CHAPTER TWO

Registration of Death, Medical Certification of the Cause of Death and the Coronial System: a Brief History

Introduction

2.1 The systems for registration of death and medical certification of the cause of death evolved in parallel. Both were the products of a growing awareness of the importance of collecting accurate statistics, including mortality statistics. It was quickly realised that information about causes of death could be used for the advancement of medical knowledge and the improvement of public health. It was also recognised that death certification could provide a safeguard against concealed homicide. In this Chapter, I shall trace briefly the origins of these systems, which have remained virtually unchanged over the last 75 years.

2.2 The coronial system has been in existence for hundreds of years, although the functions of the coroner are significantly more circumscribed now than they were in the twelfth century. Those functions are inextricably linked with the systems of registration and medical certification of the cause of death. Apart from where a death occurs in custody (when there are special requirements to report the death), the registrar is the only class of person with a statutory duty to report a death to the coroner. The coroner is the only class of person, apart from a registered medical practitioner, who can furnish the registrar with the documentation necessary for the registration of a death. If there is no doctor who can certify the cause of a death, the coronial system is the only route by which that death can be registered and by which burial or cremation of the deceased's body can lawfully take place.

2.3 Despite the interdependence of the coronial system and the systems for registration and certification of the cause of death, they have developed entirely separately. Different statutes govern them and different Government Departments are responsible for issues arising from them. Later in this Report, I shall consider the effects of this fragmentation of the various systems and I shall consider how the various systems presently in existence might be translated into one cohesive whole.

2.4 During the course of this Chapter, I shall refer to the holding of 'post-mortem examinations', meaning invasive examinations of the organs of the body, carried out after death. 'Post-mortem examination' is the term used in the relevant legislation. Many pathologists use the word 'autopsy' to describe the same procedure. In the course of this Report, I shall use both terms interchangeably.

Registration of Death and Medical Certification of the Cause of Death

The First Requirement to Register a Death

2.5 On 1st July 1837, the Births and Deaths Registration Act 1836 came into force. The aim of the Act was to **'provide the Means for a complete Register of the Births, Deaths and**

Marriages of His Majesty's Subjects in England'. A General Register Office was set up, headed by a Registrar General. The Act allowed the medical cause of death to be provided and recorded when a death was registered. However, there was no requirement that this should be done. Following registration of a death, the registrar was required to deliver to the person having charge of the funeral a certificate stating that the death had been duly registered. If an inquest was held, the coroner could issue an order for burial before registration.

2.6 Burial of the body could take place before the death was registered. No penalties were prescribed for failure to register, provided that the fact that the burial had been carried out without a certificate from the registrar or a burial order from the coroner was notified to the registrar. Consequently, even after 1837, not all deaths were registered. For those deaths that were registered, a medical cause of death was not always provided. When it was, it tended to be unreliable. There was no requirement that the cause should be certified by a medical practitioner. Nor was there any consistency in the descriptions of cause of death used by different practitioners. Despite these shortcomings, the 1836 Act laid the foundation for the present system of collecting mortality statistics.

2.7 Over the ensuing years, various steps were taken to improve the reliability of the particulars of cause of death recorded on registration. Medical practitioners who had treated a deceased person during his/her last illness were encouraged to provide the family with a written statement of the cause of death for production to the registrar. Registrars were instructed to obtain details of the cause of death direct from medical practitioners, rather than from the person giving information about the death. Efforts were made to achieve some consistency of terminology among members of the medical profession. During the 1840s, the Registrar General distributed the first books of forms for use when certifying the cause of death. These forms became known as Medical Certificates of Cause of Death (MCCD). Despite their introduction over a decade before, more than 11% of deaths registered in England and Wales in the year 1860 were registered without an MCCD.

The Duty to Provide a Medical Certificate of Cause of Death

2.8 The Births and Deaths Registration Act 1874 introduced penalties for failing to register a death, as a consequence of which the number of unregistered deaths fell. However, there was still no requirement to register the death before disposal of the body. The Act required the registrar (after registration of the death or notification that the death had occurred and a certificate of cause of death had been completed) to issue a certificate stating that the death had been registered or notified to the registrar. Coroners were also given power to issue certificates authorising burial when an inquest was held. However, the person conducting the burial was not required to be in possession of a certificate from a registrar or coroner before proceeding. The only requirement was that, if no such certificate was delivered, notice of that fact had to be given to the registrar within seven days of the burial.

