hospital setting, I consider that the certifying doctor should have a comparable degree of experience and authority. I suggest that, to be eligible to complete Form 2, a doctor should have been in practice for four years since qualification. For doctors qualified overseas, I recommend that they should not be eligible to sign Form 2 until they have been in medical practice for four years (whether in the UK or not), are registered with the General Medical Council (GMC) and have been trained in the requirements of death certification in this country.

19.49 In my view, it will be necessary to impose a statutory duty upon a doctor so as to ensure that Form 2 is completed. If the death occurs in a hospital, the statutory duty should lie upon the consultant responsible for the care of the deceased at the time of the death. The duty need not be fulfilled personally but would be satisfied if the form were completed by a suitably qualified member of the consultant's clinical team (or firm). For deaths occurring elsewhere than in a hospital, the statutory duty would fall upon the general practitioner with whom the deceased had been registered. Here again, the duty could be fulfilled by another principal in the practice (who might, for example, have seen the deceased more recently than the doctor with whom the deceased was registered). If in future, the

procedure of registering with an individual general practitioner were to be changed and patients were to be registered with a practice, the statutory duty would have to lie on all principals within the practice, until fulfilled by one of them. For deaths occurring very shortly after admission to hospital, for example in an accident and emergency department, it might be appropriate for the duty to complete Form 2 to lie upon the deceased's general practitioner. It might be thought sensible to impose a time limit within which Form 2 should be completed.

19.50 If the deceased were not currently registered with a general practitioner and the death did not occur in hospital, there would be no one to complete Form 2. In those circumstances, the death would be investigated by the medical coroner. He or she could obtain any relevant past medical records that were available and speak to any doctor with whom the deceased had been registered in the past.

19.51 I recommend that the GMC should impose upon doctors a professional duty to co-operate with the death certification system by providing an opinion as to the cause of death on Form 2 in cases where it is appropriate to do so. A failure to co-operate would be a disciplinary matter.

19.52 With Form 2, as with Form 1, an issue arises as to whether a doctor who owns or has a financial interest in a care home or private hospital where the death occurs should be eligible to complete Form 2, to provide the medical history and to suggest the cause of death. If the doctor were to be able to certify the cause of death, I would be opposed to that being done by a doctor who might find him/herself in a position of conflict of interest. If the doctor were only to express an opinion, and if the death were to be certified by someone else (such as the medical coroner or a coroner's investigator), I can see no harm in the doctor with a financial interest expressing an opinion, provided that the interest is declared.

One Option – Dual Certification by Doctors

19.53 Apart from the option of the system of death certification suggested in the Discussion Paper, which I have decided to abandon, two other options were considered at the seminars. Both received a good deal of support. Under the first option, which I shall call the 'dual certification' system, the Form 2 doctor would consider whether s/he was able to express an opinion as to the cause of death to the high degree of confidence required by Form 2. If not, the death would be investigated fully by the coroner. If s/he was confident of the cause of death, a second doctor would review the first doctor's opinion. The second doctor would be a member of a panel selected by the medical coroner and would therefore be independent of the first. The second doctor would attend the medical coroner's office on a sessional basis and, for that time, would give the whole of his/her attention to the work of certification. Those contributors to the seminars who supported this option recognised that the second doctor must not be expected or permitted to squeeze the work of certification into the interstices of an ordinary working day. The second doctor would speak to and question a member of the deceased's family and possibly a carer, check with them the accuracy of what the first certifying doctor had said about the death and ascertain whether they had any concerns. The second doctor might also examine the

deceased's medical records. Some seminar participants suggested that the second doctor might make a physical examination of the body. However, most opposed that idea; they regarded such an examination as impracticable (the facilities at many funeral directors' premises being inadequate) and pointless unless carried out by a doctor with special training. It would also be very time-consuming.

19.54 If the second doctor were satisfied with the results of his/her enquiries, both doctors would sign the certificate of cause of death. Registration would take place on the basis of the dual signatures on that certificate. The registrar would give permission for disposal as now. If during the process, any circumstance were discovered to suggest that investigation was required, the death would be referred to the coroner. This system would be similar to cremation certification, as it was originally intended to operate. Plainly, if such a system were to be adopted, there would have to be safeguards to prevent the kind of deterioration in standards that occurred with cremation certification. In the event, this 'dual certification' system is similar, although not identical, to the system proposed by the Coroners Review. As a variation on the 'dual certification' system, the BMA suggested that all deaths should be reported to the medical coroner and investigated on his/her behalf by a second doctor. If that doctor agreed with the first certifying doctor, the cause of death would be certified. If not, or if any other reason emerged, the death would be investigated further by the medical coroner.

The Second Option – Coroner's Certification

19.55 The second option considered at the seminars was that responsibility for all death certification should come under the control of the Coroner Service. The coroner's office would be notified of all deaths and Forms 1 and 2 would be considered, initially by a coroner's investigator. If the doctor completing Form 2 had given a professional opinion as to the cause of death to the high standard of confidence required by Form 2, the coroner's investigator would then question one or more of the deceased's relatives or carers. The object would be to ascertain whether there was any inconsistency between the family's understanding of events and the accounts given on Forms 1 and 2. In general, the family member would be allowed to see Form 1 but would not necessarily see Form 2, which might contain medically confidential information. However, the family member would be asked questions that would elicit his/her state of knowledge about the deceased's medical history. In this way, possible inconsistencies would be brought to light. The family would have the opportunity to raise any concerns. If no problems emerged, the coroner's investigator would certify the cause of death (using the cause given by the Form 2 doctor) and authorise disposal of the body. Registration might take place on-line from the coroner's office, thus avoiding the need for attendance at the register office. Alternatively, the family member/informant might attend the register office in person. If the Form 2 doctor were uncertain of the cause of death, if the family or any other person expressed concern or if any other circumstance were discovered that made further investigation appropriate, the death would be referred for further investigation by the medical coroner and, where appropriate, by the judicial coroner. I shall call this system the 'coroner's certification' system.

Common Features

19.56 It will be noted that both suggested options make use of the knowledge and understanding of the doctor, if there is one, who has treated the deceased in the period immediately before the death. That doctor will almost always be the person with the best knowledge available. The essential difference between the two systems is the issue of who is to review the Form 2 doctor's account and opinion – a second doctor or a coroner's investigator.

19.57 Under both proposals, there would be provision for certification of some deaths without, in the case of a community death, there being any requirement for a full external examination of the body. (For hospital deaths, there would be a full external examination at the stage of completion of Form 1.) Although a full external examination carried out in good conditions by a doctor with the necessary skills is desirable, I think it is impracticable for all deaths in the community. Often the facilities at a funeral director's premises are not suitable for a visiting doctor to examine the body. Many doctors do not have the requisite skills, although I accept that these could be taught. Even a full examination is of limited use in determining the cause of death, although it can help to detect signs of violence or neglect. Under either proposal, if any concern is expressed by a member of the deceased's family or a carer, the death would be referred for further investigation and it would be open to the medical coroner to order a full external examination by a pathologist under proper conditions in a hospital mortuary. Also, I shall suggest that all funeral directors should be placed under a duty to report to the coroner any signs of violence or neglect that they observe while preparing the body for disposal.

