CHAPTER SEVEN

Coroners and Their Jurisdiction

Status, Appointment, Removal and Conditions of Service

7.1 Coroners are independent judicial officers, answerable only to the Crown. Responsibility for appointing a coroner lies with the local authority for the district over which the coroner has jurisdiction, subject to notification being given to (or, in some cases, approval being given by) the Home Office. The local authority also has responsibility for remunerating the coroner and for funding the running of his/her office and the conduct of his/her inquests. Each district has a deputy coroner and some have one or more assistant deputy coroners.

7.2 The Lord Chancellor has power to remove a coroner from office for inability or misbehaviour in the discharge of his/her duty. As I have already mentioned in Chapter Two, the Lord Chancellor also has power (with the concurrence of the Home Secretary) to make rules governing the practice and procedures relating to inquests and autopsies. However, the Lord Chancellor's Department (LCD), which has responsibility for the judicial system, plays no part in the appointment of coroners, in their training and continuing education, or in the running of coroners' offices or courts.

7.3 The Department which provides the point of contact between coroners and central government is the Home Office, through the Coroners Section of its Animal Procedures and Coroners Unit.

7.4 The minimum qualification for the offices of coroner, deputy and assistant deputy coroner is five years' qualification as a solicitor, barrister or medical practitioner. The Inquiry heard that coroners' appointments are now generally made after an open competition. However, there still appear to be some areas where the tradition is that the office passes from partner to partner within a single solicitors' practice. Mr Michael Burgess, Honorary Secretary of the Coroners' Society of England and Wales ('the Coroners' Society') and HM Coroner for Surrey, explained that many local authorities are reluctant to appoint anyone as a coroner who has not already had experience of coronial work. Under section 6 of the Coroners Act 1988, a coroner is required to appoint as his/her deputy a person approved by the chairman of the relevant local authority. He or she may appoint as assistant deputy a person who has been similarly approved. In practice, provided that the coroner proposes for appointment somebody suitably qualified, his/her choice is likely to be approved. In effect, therefore, the coroner can select his/her deputy and assistant deputies. As these are likely to be the only persons who will ever gain experience of coronial work, and are likely therefore to be the strongest candidates for appointment as coroner in the future, it would seem that, to a large extent, coroners are still a self-perpetuating group. I do not think that such a system is consistent with the principle of equal opportunity. Also, the effect of the system is that the position of coroner may not always be held by the most suitably qualified person.

7.5 Some coroners have reciprocal arrangements with neighbouring coroners by which each acts as the other's deputy or assistant deputy. By way of example, Mr John Pollard, HM Coroner for Greater Manchester South District, was formerly a partner in a solicitors'

practice and was appointed Deputy Coroner for Cheshire by the senior partner of the practice, who was then Coroner for Cheshire. Mr Pollard's appointment took place as soon as he had attained the minimum period of five years' qualification as a solicitor. Thirteen years later, he was appointed Coroner for Greater Manchester South District. Mr Pollard's former partner (who still occupied the position of Coroner for Cheshire) then became Deputy Coroner for Greater Manchester South District. That arrangement continued until recently, when it was adjusted so that the present Coroner for Cheshire (appointed following the death of Mr Pollard's former partner) and Mr Pollard became Assistant Deputy Coroners for each other's districts and new Deputy Coroners were appointed.

7.6 As at February 2003, according to the Home Office, there were 129 coroner's districts in England and Wales and 115 coroners, of whom 23 were full-time. The Home Office has told the Inquiry that only nine or ten coroners (as opposed to deputy or assistant deputy coroners) are medically qualified. Two of those hold both a legal and medical qualification. Full-time coroners are paid an annual salary on a scale according to the population of their district.

7.7 Expenses in connection with the holding of inquests and the conduct of autopsies are met by the local authority. None of the coroners who gave oral evidence to the Inquiry reported any problems in persuading their local authorities to fund their activities. The Inquiry understands that financial constraints may be more of an issue in smaller districts served by part-time coroners.