2.9 The 1874 Act imposed a duty on any practitioner registered with the General Medical Council (GMC) who had been in attendance during a person's last illness to deliver to the informant (i.e. the person giving information about the death to the registrar) a certificate

stating the cause of death to the best of his knowledge or belief. No certificate was required if it was known that an inquest was to be held. Penalties were imposed for failure to provide a certificate (except on reasonable grounds) and for giving a false certificate.

2.10 Since many medical practitioners did not meet the standards required for registration with the GMC, the 1874 Act, which imposed the requirement to certify the cause of death only on registered practitioners, did not have the effect of securing certification of the cause of every death. In many cases, registrars still had to rely on information supplied by the family of the deceased person, or by an unregistered medical practitioner.

2.11 Under Regulations issued by the Registrar General, registrars were directed to report to the coroner any deaths which appeared to be due to violence or were attended by suspicious circumstances; such deaths were not to be registered until the registrar had received notification of the coroner's decision that no inquest was necessary or had been informed of the finding of the jury at inquest. In 1885, the circumstances in which registrars were required to report deaths to the coroner were extended by the Registrar General to include deaths where the cause was unknown and sudden deaths.

The 1893 Select Committee

2.12 In 1893, a Select Committee of Parliament was appointed:

> **'... to inquire into the sufficiency of the existing Law as to the Disposal of the Dead, for securing an accurate Record of the Causes of Death in all cases, and especially for detecting them where Death may have been due to Poison, Violence or Criminal Neglect'**.

2.13 The Committee reported that the **'loose'** system of certification of death did not guarantee a record of the true cause of death; nor did it necessarily prevent the concealment of homicide. There was no requirement for the attending medical practitioner to see the body after death or to certify the fact of death. Deaths were frequently certified by medical practitioners who had not seen the patient for months. Sometimes, the certifying doctor had never attended the deceased. Certificates could be bought from practitioners and used for the purposes of fraud, or to conceal suicide or homicide. Registration of death was known to have taken place in cases where the deceased had been murdered, or was still alive, or in circumstances where it was not known whether or not s/he had died.

2.14 The situation was said to be even worse in the case of uncertified deaths, i.e. those deaths for which the cause of death had not been certified by a registered practitioner. In 1891, uncertified deaths accounted for 2.7% of the deaths registered in England and Wales. However, the proportion varied markedly from district to district. The Committee noted the striking trend whereby the deaths of adults of working age (and therefore self-supporting) were rarely uncertified, whereas the deaths of infants and elderly people, whose age rendered them **'as a class, a burden on their friends'**, were far more likely to go uncertified. It was suggested that, for those who were not economically useful, medical treatment, from a registered practitioner at least, was less likely to be forthcoming than for those who were in work. The Committee expressed the conviction that **'vastly more'** deaths occurred from **'foul play and criminal neglect'** than the law recognised.

2.15 Where no registered medical practitioner had been in attendance upon the deceased before death and there was no medical certificate of cause of death, the registrar was constrained (unless the case was reportable to the coroner and the coroner proceeded to inquest) to take information on the cause of death from the informant. Such information was likely to be incorrect; it might even be deliberately misleading. This system was said by the Committee to be **'dangerously defective'** and to play into the hands of the **'criminal classes'**. The Committee reported that:

> **'... it seems impossible to come to any other conclusion than that an amendment of the present law is urgently required, and that if no legislation can be framed which would altogether put an end to foul play and criminal neglect as secret factors in our national death-roll, much may be done in the way of reducing the evil by the enactment of judicious checks'**.

The Recommendations of the 1893 Select Committee

2.16 The Report of the Committee makes interesting reading. Many of the issues discussed within it have been considered by this Inquiry, over a century later. For example, the Committee expressed concern about the competence of registrars, who have no medical expertise, to understand the medical terms used to describe causes of death and to determine whether or not a death should be referred to the coroner. The Report also criticised the **'very elastic fashion'** in which the phrase **'in attendance at the last illness'** had been interpreted in the past. It recommended that a single definition be adopted, namely **'personal attendance by the person certifying upon at least two occasions, one of which should be within eight days of death'**. I could give further examples but, instead, I shall confine myself to summarising the main recommendations of the Report.