My Preferred Option – the Coroner's Certification System

19.58 For reasons that I shall now explain, I strongly recommend the second of these two proposals, the coroner's certification system, under which all deaths would be reported to the Coroner Service, which would take responsibility for certification and for deciding whether or not further investigation was necessary. Cases in which the Form 2 doctor expressed an opinion as to the cause of death would be considered for certification by the coroner's investigator after consultation with the deceased's family (construed widely, as I explained at paragraph 12.24). All other deaths would go for further investigation by the medical coroner. I shall describe the way in which the system would operate in practice in some detail at Appendix M.

19.59 I have said that the essential difference between the two options is who is to review the Form 2 doctor's account and opinion, a second doctor or the coroner's investigator. I consider that it is preferable for this review to be carried out by a coroner's investigator. There are several reasons for this. First, the coroner's investigator will be manifestly independent not only of the first doctor but also of the medical profession as a whole. I have reservations about the feasibility of ensuring the independence of a second certifying doctor, even if selected and approved by the medical coroner. In rural areas, the medical community is likely to be small, and friendships and allegiances are inevitable.

19.60 Second, the task of checking the factual content of Forms 1 and 2 with the account given by the family, and of allowing the family the opportunity to express any concerns, does not

call for medical expertise. In effect, such a task could be described as a 'waste' of the second doctor's time, a scarce and valuable resource. The task could be perfectly well undertaken by a coroner's investigator and, as such a person would be accustomed to dealing with the bereaved on a daily basis, I consider that s/he might well do it better than many doctors would. The work of the investigator would be directed by a protocol, with which s/he would become very familiar. The information received could be recorded in writing. I was impressed by the way in which ambulance paramedics confirming the fact of death operate under a protocol and complete a record of their findings.

19.61 I acknowledge that a coroner's investigator would not be as well equipped to check on the medical opinion of the Form 2 doctor as another doctor would be. I recognise that, for the consideration of the treating doctor's diagnosis of the cause of death, the coroner's investigator would need some medical knowledge. He or she would have ready access to the advice of a medically qualified coroner. The coroner's investigator would have to be trained to recognise when there was reason to doubt the Form 2 doctor's diagnosis of the cause of death, in which case the medical coroner would become personally involved.

19.62 The system I have proposed would not depend upon the decision of the Form 2 doctor or of the second/panel doctor as to whether the death should be referred to the Coroner Service. As I have said, research has shown that doctors are often unsuccessful in recognising circumstances in which a full investigation is required. Any list of criteria is bound to be quite long and complex, as the Inquiry found when it attempted to compile one, incorporating the suggestions made in response to the Discussion Paper. I doubt that anyone who had to consider such a list infrequently would ever become sufficiently familiar with it to make sound decisions. I accept that the panel doctor, who could receive training in this skill, might be more successful than the Form 2 doctor. However, research suggests that a trained coroner's investigator, who would consider such issues daily, would be more successful at recognising those deaths that required full investigation. In Maryland, USA, death investigators are trained to recognise those cases in which further investigation is required by the medical examiner. We could learn much from the training and operation methods employed there.

19.63 If all certificates came into the coroner's office, it would be possible for the coroner's investigator to check that Forms 1 and 2 had been properly completed and that all matters that might be relevant to the need for further investigation had been covered. The coroner's investigator would work to a protocol. Such a system would in my view reduce the risk of material information being overlooked. If it were necessary to add a new criterion for reporting a death, it would be far easier to amend the investigators' protocol than to promulgate the requirement to a large number of doctors.

19.64 Certification by the coroner's investigator would impose substantially less of a burden on doctors than would dual certification by doctors. In particular the process of consultation with the deceased's family, which I am convinced is an essential feature, would be time-consuming. In my view, this should not be imposed upon doctors. Their time is a valuable resource, presently in short supply. It is also an expensive resource. If the task can be performed as well (or better) by a coroner's investigator, as I believe it can, that is the right solution.

19.65 Doctors would be relieved of the duty of deciding whether or not they could certify. They would have to provide factual information only; they would give an opinion only when sufficiently confident to do so. They could not then be subject to pressure to certify from families or to the temptation to provide an untrue cause of death to avoid referral to the coroner.

19.66 Under my proposal, the Coroner Service would take primary responsibility for the procedures following every death. The office would be the natural focus for all enquiries. The existence of such a focal point would remove a great deal of uncertainty. Families, funeral directors and doctors would know who to ask for information about what was to happen and when. The public would soon learn that it was normal for a death to be reported to the coroner. The anxiety the family of a deceased person now feels, on learning that the death is to be reported, would be much reduced, especially when it became known that referral did not mean that there was bound to be an autopsy.

19.67 The Coroner Service would relieve other agencies of some of the responsibilities that they presently carry. Perhaps most important, the registration service would be relieved of the responsibility for considering whether a death can properly be registered or whether it should be reported to the coroner. Those duties would rest definitively upon the Coroner Service. The registrar's duties would be purely administrative, as, in my view, they should be. I shall say more about registration below.

19.68 The police and ambulance service would be relieved of the responsibility, which they presently shoulder, of trying to locate a doctor willing and able to certify the cause of death. In a case where no criminal involvement was suspected, the responsibilities of the police would be limited to informing the coroner's office of the death and undertaking duties properly within their own province. There would, of course, always be a need for close co-operation between the Coroner Service and the police.

19.69 A further advantage of a system in which all deaths are reported to the Coroner Service would be the availability of complete data in respect of all deaths. For all deaths, there would be a minimum dataset comprising Forms 1 and 2, the investigator's record of other information received and a copy of the certificate of cause of death. For those deaths in which the medical coroner undertook further investigation, there would be additional information. The retention of this dataset would have a number of advantages. First, it would be possible to audit the process of certification. Second, it would provide an information bank, which would be an invaluable resource for public health and research and statistical purposes.

Random Checks on Deaths Certified without Further Investigation

19.70 At present, just over 60% of deaths are certified by doctors and are not reported to the coroner. I think it likely that, under the system I have proposed, a similar proportion of deaths would be certified by a coroner's investigator on the basis of the treating doctor's opinion, following consultation with the deceased's family. There are two reasons why it would be desirable that the operation of that system of certification should be subject to some form of random check. First, audit is a useful exercise in itself, to check that the system is operating as it should. Second, I recognise that any system that does not

provide full investigation of every death is potentially open to abuse, particularly where two people who take part in the process of certification collude to conceal some act of wrongdoing. For example, if a family member and doctor were to collude in the hastening of the death of an elderly or terminally ill patient, it would be almost impossible to discover the wrongdoing unless all deaths were subject to full investigation, including autopsy with toxicology, and not necessarily then. A similar problem might arise if a doctor were to collude with a nurse in charge of a care home in the concealment of homicide, malpractice or neglect. Such risks are probably very small but I do not think they can be ignored.

19.71 For those two reasons, I propose that a proportion of all deaths certified by a coroner's investigator on the basis of the opinion of the Form 2 doctor should be selected randomly for fuller investigation at the discretion of the medical coroner. Such a fuller investigation would be conducted according to a protocol which might include external examination of the body, perusal of medical or nursing records, a blood test taken for toxicological screening and a discussion with any person mentioned on Forms 1 or 2 as having knowledge of the circumstances of the death or nursing history. It would not, unless a specific reason arose, entail an autopsy. The medical coroner would be under a duty to carry out a specified number of such fuller investigations and his/her performance of them would itself be the subject of audit.