7.8 The quality of facilities available to coroners varies widely. Mr Christopher Dorries, HM Coroner for South Yorkshire (West), has his main office at the Medico-Legal Centre in Sheffield. The lower floor houses the city's public mortuary. The office of Mr Dorries and his staff, together with a dedicated court room, is on the upper floor. Also situated on the upper floor is the University of Sheffield Department of Forensic Pathology, with a staff of four forensic pathologists (including two professors), a professor of toxicology and a forensic anthropologist. Thus, Mr Dorries has both ready access to medical advice and the benefit of having many of the autopsies which he orders carried out on the premises by specialist forensic pathologists. His staff of two coroner's officers (both serving police officers) and the equivalent of a full-time administrative assistant and a full-time secretary work from the main office in Sheffield; another coroner's officer is employed at a small office in a police station in Barnsley.

7.9 By contrast, the Inquiry has been told about another full-time coroner who works from home with, apparently, no secretarial assistance or access to fax machines or computer. Mr Burgess, also full-time, described how he works sometimes from his home, sometimes from the premises of the solicitors' practice in which he was previously a partner and, at other times, from a retiring room (equipped with a computer and telephone) at one of the courts at which he holds inquests. He has no clerical support; if an acute need arises, it is met by using clerical staff from his former practice.

7.10 The arrangements for the provision of staff to support the coroner in his/her work vary considerably from district to district. Traditionally, the coroner was supported by coroner's officers who were serving police officers. Today, most coroners have civilian coroner's

officers, but also rely to some extent on serving police officers and administrative staff. I shall describe these arrangements more fully in Chapter Eight.

Part-Time Coroners

7.11 As I have said already, according to the Home Office, there are 23 full-time coroners in England and Wales. The remainder are part-time and may continue to pursue their legal or medical practice when not engaged on coronial duties. Part-time coroners are paid according to the number of deaths they deal with over a given period. The terms vary. Some authorities pay on the basis of the number of cases which are formally reported to the coroner and in respect of which s/he accepts jurisdiction; others pay on the basis of the number of cases reported to the coroner, whether formally or informally. It is not uncommon for part-time coroners who practise as solicitors to discharge their coroner's duties from their practice premises, with secretarial and administrative assistance from practice staff. Others carry out their duties from home.

7.12 Most part-time coroners are solicitors in private practice. I am unsure to what extent there is recognition of the potential problems of conflict of interest and loss of independence inherent in these arrangements, but the potential undoubtedly exists. Take, for example, the position of a part-time coroner who is investigating the death of the driver of a motor vehicle involved in a road traffic accident. If the coroner's partner were instructed by the widow of the deceased to bring a claim for damages against the driver of the other vehicle involved, the coroner could face a conflict of interest. As a partner in the firm, s/he might well have an interest in the successful conclusion of the widow's action. Alternatively, one might consider the position of the part-time coroner who is also a partner in a solicitors' firm with a criminal practice. It would be quite possible for his/her firm to be dealing with a murder that is also being dealt with in the coroner's office.

7.13 The problem is exacerbated by the lack of facilities provided by local authorities. As I have said, it is not uncommon for a coroner to work from the premises of his/her legal practice. As I understand it, coroners use such premises, not from choice, but because the local authority has failed to provide an office from which to conduct the business of the coroner. In my opinion, the use of the premises of a private legal practice for the work of a part-time coroner is most undesirable. The coroner should be, and should be seen to be, independent of legal practitioners within the district.

Deputy Coroners

7.14 A coroner is required to hold him/herself ready at all times to undertake by him/herself or his/her deputy or assistant deputy any duties in connection with inquests and autopsies. Section 7 of the Coroners Act 1988 provides that deputy coroners may lawfully act for their coroners only in limited circumstances, namely when the coroner is ill, absent for some lawful or reasonable cause or disqualified for some reason from sitting on a particular inquest. Construed strictly, the limitations mean that, if a coroner is engaged, for example, on a substantial inquest within his/her district (so that s/he is not 'absent'), his/her deputy cannot be used to carry out other duties which require attention. Some coroners, however, consider that, if they are engaged on their duties in one part of their district, they are

lawfully 'absent' from other areas and can therefore use their deputies to assist in carrying out necessary work in those areas. Assistant deputies can exercise the same functions as a deputy coroner, but only if the deputy coroner is ill or absent for some lawful or reasonable cause or disqualified from sitting on an inquest.