2.17 The Committee was determined that uncertified deaths should, as a class, cease to exist and that, henceforth, **'... as far as may be, it should be made impossible for any person to disappear from his place in the community without any satisfactory evidence being obtained of the cause of his disappearance'**. It recommended therefore that no death should be registered without production of a certificate of the cause of death, in a prescribed form, signed by a registered medical practitioner or a coroner after an inquest. The Committee also recommended that the practice of permitting disposal to take place before registration or authorisation by the coroner should be stopped.

2.18 In order to deal with those cases where no attending doctor was available, the Committee recommended that registered medical practitioners should be appointed as public medical certifiers of the cause of death in such cases. When informed of a death, the certifier should be required to attend and examine the body and make such enquiries and examination (including post-mortem examination) as he may think necessary to enable him to form an opinion as to the cause of death. If satisfied that the death was due to natural causes, he should forward a certificate to the registrar. If the certifier was of the opinion that the death was due to accident, violence, poison or neglect, or that the circumstances were in any respect indicative of foul play, he should be required to report the case to the coroner.

2.19 The Committee was concerned about the lack of any requirement for the certifying doctor to view the body of the deceased before providing a certificate. This gave rise to a risk of fraud or concealment of crime and also, the Committee recognised, to the risk that the 'deceased' might in fact still be alive. It was therefore recommended that, before giving a certificate of cause of death, the medical practitioner in attendance should be required personally to inspect the body; if he were unable to do so, the fact of death should be certified by two neighbours of the deceased and their certificate should be attached to the certificate of cause of death forwarded to the registrar.

After the 1893 Select Committee

2.20 No immediate step was taken to implement these important recommendations. In 1902, the Departmental Committee charged with preparing draft Regulations to be made under the Cremation Act 1902 observed that:

> **'... burial may take place either without any certificate of the cause of death or on the certificate of one medical man which may be in the vaguest and most uncertain terms. Unless, therefore, some definite ground of suspicion arises, there is no investigation of those cases where the cause of death is obscure, and where the ambiguity of the symptoms can be slurred over in a certificate which it is no one's business to question or criticise.'**

2.21 The Births and Deaths Registration Act 1926 prohibited the disposal of a body except following receipt of a certificate of the registrar or an order of the coroner. The person arranging the disposal was required to deliver notification to the registrar of the date, place and means of disposal. The form of the certificate of cause of death was prescribed; the Act required the certificate to be delivered by the medical practitioner to the registrar. To a large extent, these provisions implemented recommendations made in the 1893 Report. However, in two important respects, the intentions of the 1893 Committee were not adopted.

2.22 First, the 1893 Committee had intended that the qualification of the medical practitioner who was to issue the MCCD should continue to be defined by reference to attendance on the deceased during the last illness. The Committee had recommended that the phrase should be precisely defined: see paragraph 2.16. Following the passage of the 1926 Act, the duty to complete an MCCD continued to be imposed on the medical practitioner who had been in attendance during the deceased's last illness. However, the phrase was not defined in the Act. Second, the Committee had also recommended a requirement that either the certifying practitioner should inspect the body after death or the fact of death should be certified by two **'neighbours'** of the deceased. However, the 1926 Act imposed no such requirement.

2.23 The 1926 Act must be read in conjunction with the Registration (Births, Stillbirths, Deaths and Marriages) Consolidated Regulations 1927. They provided that a registrar would be under a duty to report a death if, on the face of the MCCD, it appeared that the certifying practitioner had not either seen the deceased within 14 days before death or seen the body after death. I shall refer to this rule as the 'either/or rule'. It appears that, even if the

certifying doctor were unable to comply with either of these requirements, this would not affect the doctor's qualification to certify the cause of death. That qualification depended solely on the doctor's undefined **'attendance during the last illness'**.

2.24 It appears that the 'either/or rule' came about as the result of a legislative compromise. The passing of the 1926 Act followed several attempts to amend the law relating to the registration of deaths. Private Member's Bills were presented in 1923, 1924 and 1925. All failed. The Bill of 1925 contained a clause, which, if enacted, would have provided that, before a registrar could issue a disposal certificate, a certificate of the fact of death must have been supplied by a medical practitioner, who had examined the body and had satisfied himself that life was extinct. This was thought desirable by many as, at that time, the deceased's body was examined by a doctor after death in only about 40% of cases and there was concern in the country that people had been buried while still alive. However, the clause was opposed by the medical profession and was defeated in the House of Commons. When a further Private Member's Bill was presented in 1926, the clause was replaced by a proposal that a local authority could direct a medical practitioner to inspect the body to ensure that life was extinct. The clause containing that proposal was deleted during the committee stage. At the report stage, an attempt was made to re-introduce the clause from the 1925 Bill, requiring the provision of a certificate of the fact of death by the medical practitioner who was to certify the cause of death. However, this amendment was again opposed on the ground that it would impose an unreasonable burden upon doctors.