19.72 I consider that a general awareness of such a system of random investigation would act as a deterrent to misconduct and would promote good certification practice.

Targeted Checks

19.73 One of the shortcomings of the present system is that a coroner cannot investigate any death unless it is individually reported. He or she cannot, for example, investigate all the deaths certified by a particular doctor or all those occurring at a particular care home. I recommend that, in future, the Coroner Service should have the power to undertake targeted investigations both prospectively and retrospectively. The Coroner Service might examine the targeting methods adopted in Ontario, Canada, which I described in paragraphs 18.46 and 18.47.

The Two-Doctor System Advocated by the Coroners Review

19.74 The Coroners Review has proposed a dual system of certification of death. It would operate slightly differently for hospital and community deaths. However, in each case, two doctors would consider the cause of death and whether the death should be reported to the coroner. In respect of hospital deaths, the first certifier would be any fully registered doctor who had treated the deceased in the last illness. The second certifier would be a doctor of consultant status from a different 'firm' within the hospital and would have to be 'approved' by the SMA. In the community, the first certification could be carried out by any doctor in the general practice looking after the patient, provided that the certifying doctor or another member of the practice had seen the patient within 28 days before the death. If there was a doctor willing and able to certify the cause of death, that doctor would then contact a second doctor, who would be a member of a panel selected by the SMA and trained for the work. The second doctor would review the decisions of the first certifying

doctor, both as to the cause of death and as to the decision not to report the death to the coroner. For these purposes, the second doctor would speak to the first doctor and examine the most important extracts from the clinical notes. If the two doctors disagreed about the cause of death, or if either of them thought that the death should be reported to the coroner, that would be done. If both agreed about the cause of death and that there was no need to report it, the second doctor would countersign the MCCD and would issue a disposal certificate, permitting disposal by burial or cremation. Registration would take place later. There would have to be safeguards to ensure that registration took place. At present, the incentive to register the death is that, without registration, there can be no disposal.

19.75 This proposal bears a strong resemblance to the old system of cremation certification, with some improvements. First, instead of the second doctor being any doctor registered for five years, s/he would be selected by the SMA and should, in theory, be independent of the first certifying doctor. However, this would depend upon how the panel doctor was selected for the individual case. At present, the proposal is that the first doctor should 'choose' the second doctor and, either him/herself or through his/her practice staff, inform the deceased's family of the second doctor's name and contact details. Second, the panel doctors would receive training in death certification procedures and in the recognition of which cases ought to be investigated by the coroner. Under cremation certification procedures, the Form C doctor was not even required to consider whether the death should be reported to the coroner.

19.76 The proposal that the cause of death should be certified and permission to dispose of the body be given by the second doctor would have the beneficial effect that the registration service would be relieved of the duty to consider whether or not the death should be reported to the coroner. Whether that duty should rest solely upon doctors, in my view, requires further consideration. In any event, there are real dangers inherent in the proposal that disposal certificates should be allowed out of the control of the register office or Coroner Service. Although the proposal is that only 'approved' doctors would be on the panel and would be trusted with disposal certificates, it must be recognised that Shipman himself would certainly have applied for and received approval as a panel doctor. He was highly respected in the area by colleagues as well as patients. Many people considered him to be the best doctor in Hyde.

19.77 My main concern about this proposal is that it is not intended that the second doctor should contact the family of the deceased. Instead, it is intended that the family should be made aware that the second doctor is available to them, in the event that they wish to express any concern. I draw particular attention to that aspect of the proposal because the evidence heard by the Inquiry (to which I referred in Chapter Twelve) suggested that families are often either reluctant or too shocked to take the initiative to express a concern to a stranger, even if they are conscious of one. In many of the Shipman cases, the family members were not aware of any reasons for concern, even though they were in possession of information which, if known to the second doctor or some other person with an overview of the case, would have signalled a cause for concern. Also, many people are intimidated by the thought of telephoning a doctor's surgery and asking to speak to the doctor personally. Arrangements for a consultation might have to be made through the

surgery staff and the doctor would have to fit the relative in among his/her patients. If the Coroners Review proposal were amended to require the second doctor to question a member of the deceased's family or other person with knowledge of the recent history and circumstances of the death (a feature that I regard as vital), the system would place a heavy demand on the time of the panel doctors. It would also be costly for that reason. I also consider that, if a relative wished to express a concern about the treatment provided by the doctor providing the first certificate, s/he would probably find it easier to do so to a coroner's investigator than another doctor.

19.78 I have other reservations. I note that it is not intended that the second doctor should devote him/herself to certification duties for specific sessions, although no doubt that could be required. I do fear that a doctor who tries to fit certification into an ordinary working day may not give it the care and attention it warrants. I have already explained the reasons why I doubt that it is possible to ensure true independence on the part of the second or panel doctor. In rural areas, where the medical community is small, independence would be impossible. Even in urban areas, there could be no real independence if it were left to the first certifying doctor to select which panel doctor s/he contacted. The Coroners Review suggests a rota system, although I am not sure how it is proposed that that would work in practice. In my view, to ensure independence, individual cases would have to be allocated by the SMA to a doctor from a different locality from that of the first certifying doctor. I think this would give rise to inconvenience and practical difficulty. I note that the Coroners Review proposal is that, for hospital deaths, the second doctor would be a consultant employed in the same hospital as the first. I doubt that such a proposal would be acceptable to consultants and I fear that doctors of a lower status would be authorised. In those circumstances, I doubt that the second doctor could be sufficiently independent, even though approved by the SMA. In short, I consider that this proposed scheme is far too closely related to the current system of cremation certification, which manifestly failed to protect Shipman's patients or to detect Shipman as a murderer.

Registration

19.79 I have already said that Form 2 is not a medical certificate of cause of death; it provides information and, possibly, an opinion. There would be a need for a certificate of cause of death, on which registration would be based. The Inquiry has not attempted to devise such a certificate. The ONS has particular views about what information should be provided in such a certificate and how it should be presented. The layout and content of that form should be a matter for discussion between the Coroner Service and the ONS. However, the fact that this certificate would be completed in the coroner's office, rather than by a doctor, would provide an opportunity to include information and classifications of the death for statistical purposes which would not otherwise be possible. The certificate would be completed by trained staff, under instructions, whose work would be susceptible to quality control. The certificate might include such information as whether the death was industrial or whether there had been an operative procedure within, say, the last 30 days.

19.80 At present, apart from the cause of death, which comes from the MCCD, the particulars required for registration (together with other information required for statistical purposes) are provided by the informant during a visit to the register office. If an inquest is held, the

coroner provides all the information required for registration. Under my proposed scheme, a member of the deceased's family would usually, although not always, attend the coroner's office for a discussion about the death. It seems to me that, in cases where that occurred, the opportunity could be taken to obtain the particulars required for registration and any other necessary information. If this were done, it might avoid the need for the informant to visit the register office as well as the coroner's office. As I explained at the end of Chapter Six, changes are proposed for the registration service. It is contemplated that registration might take place on-line or by telephone. If such a facility were to be made available, registration of deaths could be conveniently effected from the coroner's office at the time of the visit. Once the cause of death had been certified (whether by the investigator or the medical coroner), the particulars required could be obtained from the family member, the death could be registered on-line and a disposal certificate and a certified copy of the entry in the register of deaths obtained by return. Such an arrangement would provide the 'one-stop shop' advocated by many respondents to the Inquiry. For those who seek early disposal of their dead, such as members of religious and ethnic minorities, it should be possible for the investigator to issue a disposal certificate at a weekend, at a time when the register office is closed, and send the particulars on-line to the register office on the next working day. For those families who do not attend the coroner's office for a face to face discussion about the death, registration could take place as now, by attendance at the register office or, if the facility were available, on-line or by telephone. The certificate of cause of death could be sent direct from the coroner's office to the register office. Whether on-line registration will be brought in remains to be seen but the intention has been announced.