The Basis of the Coroner's Jurisdiction

7.15 A coroner can act only if and when a death is reported to him/her. In 2001, 37.8% of all registered deaths were reported to coroners. Doctors are responsible for reporting most deaths (95.7% in 2001), with the police and other agencies reporting less than 1%. Registrars account for about 4% of reported deaths. Coroners receive no information about (and cannot therefore take any steps in connection with) deaths that are not reported to them.

7.16 The jurisdiction of the coroner is based in statute. The current legislation governing the coronial system consists of the Coroners Act 1988 (which is largely a consolidation of previous Coroners Acts) and the Coroners Rules 1984.

Section 8 of the Coroners Act 1988

7.17 Section 8 of the Coroners Act 1988 provides that:

> **'(1) Where a coroner is informed that the body of a person (''the deceased'') is lying within his district and there is reasonable cause to suspect that the deceased –**
>
> **(a) has died a violent or an unnatural death;**
>
> **(b) has died a sudden death of which the cause is unknown; or**
>
> **(c) has died in prison or in such a place or in such circumstances as to require an inquest under any other Act,**
>
> **then, whether the cause of death arose within his district or not, the coroner shall as soon as practicable hold an inquest into the death of the deceased ...'**.

7.18 There is no statutory definition of the words **'violent'**, **'unnatural'**, or **'sudden'**. I shall deal later in this Chapter with the problems that arise in understanding and applying these terms.

7.19 Section 8, therefore, requires the coroner to make a decision as to whether the reported death falls within the ambit of the section, i.e. whether there is reasonable cause to suspect that the death was violent or unnatural, or sudden and of cause unknown or that it occurred in prison. It follows that the coroner might decide that the circumstances of the death demand an inquest, even though the cause of death is clear. The death of a motorcyclist suffering fatal head injuries in a road traffic accident would be an obvious example. There would plainly be reasonable cause to suspect that the death was violent. There would also be reasonable cause to suspect that it had not been caused by a natural disease process and was therefore **'unnatural'**. On either of those two grounds, therefore, an inquest would have to be held. Alternatively, the coroner might consider that the reported circumstances of a death do not give rise to reasonable cause for him/her to suspect a

violent or unnatural death, but that the cause of death is not known or not known with a sufficient degree of confidence to permit certification of the cause of death by a doctor. In that event, the coroner would have to hold an inquest because of section 8(1)(b). Sometimes, of course, there will be reasonable cause to suspect that the deceased has died a sudden and unnatural death of which the cause is unknown (i.e. a death falling within section 8(1)(a) and (b)). This would arise, for example, where a decomposed body is found in circumstances suggestive of a fall or other form of violent death.

7.20 However, in relation to many cases reported to him/her, the coroner will conclude that the death does not come into any of the categories set out in section 8, and that, consequently, there is no power or requirement to hold an inquest.

7.21 In those circumstances, the coroner will often issue a Form 100A. I referred to the use of Form 100A in Chapter Six. On the form, the coroner states, **'The circumstances connected with the death of the above person have been reported to me and I do not consider it necessary to hold an inquest'**. The purpose of the form, which is supplied by the Registrar General, is to notify the registrar of the coroner's decision not to hold an inquest. The form also indicates that no post-mortem examination is to be held.

Section 15 of the Coroners Act 1988

7.22 Section 15 of the Act deals with the situation where the coroner has reason to believe that the circumstances of a death require an inquest but where the body has been destroyed or removed from his district. In such a situation s/he may report the death to the Home Secretary, who may then order him/her to open an inquest.

Sections 19 and 20 of the Coroners Act 1988

7.23 By section 20(1) of the 1988 Act, a coroner may, at any time after he has decided to hold an inquest:

> **'(a) request any legally qualified medical practitioner to make a post-mortem examination of the body or a special examination of the body or both such examinations; or**
> **(b) request any person whom he considers to possess special qualifications for conducting a special examination of the body to make such an examination'**.