2.25 A compromise solution was proposed by the Government. There was to be no specific requirement that the certifying doctor should see the body after death. The MCCD was to be redrafted to require the doctor to state whether he had seen the deceased after death and how long before death he had last seen him/her alive. The registrar would then be required to refer to the coroner any death in which the doctor had not seen the body after death or had not seen the deceased within a **'reasonably short period before death'**. It was suggested that this provision would have two desirable effects. It would increase the number of cases in which a doctor saw the body after death and it would ensure that **'a large class of the more doubtful cases'** was reviewed by the coroner. On the basis of the proposed compromise solution, the amendment was withdrawn and, in due course, the Bill went through. At that time, the **'reasonably short period'** within which the doctor was required to have seen the deceased had not been defined. In 1927, it was decided that the period should be 14 days. The Regulations of 1927 were brought into force and the 'either/or rule' was established.

2.26 I do not think that the Members of Parliament who considered the effect of the compromise accepted in 1926 can have realised how the 'either/or rule' would work out in practice. It may be that requiring the doctor to state on the MCCD whether or not he had seen the body after death had the desired effect of increasing the proportion of cases in which that happened. However, the effect of the rule was that, provided the doctor had seen the body after death, it mattered not how long before death the doctor had last seen the patient alive. The provision, as passed, completely failed to ensure that 'doubtful cases', such as cases in which the doctor had not seen the patient for months before death, would be reported to the coroner. If the doctor took the trouble to see the body after death, it would

not matter when he had last seen the patient alive. He might be in no good position to certify the cause of death, although he could be quite certain that life was extinct. There was still no definition of **'attendance during the last illness'**. The sensible intentions of the 1893 Committee were thus frustrated. I shall return to the effect of the 'either/or rule' later in this Report.[1]

2.27 The 1926 Act also imposed controls on the removal of bodies into and out of England and Wales. Meanwhile, by the Coroners (Amendment) Act of the same year, coroners were given the power to direct a post-mortem examination if there was reason to believe that such an examination might render an inquest unnecessary.

2.28 The effect of the Births and Deaths Registration Act 1926 was to bring about a situation whereby registration of a death became virtually impossible without either an acceptable medical certificate of cause of death, completed by a registered medical practitioner, or a coroner's certificate issued after inquest or post-mortem examination. Disposal of a body could take place only on the authority of a registrar or coroner.

2.29 Despite these measures, I was told that there still remain a very small number of 'uncertified' deaths, even today. These usually occur when there is no doctor qualified to issue a medical certificate of cause of death (perhaps because the patient's usual general practitioner is on holiday or ill) and the coroner declines to order an autopsy or hold an inquest. I shall refer to these deaths again in Chapter Seven.

2.30 Registration is now governed by the Births and Deaths Registration Act 1953. In 1965, the Brodrick Committee was set up to examine the systems of death certification and coroners. It reported in 1971. The Report recommended a 'tightening up' of the procedures for medical certification of the cause of death. A new form of MCCD was proposed. For reasons that I shall explain in Chapter Three, its recommendations were never implemented. As a consequence, the systems for registration of death and medical certification of the cause of death remain much the same now as they were in 1927.

The Origins of the Coronial System

The Role of the Coroner in Early Times

2.31 The first real evidence of the existence of the office of coroner dates from the twelfth century. At that time, the Latin title for the office was '*custos placitorum coronas*' which, with time, was translated to 'crowner' and, thence, 'coroner'. Holders of the office were elected by the counties and, later, by the boroughs in which they resided.

2.32 The coroner had both financial and judicial responsibilities. From the earliest times, one of the coroner's most important duties was to enquire into unnatural, violent and sudden deaths. He was also required to keep a record of revenue due to the King in connection with the administration of justice; a violent or unnatural death might be a source of such revenue. For example, if it could not be proved that the victim of a violent death was English, it would be presumed that the deceased was Norman and a fine (the 'murdrum')

[1] The Inquiry is grateful to Mr Thomas Hennell for his research into the origin of the 'either/or rule'.

was payable to the Crown by the local inhabitants. In the case of homicide or suicide, the weapon which caused the death was forfeit to the Crown as a 'deodand', as was any animal or object which caused a death by misadventure. The chattels of those committing homicide or suicide were also liable to forfeiture.