19.81 At present the registration service uses the informant's visit as an opportunity to provide information and advice about post-death formalities. If registration were to be carried out from the coroner's office, it might not be possible in many cases for the registrar to fulfil that function. However, I do not see why such information should not be made available at the coroner's office. Moreover, if on-line registration is to be permitted, some informants would not visit the register office in any event. It seems to me that discussions should take place between the interested parties in order to establish some arrangement whereby bereaved families are provided with the advice they need, the registration service receives accurate information and, if possible, families are not required to visit two separate places or discuss the death with more than one public official.

The Next Stage – Further Investigation

19.82 I now turn to describe my proposals for the treatment of deaths which are not certified on the basis of the treating doctor's opinion but which, for some reason, require further investigation. In this area, there is much common ground between my proposals and those of the Coroners Review.

Criteria

19.83 The Coroners Review has suggested a list of criteria for determining which deaths should be reported to the coroner and has suggested that the definitive list should be compiled

and promulgated by the body with overall responsibility for the Coroner Service. As I recommend that all deaths be reported to the coroner, there would be no need for a list of reportable cases. However, coroners would need some guidance as to which types of case would call for further investigation and would not be suitable for certification by a coroner's investigator, even if the cause of death were sufficiently known. In my view, the list suggested by the Coroners Review would be a good starting point from which to prepare that guidance. In summary, this includes all traumatic deaths, the deaths of all detained persons, deaths due to any listed communicable disease, deaths due to occupational disease, deaths due to medical error, defective treatment, neglect and adverse drug reactions, deaths associated with childbirth, deaths of vulnerable children, drug-related deaths and deaths of which the cause is uncertain or in respect of which there is concern about the circumstances.

19.84 In my view, it will be extremely difficult to provide a list that encompasses all those deaths which require further coronial investigation. However, it should, in my view, be quite possible to train coroner's investigators to recognise the type of circumstances that call for investigation. Under my proposals, a coroner's investigator would consider the circumstances of deaths daily, if not several times a day, and would make a decision on whether further investigation were required. Familiarity with the concepts and frequent repetition of the decision process should, in my view, lead to a far higher degree of accurate recognition than would be achieved by doctors undertaking the task much less frequently.

19.85 I am also of the view that there should be some flexibility as regards the referral of a death for further investigation. A death should not be certified just because it does not fit into one of the criteria if there is some reason why it should be looked at more closely. For example, where a young, fit person succumbs rapidly to a virulent infection, the cause of death might be established by autopsy and ancillary tests and the death might not fall within any category calling for further investigation. However, in such a case, it might well be worth trying to discover how the deceased was infected, what the signs were and what treatment was given. Such an investigation could be of value to medical science. If such a death were brought to the attention of the medical coroner, s/he would have the option of taking the investigation further.

19.86 I agree with the Coroners Review that the coroner's investigators' guidance or the doctors' list of reportable criteria should be kept under constant review. It is not possible to foresee all the circumstances that might call for death investigation. For example, a year ago, no one would have foreseen the need for a sudden death from pneumonia to be investigated by the coroner. Yet today, no one would disagree with the proposition that a death in this country from severe acute respiratory syndrome (SARS), which is a form of pneumonia, should be investigated by the coroner, not because it is an unnatural death (it plainly is not) but because it would be in the public interest to discover how it had been contracted, the course of the disease and where and how it had been treated. Under the existing requirements, a death from SARS would not be reportable. Under the list suggested by the Coroners Review, SARS could be included by amendment of the list of reportable communicable diseases.

The End Product of Further Investigation

19.87 In Chapter Nine, I said that in general there should be an inquest only in a case in which the public interest requires a public investigation for reasons connected with the facts and circumstances of the individual case; an inquest should not be held merely because the case falls within a broad category such as those defined by section 8 of the Coroners Act 1988. I suggested that there should be a few quite narrow categories in which an inquest would be mandatory; otherwise the decision as to whether the public interest required an inquest would be for the judicial coroner and would be subject to appeal. Such a system would allow a proper balance to be held between the public need to know about some deaths and the right of bereaved families to privacy in cases in which no issue of public interest arises. As I have said, I am in agreement with many of the views expressed in the recent Report of the Coroners Review relating to the outcome, scope and conduct of inquests. I have identified at paragraph 9.76 the precise areas of agreement.

19.88 In a case in which there is no sufficient public interest to warrant an inquest, the product of the further investigation would be the provision of a coroner's report explaining how and why the deceased died. The report would also set out any recommendations which the coroner thought appropriate for the avoidance of death and injury in future. The report would be prepared by the medical or judicial coroner who had undertaken the investigation. Occasionally, they might write a joint report. The report should be primarily for the benefit of the family of the deceased but should also be provided to any party or public body with a proper interest in its receipt. The question of whether such a report should be available to the general public is a difficult one and, in my view, requires careful further consideration. I note the views of the Coroners Review. I myself do not feel that this issue has been covered in sufficient detail during the Inquiry for me to be able to express a concluded opinion. I suggest that there should be close consideration of the practice followed in Ontario, Canada, which I referred to in Chapter Eighteen.

19.89 The report of the death would append the result of an autopsy or other special investigation or expert opinion. If the family wished to have the decision explained in a face to face interview at the coroner's office, this could be done either by a coroner's investigator or, in a more complex case, by the medical coroner and, possibly, the pathologist who had conducted the autopsy.

19.90 The report prepared by a medical coroner alone would also contain a statement that the medical coroner did not consider that there was any reason to refer the death to the judicial coroner. If a member of the family wished the judicial coroner to consider the death with a view to further investigation of the circumstances of the death or the holding of an inquest, the death would be so referred. If the judicial coroner declined to investigate, an appeal could lie to the Chief Judicial Coroner.

19.91 An important objective of further investigation (whether conducted privately or publicly at inquest) should be to learn from past experience, in particular in seeking to avoid the repetition of avoidable injury and death. At present, the coroner's power to make a recommendation, useful though it is, lacks force. I suggest that the recommendation of a medical or judicial coroner should be submitted to the Chief Coroners. If they ratified it, they would then be responsible for taking it forward, at a high level, first by submitting it to

the appropriate body and then by pursuing that body until a satisfactory response had been received and action taken. This procedure would give recommendations greater authority than at present. The process could be dealt with speedily where necessary.

Procedures

19.92 The framework for the investigative procedures to be followed once a death had been identified as requiring further investigation would be for the Board of the Coroner Service to determine. In any individual case, the course to be followed would be a matter for the individual medical or judicial coroner to decide. The remarks in the following two paragraphs are by way of suggestion only.