7.24 Thus, section 20 authorises a post-mortem examination and/or a **'special examination'** to be ordered in cases in which the coroner has decided to hold an inquest.

7.25 The situation will often arise, however, where an immediate decision about whether to hold an inquest is not possible. This situation could arise, for example, where there is no reason to suspect that the death was violent, unnatural or occurred in prison, but where the cause of death is not sufficiently known to permit certification by a doctor and may be revealed by a post-mortem examination. In that event, the coroner may, under section 19, order a post-mortem examination to be carried out, if s/he is of the opinion that such an examination may prove an inquest to be unnecessary. If, as a result of the post-mortem

examination findings, the coroner is satisfied that an inquest is unnecessary, s/he must send to the registrar a certificate, stating the cause of death as disclosed in the post-mortem examination report. That certificate is known as Form 100B. I referred to this form in Chapter Six. The informant then attends the registrar in the usual way. When the death is registered, the cause of death is taken by the registrar, not from an MCCD (there is unlikely to be one in existence), but from the coroner's Form 100B. If the post-mortem examination does not disclose an ascertained cause of death, the coroner must proceed to hold an inquest.

7.26 A **'special examination'** is defined in section 20 of the 1988 Act as an examination:

> **'... by way of analysis, test or otherwise of such parts or contents of the body or such other substances or things as ought in the opinion of the coroner to be submitted to analyses, tests or other examination with a view to ascertaining how the deceased came by his death'**.

7.27 Section 19 does not appear to confer on a coroner the power to order a special examination where no decision has been taken to hold an inquest. Moreover, the authority given by section 20 seems to authorise a coroner to request a special examination of the body only in those cases where s/he has already decided to hold an inquest. Yet coroners do order special examinations in cases where no decision to hold an inquest has been taken.

7.28 When ordering a special examination in a case where no decision has yet been taken to hold an inquest, some coroners rely on the provisions of section 19(2), which provides that, where a post-mortem examination is directed in a case in which the coroner believes that the examination may prove an inquest to be unnecessary, s/he shall have **'for the purposes of a post-mortem examination under this section ... the like powers, authorities and immunities as if the examination were a post-mortem examination directed by the coroner at an inquest into the death of the deceased'**. They contend that section 19(2) gives the coroner the power to order a special examination, even where the post-mortem examination has been ordered under section 19. Others view histological examination as 'part of' the post-mortem examination. This view is given some limited support by the fact that Form 100B contains the question **'Is a histological or bacteriological examination to be made?'** Since that form is only used when a decision has been made not to hold an inquest (i.e. when a post-mortem examination under section 19 has been carried out and has revealed a medical cause of death), and since section 19 appears to confer no power to order special examinations, it would make little sense if the examinations referred to on Form 100B were to be regarded as special examinations. So, the argument goes, they must be regarded, not as special examinations, but as part of the post-mortem examination.

7.29 Whatever the current legal position, it is obviously desirable that coroners should have the full range of investigative tools at their disposal in every case, not only where an inquest is inevitable from the start.

Concurrent Proceedings or Inquiries

7.30 In the event that criminal proceedings have been commenced in connection with a death, the coroner must adjourn the inquest unless the Director of Public Prosecutions (DPP)

informs him/her that an adjournment is unnecessary. The inquest may be resumed only at the conclusion of proceedings (unless the DPP notifies the coroner that it is open to him/her to do so earlier) and if, in the coroner's opinion, there is sufficient cause to resume. In most cases, the coroner will not resume the inquest, but will merely send the registrar a certificate stating the results of the relevant criminal proceedings. An inquest must also be adjourned, in the absence of exceptional reasons to the contrary, where the Lord Chancellor informs the coroner before the conclusion of the inquest that a public inquiry conducted or chaired by a judge is being or is to be held into the events surrounding the death. This provision was used to prevent simultaneous investigations into the deaths of Shipman's patients being conducted by the coroner and by this Inquiry: see Chapter Two of my First Report.