2.33 When a sudden death occurred, the coroner was required to attend the scene of death and view the body. Jurors, consisting of representatives from the local townships, were summoned to view the body with the coroner and to participate in the inquest. Although inquests were a common feature of life in thirteenth century England, it seems likely that many sudden deaths were concealed in order to avoid the various financial penalties consequent thereon.

2.34 During the fourteenth and fifteenth centuries, a series of changes to the legal system (in particular, the increasing role of the justice of the peace) resulted in a decline in the extent and importance of the coroner's functions. By the beginning of the sixteenth century, almost the only significant function left to the coroner was the investigation of unnatural deaths. The ensuing centuries saw dissent between coroners and justices of the peace about the ambit of the coronial jurisdiction. The justices contended that the coroners' jurisdiction was confined to the investigation of obviously violent deaths only. The coroners, who were paid by reference to the number of inquests held, asserted their right to investigate all sudden and unexplained deaths.

The Development of the Current Coronial System

2.35 The implementation of the Births and Deaths Registration Act 1836 had the effect of giving coroners a role in the drive to collect and record accurate statistical information about deaths by means of the new system of registration. Under the Act, coroners were required to notify the registrar of bodies **'found exposed'** which were reported to them. After an inquest had been held, the coroner was to give notice to the registrar of the particulars to be registered. Burial of a body was permitted upon receipt of a registrar's certificate or a coroner's burial order, issued after an inquest had been opened. However, burial without receipt of either such certificate was lawful, provided that notification was given to the registrar of the fact within seven days of the burial being carried out. Penalties were imposed upon persons who carried out burials of deceased persons without a certificate from the registrar or the coroner and who did not notify the registrar of the burial.

2.36 Also in 1836, an Act was passed, giving coroners power to compel the attendance of a medical witness at an inquest and to order the witness to perform an autopsy, if the cause of death remained uncertain. The effect of this measure was to increase the potential for the detection of cases of homicide. Over the years that followed, the number of inquests increased. The Coroners Act 1887 consolidated the laws relating to coroners and placed the emphasis upon their role in investigating the cause of, and the circumstances surrounding, deaths which were suspected of being violent or unnatural or which had occurred in prison or in such place or under such circumstances as to require an inquest. Coroners did, however, retain the duty to enquire into treasure trove, a vestige of their former role in protecting the financial interests of the Crown. In the following year, the Local Government Act 1888 abolished the practice of electing coroners, who were henceforth to be appointed by the local authority.

2.37 By 1901, coroners were being notified of about 60,000 deaths per annum, i.e. just over 10% of all deaths in England and Wales at that time. Inquests were held in just over two-thirds of those cases. Since the coroner had no power to order an autopsy without an inquest, almost one-third of deaths referred to the coroner were registered without further medical investigation. In a sizeable proportion of those (about 7500 in the year 1900), no MCCD had been completed, so that the death was eventually registered as 'uncertified'.

2.38 The Coroners (Amendment) Act 1926 introduced important reforms, some of which had been recommended by a Select Committee which had reported 16 years previously. The coroner was given the power to order an autopsy without having to proceed to an inquest in cases where there was no suspicion that the death had arisen as a result of anything other than natural causes. Also, in an attempt to introduce a higher standard of competence among coroners, a new requirement provided that future holders of the office should have medical or legal qualifications and not less than five years' standing in their profession. The number of circumstances in which a jury had to be summoned was reduced and the Lord Chancellor was given power to make rules of practice relating to procedure in coroners' courts and in relation to the conduct of autopsies.

2.39 As a result of the implementation of the Births and Deaths Registration Act 1926, and the consequent tightening up of the registration procedures, the number of deaths reported to coroners rose over the ensuing years. In 1926, there were just over 54,000 reported deaths; the number had risen to nearly 70,000 ten years later. Of those 70,000 deaths, less than half (almost 31,000) were followed by inquest. Over 12,000 autopsies were ordered by coroners in non-inquest cases.