19.93 I would suggest that any death that required further investigation should be considered first by the medical coroner. If uncertainty arose as to the medical cause of death, the medical coroner's first duty would be to establish the cause, if possible. He or she would give instructions as to what was required. If it appeared that the cause of death was known but that there were factual circumstances requiring investigation, the medical coroner might refer the case directly to the judicial coroner or could consult with the latter as to how to proceed. If it appeared that issues of both a medical and a circumstantial nature arose, the medical and judicial coroners would decide together what investigations were to be carried out and by whom. I do not envisage that the judicial coroner would have to be involved in every death in which any need arose to investigate the circumstances. After all, doctors are accustomed to making diagnoses in the context of the surrounding factual circumstances. They do not approach the medical issues in isolation. By way of example, a death following an injury caused by a fall would not usually require consideration by the judicial coroner. It would be possible to develop protocols for the investigation of the most commonly occurring types of death. For example, a protocol might require that, in any death which involved a piece of equipment in which a defect might have caused the death, the equipment should be inspected by an expert.

19.94 In general, the medical coroner would retain responsibility for all investigations in which it appeared likely that s/he would be able to reach a conclusion about the cause and circumstances of the death and in which there would be no need for an inquest. In any case in which it appeared to the medical coroner that there should be an inquest, or if it appeared that the judicial coroner might wish to order an inquest in the public interest, the investigation would proceed under the joint direction of the judicial and medical coroners, at least until the cause of death had been established. At any stage thereafter, the judicial coroner might decide to assume total responsibility for the further conduct of the case. The judicial coroner might still use the services of the district investigative team or s/he might call upon the regional facilities, including the regional investigator.

19.95 The judicial coroner should, in my view, exercise the powers to order entry and search of premises and seizure of property and documents relevant to a death investigation, which powers should be made available, as I suggested in paragraph 9.71. The medical coroner should have the power to seize medical records and drugs relevant to a death investigation. The judicial coroner should hear appeals from certain decisions made by a medical coroner, such as a decision to order or not to order an autopsy or the seizure of medical records or drugs.

Investigation of the Medical Cause of Death

19.96 In cases where the medical cause of death is to be investigated, there should not be an automatic resort to autopsy. The medical coroner would have a variety of investigative tools at his/her disposal. He or she might direct that there be an inspection of the scene of the death and that witnesses, including the deceased's family and any carers, be interviewed. He or she might examine the medical records and discuss the case with any doctor with knowledge of the case. A pathologist might be instructed to carry out an external examination of the body. In some cases, a full autopsy with histology and toxicology might be necessary. In others, toxicological screening from a blood or urine sample might be carried out, without autopsy. That might be done, for example, after a road traffic accident, where the cause of death might be obvious, but there was a need to see whether drink or drugs might have contributed to the cause.

19.97 Where the medical coroner was considering ordering an autopsy, s/he or the investigator involved in the case would speak to the next of kin or family member with whom contact had been established, to explain why an autopsy was considered necessary. As I have said in Chapter Twelve, the evidence I heard suggested that, if the need were explained, there would rarely be any objection. However, in some cases, there will be an objection, whether for religious or cultural reasons or as a matter of personal conviction. In my view, there should be an opportunity for that objection to be advanced, so that the medical coroner could make his/her decision in the light of it. Then, if the medical coroner nevertheless decided that an autopsy was necessary, there should be a right to appeal the decision to the judicial coroner. Conversely, in a case in which the medical coroner had reached a conclusion that the cause of death had been identified and that no further investigation was required, but the family were of the view that there should be an autopsy, there should be a right to make representations to the medical coroner and to appeal to the judicial coroner. Indeed, I consider that there should be a general willingness to receive representations from families whenever a significant decision about the conduct of the investigation is made.

19.98 In general, the medical coroner should seek to establish the cause of death to a high degree of confidence, comparable to that envisaged by Form 2. However, in an appropriate case, it should be open to a medical coroner to certify the cause of death to a lower degree of confidence. In my view, provided that the medical coroner has satisfied him/herself that there is no other reason why the death should be investigated further, it should be sufficient that the cause of death be established on the balance of probabilities. In such circumstances, it is undesirable that there should be exhaustive investigation, including an autopsy, designed to establish which of two or more potentially fatal conditions from which the deceased suffered had actually caused the death. In some cases, it might be appropriate for the medical coroner to certify that the death was due to 'unascertained natural disease process'. I recommend that such a cause should not be certified without toxicological screening of a blood or urine sample.

19.99 Such cases would most often arise with the death of a very elderly person, where it is frequently difficult to determine which condition has proved fatal and often inappropriate to conduct an autopsy for that purpose. It should be rare for the death of a younger person

to be certified to this lower standard of confidence. In making this distinction, I am not suggesting that lower standards should suffice for the elderly; far from it. However, it must be recognised that many elderly people have multiple pathologies, any one of which might be fatal. The safeguard for the elderly must be not so much to ascertain the precise cause of death as to ensure that the circumstances of the death give rise to absolutely no cause for suspicion or concern.

19.100 I would also suggest that a medical coroner should be permitted, in an appropriate case, to certify that a death was due to 'old age'. In the event that a system of certification by doctors were to be retained, I would not be in favour of allowing a treating doctor to certify a death as due to that cause. Although, if strictly applied, the criteria for certifying a death as due to 'old age' can amount to a positive diagnosis of a cause of death, in general, the term implies a degree of uncertainty as to which organ failure has precipitated the death. In those circumstances, certification of the cause of death to the high degree of confidence required by Form 2 would seem impossible.

19.101 A medical coroner might on occasions have to certify that the cause of death was unknown, but that should, in my view, be acceptable only after a full autopsy with toxicology had been carried out.

19.102 Some investigations might be quite long and complex. Some might entail consultation with or referral to the regional medical coroner or the judicial coroner. The medical coroner should always seek to allow the disposal of the body at the earliest appropriate time. This could be done as soon as the body has been identified and it has been decided that it will not be required for further investigations. Usually, it would, as now, be possible to permit disposal of the body before investigation of the circumstances of death is complete and possibly before a conclusion has been reached as to the cause of death. If the medical coroner was satisfied that the cause of death was known, but the investigation into the death was not yet complete in other respects, s/he would inform the family and the register office of that cause. If there remained any uncertainty about the cause of death, which could not be resolved until the circumstances had been fully investigated, the medical coroner should provide the register office with a provisional cause. At the seminars, the ONS stressed the need for them to receive details of deaths, with provisional causes, more promptly than is often the case at present.

Investigation by the Judicial Coroner

19.103 I have said that the main function of the judicial coroner would be the conduct of inquests and the direction of the preceding investigation, possibly in conjunction with a medically qualified coroner. In addition, the judicial coroner would direct the more complex investigations into the circumstances of deaths where an inquest was not envisaged. In those cases in which both medical and circumstantial investigations were required, the two coroners would work together, each applying his/her professional expertise to the problem.

19.104 I think, although I cannot be certain of this, that fewer judicial coroners would be required than at present and I envisage that they would operate from the regional offices rather than being present in every district office.

19.105 As I said in Chapter Seventeen , I consider it desirable that judicial coroners who have to conduct inquests should be relieved of the day-to-day responsibility for the pre-inquest investigation. They should direct the investigation but responsibility for the collection of evidence should devolve onto a legally qualified person in the regional office. I also consider it desirable that the judicial coroner should have the assistance of that person or, in the more complex cases, counsel to the inquest, who would present the evidence and call the witnesses.

Inquests Arising from Criminal Cases and Deaths Investigated by Other Agencies

19.106 Where the police suspected criminal involvement in a death, the Coroner Service would co-operate with their investigation, for example by ordering an autopsy. The Service would not in any way interfere with the police investigation. If criminal proceedings were commenced, there should be no need for an inquest to be opened and adjourned, as is the present practice. If the proceedings resulted in a conviction, the medical coroner would usually need to do no more than write a report recording the fact of the conviction, the cause of death and the brief circumstances of the death. In a rare case, a public interest issue might arise, in which case an inquest would be appropriate, but in most cases there would be no need for an inquest in any case following a conviction for murder, manslaughter, infanticide or causing death by dangerous or careless driving. If the proceedings led to acquittal, the death would be referred to the judicial coroner for inquest.

19.107 If any other agency (such as the Health and Safety Executive) were to investigate a death, the medical coroner would normally await the report of that investigation before proceeding with any investigation other than that necessary to establish the cause of death. When the other agency's investigation was complete, the report and the result of the medical coroner's investigation of the cause of death would be sent to the judicial coroner, who would decide whether any further investigation was required and whether an inquest should be held. If no inquest were to be held, the judicial coroner would write a report.

Allegations of Medical Error or Neglect

19.108 The evidence suggests that cases in which death was or might have been caused or contributed to by medical error or neglect are under-reported. It also appears that many doctors consider that it would be wrong for the coroner to examine the possibility that medical error might have contributed to a death. I cannot accept that doctors should be treated any differently from others whose errors lead to death. A driver whose negligence causes death is likely to face criminal prosecution and the death will be investigated by means of a coroner's inquest. If a workman dies as the result of a fall from an unsafe place of work, the employer responsible is likely to face criminal prosecution and a coroner's investigation. I cannot see why mistakes made by doctors should not be investigated by the coroner. Yet, at present, it appears that many cases of potential medical error are not reported to or investigated by coroners. The coroner's conclusions would not be determinative of civil liability.

19.109 At the international seminar, I learned that similar reporting problems had been experienced in Victoria, Australia, where a system of identifying and investigating cases of potential medical error is being developed. I recommend that the Coroner Service should study that system with a view to introducing something of a similar nature in this country.

19.110 At present, cases of possible medical error or neglect are usually brought to the coroner's attention as the result of an expression of concern by a member of the deceased's family. Sometimes, such cases are reported by hospital staff. Under the new system, I would suggest that, in any such case, the medical coroner should carry out an initial investigation. If s/he were to conclude that the allegation had some foundation and that the error or neglect complained of might have caused or contributed to the death, s/he would refer the case to the regional office for investigation by the regional medical coroner and judicial coroner. In my view, such investigations are likely to be time-consuming and also require special expertise. They should not in general be dealt with by the medical coroner, who will usually be busy with his/her daily caseload and the management of the district office. If, after initial investigation, it appeared to the medical coroner that there was no evidence of medical error or neglect, or that any such error or neglect could not have caused or contributed to the death, the medical coroner would advise the family that s/he intended to certify the cause of death without further investigation. It would be open to the family to appeal to the judicial coroner against that decision. The medical coroner would also advise the family of the possibility of making a complaint to any relevant authority. He or she would write a report of the investigation, including an account of the original expression of concern.

19.111 Cases transferred to the regional office would be investigated under the direction of a legally qualified person. There should be a small team of investigators at every regional office who can develop expertise in medical cases. Appropriate expert opinions would be obtained. At the Inquiry seminars, there was discussion of the idea that the coroner might refer a case to a multi-disciplinary committee of experts, similar to those set up by the National Confidential Enquiry into Perioperative Deaths. That seems to me to be a good idea in a case where more than one or two expert opinions would be required for proper investigation. I was also interested in the method of investigation adopted in Ontario, Canada, where standing committees of experts are used to review cases of possible medical error and also review the treatment provided in various types of case, where lessons might be learned from examination of the treatment provided before death. A system of investigation is also being developed in Victoria, Australia, which I described in paragraph 18.24. I recommend that the Coroner Service should consider all these ideas.

19.112 At the end of the investigation, the judicial coroner would decide whether or not an inquest should be held. In cases in which s/he decided not to do so, the judicial coroner and the regional medical coroner would agree between themselves as to which of them should write the report or whether they should write a joint report.

Funding, Resources and Recruitment

19.113 Implementation of my proposals would require adequate funding and resources for the Coroner Service. A new improved service is bound to cost more than the old, which in

some places appears to have been run on a shoestring and does not, in any event, provide good value for money. I have not commissioned work on costings for the reasons I explained in Chapter One. I recognise that my proposals will not work satisfactorily and will lead to unacceptable delays in death certification and in the disposal of bodies unless the system is properly funded.

19.114 There are a number of features common to the system I propose and to that proposed by the Coroners Review. Under both proposals, there will be a need for a central organisation. Under both, all deaths will be subject to some degree of scrutiny. Under both, there will be a need for medically qualified persons in the district coroner's office. It is likely that the rather more responsible position that I envisage for the medical coroner will be slightly more expensive to fill than the post of SMA, proposed by the Coroners Review. It may be that the status, managerial responsibility and higher remuneration of the medical coroner would prove more attractive to candidates of a high calibre than the more limited and routine functions of the SMA. Both sets of proposals recognise the need for trained coroner's investigators.

19.115 The resource implications of the choice between my proposals for certification and those of the Coroners Review are, I think, quite considerable. Under both sets of proposals, a substantial percentage of deaths (currently about 40%) would require full investigation by a coroner. The cost of such investigation is likely to be similar under each set of proposals. However, the remaining 60% (about 320,000 deaths per year) would be certified either by a coroner's investigator on the basis of the Form 2 doctor's opinion (my proposal) or by a second doctor who had reviewed the first certifying doctor's opinion (the Coroners Review proposal). It seems to me that my proposals have resource advantages because they place a lesser demand upon the services of doctors than do the Coroners Review proposals, even as presently envisaged. However, if the Coroners Review system were amended to include a requirement that the second doctor must question a member of the deceased's family (which I believe is essential), it would then place very heavy demands on the doctors. It seems to me that there are two resource advantages in using coroner's investigators rather than doctors. First, the coroner's investigator is likely to be a less expensive resource than a doctor. Second, a fully trained coroner's investigator could be, within a relatively short time, a less scarce resource than a doctor.

19.116 At all stages of the Inquiry, concern has been expressed about the shortage of doctors and the pressures on their time. I have tried to take those factors into account. Both my proposals and those of the Coroners Review will require the full-time appointment of doctors to the Coroner Service. At the seminars, both the BMA and the DoH representatives expressed the view that, if the position of medical coroner had sufficiently attractive terms and conditions of service and if steps were taken to avoid professional isolation, there would be a pool of suitable applicants seeking a career change and these would be doctors who were likely to leave clinical practice in any event. They would not, therefore, be lost to practice as a direct result of the creation of the role of the medical coroner. Whether an adequate supply of second certifying doctors could also be provided, I cannot say. Both my proposals and those of the Coroners Review would require the appointment of investigators, some of whom should come from a medical or nursing background. My proposals would require more such investigators than would

those of the Coroners Review. I recognise that there is also a severe shortage of nurses. However, I believe that many nurses retire from hospital work at a relatively early age. I envisage that some nurses and paramedics, who might in any event give up their work in, say, their 40s or early 50s, might be attracted to a new career (possibly part-time) in which their medical knowledge could be used.