2.40 In 1936, the Report of a Departmental Committee ('the Wright Committee'), chaired by The Rt Hon Lord Wright, was published. The Committee had been appointed following criticism of the conduct of some recent inquests. At the time of its deliberations, there were 309 coroners holding 354 coronerships; 13 coroners were engaged full-time and the rest part-time. The part-time coroners had little experience in the performance of their coronial duties and little prospect of gaining such experience. The Committee recommended a reduction in the number of coroners by means of the merger of smaller jurisdictions. It also recommended that those appointed to the post of coroner should be legally (not medically) qualified, preferably with experience as a deputy coroner and having undertaken a course in forensic medicine. They also recommended that deputy coroners be appointed by local authorities, not by the coroners themselves. The Committee proposed changes (including a restriction on press reports) to the conduct of inquests in the case of suicides. It was also recommended that coroners should have discretion to dispense with an inquest in certain cases (e.g. 'simple accidents', deaths under an anaesthetic or during an operation). Few of the recommendations of the Wright Committee were ever enacted.

2.41 The Brodrick Committee was set up in 1965 and gave detailed consideration to the arrangements existing in the coroner service. The Committee reported in 1971. The Committee recommended retention of the existing system whereby coroners were the recipients of reports of deaths that required investigation. The Committee envisaged the

coroner becoming **'a principal agent in the certification of medical causes of death'**. Members of the Committee agreed with the Wright Committee that a service comprising full-time coroners only should, in time, replace the existing system whereby many coroners were employed part-time. The Committee recommended measures to compel the new county and metropolitan local authorities to submit for approval by the Home Secretary proposals for the organisation of a coroner service in their area. Any proposals for creation of part-time coroners' districts would have to be justified carefully and might be rejected. The Committee also suggested that measures should be taken to create panels of coroners who would be available for special inquiries as and when necessary. Panel members would also be available to give temporary assistance to coroners in other areas if required.

2.42 The Committee was anxious to bring to an end the system of local appointment of coroners. The Report therefore recommended that all coroners, deputies and assistant deputies should be appointed by the Lord Chancellor's Department, after consultation with the relevant local authority. The Lord Chancellor should also have power to remove a coroner for any incapacity or misbehaviour that rendered him unfit to continue in office. This would have had the effect of removing the restriction whereby a coroner could be removed only for misconduct relating to his office as coroner.

2.43 The Committee proposed that only persons with appropriate legal qualifications should be eligible to act as coroners. The Committee came to this conclusion because of the quasi-judicial decisions taken by coroners, even outside the formal context of an inquest. Members of the Committee felt that a lawyer would be better able to assess the value of evidence, both medical and factual, and would be more likely to command the confidence of the public because of his independence from the medical profession, on whose evidence the coroner frequently had to rely. The Committee also suggested that a medically qualified coroner might be assumed to have a specialist and up-to-date medical knowledge that in fact he did not possess. Consequently, the Committee came to the same conclusion as the Wright Committee, namely that possession of a legal, rather than a medical, qualification was to be preferred. The Brodrick Committee recommended that the use of police officers as coroner's officers should be phased out and that they should be replaced by civilian coroner's officers and, where necessary, secretarial staff. The Home Secretary should have a statutory duty to secure the provision of suitable and sufficient staff and accommodation for the coroner.

2.44 The Committee made a number of other important recommendations about the procedures for investigation by coroners, as well as the conduct of inquests. In 1976, a Working Party was set up to consider implementation of the recommendations. The Working Party reported in October 1977 and April 1980. As a result of its work, some of the recommendations were implemented.

2.45 However, there has been no substantial change in the way the coronial system is organised since the Brodrick Committee reported. There has been a significant reduction in the number of coroners' districts; as at February 2003, there were 129. But the majority of coroner appointments continue to be part-time; Home Office figures suggest that there are currently only 23 full-time coroners. They are still appointed by local authorities, which

retain responsibility for their remuneration and for the funding of their staff and office (if any). As I shall explain later in this Report, there have been moves to introduce more civilian coroner's officers, but it is still not unusual for coroner's officers to be serving police officers, employed and paid by the local police authority. The restrictions on the removal of coroners remain.

2.46 In the summer of 2001, the Home Office set up the Fundamental Review of Death Certification and the Coroner Services in England, Wales and Northern Ireland ('the Coroners Review'), chaired by Mr Tom Luce. The Coroners Review published a Consultation Paper in August 2002. In May 2003, it presented its final Report to the Home Secretary. I shall refer further to that Report and its recommendations in Chapter Nineteen.