19.117 I have been anxious to avoid any proposal that would significantly increase the time spent by doctors on death certification. It seems to me that the absolute minimum that must be provided by doctors is the medical history. The completion of Form 2 might take a little longer than the conscientious completion of an MCCD and cremation Form B. I recognise that this requirement would be imposed in all cases and not only those to be followed by cremation. If the doctor also completed Form 1, there would be additional work, but there is some overlap, and parts of Form 2 are not to be completed if Form 1 has, to the knowledge of the Form 2 doctor, been correctly completed. When I take into account the time presently spent by doctors in visiting mortuaries and funeral directors' premises for the purpose of completing cremation Forms C, I do not think that my proposals will impose much additional burden on the medical profession. In any event, if there is an additional burden, I think that the importance of the function is such that the increase must be borne.

19.118 I do not think it appropriate that I should suggest whether and, if so, how doctors should be paid for the completion of Forms 1 and 2. At present, they receive no payment for the completion of an MCCD. Cremation certification is paid for by the deceased's family or estate. What should happen in future should be a matter for Government. However, consideration could be given to the idea, which received some support at the seminars, that the responsibility of the National Health Service towards patients, which at present ceases at the moment of death, should continue until disposal of the body. In that way, a doctor's duty to complete Forms 1 and 2 could become a contractual duty, rather than merely a professional one.

Pathology Services

19.119 Under the system I have proposed, I hope and anticipate that there would be a reduced demand for routine coroner's autopsies. If so, there would be less pressure on the existing resources and it should be possible for autopsies to be carried out to a consistently high standard, which is not always possible at present. In my view, all autopsies should be carried out to the standards recommended by the Royal College of Pathologists (RCPath) in their document 'Guidelines on autopsy practice' that I referred to in Chapters Nine and Ten. I endorse the suggestion made by Dr Peter Goldblatt of the ONS that the content of a properly conducted autopsy should be formally recognised, possibly by the production of a code of practice with statutory force. This could be negotiated between the Coroner Service and the RCPath. Pathologists should be provided with improved background information about the deceased's medical history and the circumstances of the death, so that they can interpret their findings in context. They should be free to carry out whatever special examinations they consider necessary for the completion of a thorough and accurate report, provided that there is proper medical justification for the conduct of those examinations. It should not be acceptable for coroners to restrict the professional freedom of the pathologist. I would also endorse the suggestion made at the pathology seminar that

it should be acceptable for a coroner's autopsy to be conducted by a trainee, provided s/he was properly supervised. Now that so few hospital autopsies are carried out, such a practice is essential if a proper supply of trained pathologists is to be maintained.

19.120 It seems to me that greater use should be made of toxicology in the investigation of deaths of which the cause is not immediately apparent. I say that not only in the light of experience of the Shipman case. Evidence about the medical examiner system operated in Maryland, USA, convinced me of its general usefulness. Dr David Fowler said that their system of toxicological screening exposed a number of drug-related deaths that had been wholly unsuspected. The objection is that toxicology is expensive and slow. The experience in Maryland persuaded me that the process need not be slow, at least if what is required is a preliminary screening process, generally using chromatography. Once the equipment has been purchased for such screening, the more it is used, the cheaper each test becomes. Only in the minority of cases, where screening has revealed something of real concern, would there be a need for the more expensive and delaying quantitative analysis. It should be the aim of medical coroners to move towards the use of toxicology in virtually all autopsies and in some cases in which no autopsy is conducted.

19.121 During the seminars, there was little support for the proposal that a limited autopsy should ever be carried out in a case where the cause of death was not known. I accept that such a procedure risks the failure to discover the true cause of death. I also respect the view expressed by Professor Margaret Brazier, Chair of the Retained Organs Commission, that there would be little call for a partial autopsy if the reasons for and benefits of the autopsy procedure were fully explained to the family. However, it is clear that some people express a strong wish that their bodies should not be invaded after death and some families and religious or ethnic groups are strongly opposed to an autopsy. I am of the view that it should be possible for the medical coroner to authorise a partial autopsy. Any limitation would have to be very clearly defined and would have to be subject to the stipulation that, if the pathologist needed to go beyond what had been authorised, in order to reach a satisfactory conclusion as to the cause of death, s/he would be free to do so.

19.122 It appears to me that non-invasive diagnostic techniques, such as magnetic resonance (MR) scanning, may well be able to make a real contribution in the future. At present, they are of limited use. Under my proposals, it would be open to a medical coroner to make use of such methods, although I do not think it could be expected at present that such a facility should be provided at public expense. If the medical coroner were satisfied that an MR scan provided a sufficiently certain cause of death, s/he could certify the death on that basis.

19.123 I do not propose to say much about the retention of organs and tissues following a coroner's autopsy. Plainly this issue will have to be addressed at some stage and guidance provided for coroners by the Coroner Service. It seems to me that the principles should be similar to those I have suggested in connection with the autopsy itself. The medical coroner must have the power to order retention of organs and tissues if such is necessary for the purpose of his/her investigation. However, there must be complete honesty with the family of the deceased and they must have the opportunity to object to retention and to appeal to a higher level within the Coroner Service if dissatisfied with the

medical coroner's decision. I anticipate that, provided the principles explained by Professor Brazier at the pathology seminar are followed, little difficulty is likely to be encountered. Professor Brazier's experience is that, provided that families are told the truth and the reasons why the organ or tissue is needed are fully explained, most will not object.

19.124 The shortage of pathologists, particularly those with a special expertise, gives rise to concern. The particular problems caused by a shortage of forensic pathologists has been recognised and, as I reported in Chapter Ten, considered in a Home Office Review. The proposal is that there should be a national forensic pathology service integrated into the Forensic Science Service (FSS), which is an Executive Agency of the Home Office. The Review rejected the alternative suggestion that the forensic pathology service should be within the jurisdiction of the DoH and should be given a measure of independence by the creation of a Special Health Authority. One of the reasons why the Home Office Review opted for integration with the FSS was the close association of forensic pathologists with the criminal justice system. That I can well understand. Another reason, however, was the association between the forensic pathologists and the coroners, who presently fall within the remit of the Home Office. However, if either my proposals for the new Coroner Service or those of the Coroners Review are implemented, coroners will no longer be associated with the Home Office but will either be run by the Department for Constitutional Affairs or be an ENDPB associated with either or both of the Department for Constitutional Affairs and the DoH (or its Welsh equivalent). The rationale for the integration of the forensic pathology service into the FSS would be much weakened. From the seminar discussions, it appeared to me that there are strong arguments to suggest that the criminal justice system and the Coroner Service would both be well served by a pathology service which included both forensic pathologists and those histopathologists who conduct most coronial autopsies and which operated under the auspices of a Special Health Authority.

19.125 The Home Office Review also suggested that the pathology service should attempt to set up regional 'centres of excellence'. These would make the best possible use of the scarce resources of forensic pathology and other specialist services. Such a suggestion would fit well with my proposal for regional coroner's offices where deaths raising more difficult or complex issues or requiring such special facilities would be investigated. A close association between the Coroner Service and specialist pathology services, such as exists in Victoria, Australia, would be of immense benefit.

The Duty to Report Concerns to the Coroner

19.126 The imposition of a statutory duty to report matters of concern to the coroner was discussed at length during the seminars and is reported at paragraphs 17.74 to 17.84. In my view there should be a statutory duty on any qualified or responsible person to report to the Coroner Service any concern relating to the cause or circumstances of a death of which s/he becomes aware in the course of his/her duties. In the class of 'qualified' persons, I include doctors, nurses, midwives and paramedics. In the class of 'responsible' persons, I include hospital and hospice managers, registrars, care home owners and managers, police officers, firefighters, funeral directors, embalmers and mortuary technicians. The duty upon such a person should be to report to a coroner or coroner's

investigator, as soon as practicable, any information relating to a death believed by that person to be true and which, if true, might amount to evidence of crime, malpractice or neglect. The duty upon funeral directors, mortuary technicians and embalmers would obviously be related to any signs of violence, medical malpractice or neglect which they might observe when preparing the body for disposal or autopsy.

19.127 I do not think that unqualified persons or those without any specific responsibility for a deceased person or in respect of any post-death procedure should be under a statutory duty to report concerns about a death to the coroner. All relevant employers should, however, encourage employees to report any concerns they may have and should ensure that such reports as are made to them are passed on to the appropriate quarter without delay and without any possibility of the reporter being subject to criticism or reprisal.

19.128 At present, all citizens are under a common law duty to report to the police or coroner any information likely to lead to an inquest. The existence of this duty is not well known, although everyone knows that they should report suspicions of crime to the police. I recommend that the Coroner Service should seek to educate the public about the functions of the Service and, at the same time, encourage members of the public to report any concerns about a death.

Audit and Appeal

19.129 At present there is virtually no audit of any post-death procedure. The registration service carries out some inspection procedures but there is no audit of death certification by doctors or of any aspect of the work of coroners.

19.130 Under the new system that I propose, there should be systematic audit of every function. First, there must be audit of the certification procedures. This will include examination of the standards of completion of Forms 1 by health professionals and Forms 2 by doctors as well as the quality of the notes kept by investigators of their conversations with doctors, relatives and others providing information. There must be audit of the decision taken whether to certify the cause of death or to pass the case to the medical coroner for further investigation. Most importantly, the quality of in-house certification must also be audited, as must the time taken to complete the post-death procedures. Such work could be carried out by 'an auditor' working in either the district or regional office.

19.131 The efficiency and effectiveness of the investigative procedures of the medical and judicial coroner's office should also be capable of audit. So could the quality of information provided in a medical or judicial coroner's report of a death. This form of audit should be a function of the central office of the Service. However, the correctness of the decisions made by a coroner cannot be subject to audit, as this would tend to interfere with his/her independence of judgement.

19.132 Any decision made by a medical or judicial coroner could be subject to judicial review. However, a quicker and cheaper means of appeal could and, in my view, should be provided, whereby decisions (whether in a report or at inquest) that are wrong in law or plainly wrong on the facts or fail to set out the facts found or give reasons for the conclusions can be set aside. I would suggest that the Chief Judicial Coroner should

decide such appeals, if appropriate with the Chief Medical Coroner acting as medical adviser. From his/her decision, there should be a statutory right of appeal to the Divisional Court on a point of law only.

The Human Rights Act 1998

19.133 In the course of this Report, I have not specifically adverted to the provisions of the Human Rights Act 1998 or the European Convention of Human Rights. I have, however, borne the provisions of the Act and the Convention in mind at all times. I have sought to make proposals which not only comply with human rights law but fully respect its underlying principles and ideals.

Transitional Arrangements

19.134 I am aware that the proposals I have advanced would require legislation and the allocation of increased resources. I am conscious that the Coroners Review has suggested changes that, although similar to and compatible with mine, are different in some important respects. We have both recognised similar problems and seek to secure the same objectives. We both hope that radical changes will be made. If changes are to follow, important decisions must be made as to which proposed solutions should be adopted.

19.135 All this will take time. Meanwhile the existing systems must continue to function. They could, in my view, function better than they do by the adoption of some measures that would not require legislation. Moreover, some such improvements would be compatible with the proposals for change and would amount to steps towards reform.

19.136 I have already suggested that, if the current system of cremation certification is to be maintained for even a few months after the publication of this Report, which seems likely, the procedures should be tightened up in the respects I have advocated in paragraphs 11.133 and 11.134. The Home Office has already begun to take steps towards these ends. The requirement that the Form C doctor should question someone other than the Form B doctor and should provide a positive answer to one of questions 5–8 would strengthen the cremation certification process.

19.137 The Home Office should provide funding and support for improved training for coroners, in conjunction with the Judicial Studies Board. New practices should be introduced into coroner's offices, for example allowing for greater involvement of the relatives of the deceased. Improved methods of investigation could be introduced, so that, for example, a coroner need not accept the opinion of a pathologist in isolation but would consider it in the context of other evidence. Coroners could develop and promulgate protocols for the work of coroner's officers. Recruitment policies could be changed to reflect the relevance of medical knowledge and experience to the work of the coroner's officer.

19.138 Funding should be provided for better pathology services with increased use of histology and toxicology. Coroners should ensure that pathologists provide full reports but that the opinions expressed are limited to the scope of their expertise. A pathologist should not be expected to act as an 'all purpose' medical expert to the coroner.

19.139 Training should be provided for coroner's officers and coroner's liaison officers. The work of the Coroner's Officers Association should be funded, supported and expanded upon. The Association should be encouraged to develop protocols of good practice.

19.140 In suggesting that these steps be taken, I would not wish that these suggested improvements to the present arrangements should be pursued at the expense of progress towards more radical reform. It seems to me that the essential step is to decide what the structure of the Coroner Service is to be. Legislation to provide broad enabling powers could be passed and appointments made to provide the leadership which both the Coroners Review and I agree is vital.

19.141 Before the final form of the new system is decided, it may be that it will be suggested that my proposals and those of the Coroners Review should be tested in pilot schemes. I agree that the proposed Forms 1 and 2 could be tried out alongside existing certification procedures. The Inquiry commissioned a small feasibility study in respect of an earlier version of these forms. Further studies would, I think, be useful. However, there would be considerable difficulty in running a satisfactory trial of the certification system. To be realistic, a medically qualified coroner and some suitably trained coroner's investigators would have to be involved. It simply would not work without appropriate personnel.

19.142 In 1971, the Brodrick Committee recommended wide-ranging changes to the current systems of death and cremation certification and coroner investigations. Hardly any of its proposals were implemented. I explained why in Chapter Three. As it happens, I do not think that implementation would have prevented the Shipman tragedy. But, in many respects, the systems would have been improved. Today, the systems do not meet the needs of society. There is a groundswell of opinion in favour of change. It is to be hoped that the proposals of the Coroners Review and of this Inquiry do not, as did those of Brodrick, end in stalemate.