Some Weaknesses of the Current Coronial System

The Dual Nature of the Coroner's Duties

7.31 I have said that the professional qualification of the coroner may be either medical or legal. Some functions of the coroner (such as the conduct of inquests) require legal knowledge and experience and some (such as the determination of whether a death is or is not due to a natural disease process) require medical knowledge and experience. It seems to me that, in order to be able to fulfil all the present duties, a coroner should, ideally, have knowledge and experience of both medicine and the law. I have already said that a small number of coroners are, in fact, dually qualified.

7.32 Some legally qualified coroners now seek to appoint a medically qualified deputy. This may reflect their recognition of the need for medical expertise in the coroner's office. This solution is not ideal. The coroner and deputy cannot work in harness. As I have said, section 7 of the 1988 Act permits a deputy or assistant deputy coroner to act only when the coroner is ill or is absent for any lawful or reasonable cause. The deputy may also conduct an inquest which the coroner is disqualified from holding. Some coroners say that they seek advice from their deputies, which suggests that they are doing so when the deputy is not on duty. Others make it plain that they disregard the statutory rule; the deputies work even though the coroner is not 'absent'. Dr Nigel Chapman, HM Coroner for Nottinghamshire, told the Inquiry that he is so busy with and interested in the medical aspects of his work that he instructs one of his legally qualified deputies to conduct many inquests. This practice, which may seem sensible, breaches section 7 but no action has been taken to stop it.

7.33 As I shall go on to explain, it seems to me that the fact that both medical and legal expertise is not available in each coroner's office at all times is a serious weakness of the present system.

Competing Demands on the Coroner's Time

7.34 In cases that go to inquest, the coroner is involved in the process of enquiry from an early stage until the day of the inquest when s/he also assumes his/her judicial role. There is an obvious tension between, on the one hand, the demands on a coroner's time made by the

requirement of preparation for and attendance at inquests, together with other duties necessitating his/her absence from the office, and, on the other hand, the need to deal with the constant daily stream of cases referred by doctors, registrars, the police or other agencies for advice and decisions. Mr Pollard's evidence was that he spends the equivalent of three full days a week in preparing for and conducting inquests. Mr Burgess said that he typically spends between two and two and a half days each week sitting on inquests and a further half to one day on preparation. Inquests are frequently held at some distance from a coroner's office, making communication between the coroner and his/her staff more difficult.

7.35 Whilst the conduct of inquests might at first sight appear more important, the other decisions for which the coroner is responsible are also of considerable potential importance, since they will determine whether or not an individual death is to be subjected to any official investigation. If, in relation to an individual death that has been reported to the coroner, the coroner decides that s/he has no power to hold an inquest and the cause of death is certified by a doctor, the overwhelming likelihood is that the death will pass through the remaining formal procedures without difficulty. If the deceased is to be buried, the death will be subjected to no further check. If s/he is to be cremated, the death is still unlikely to be subjected to any significant investigation. The fact that the death has been reported to the coroner and the coroner has 'cleared' the MCCD will confer on that certificate an authority which is likely to discourage further enquiry. Even if anyone has concerns or doubts about the death, those are likely to be quieted by the knowledge that the coroner has been informed of the death and permitted certification. It is not widely recognised that the involvement of the coroner often amounts only to a brief telephone conversation between a member of his/her staff and the certifying doctor, with no other investigation of the circumstances of the death.

7.36 Some decisions about the cause of death require urgent attention; delay can frequently mean disruption of the funeral arrangements. This is always a distressing prospect, but particularly so for members of certain religious groups. One of the important issues which I shall address later in this Report is whether it is practicable and appropriate for one person to combine the coroner's role of presiding over and preparing for inquests with the task of giving careful and proper consideration to the investigation and resolution of the issues of medical cause of death which are referred to the coroner's office on a daily basis.

Variability of Standards and Practice

7.37 One of the most frequent criticisms of the coronial system is that it operates very differently in various parts of the country. I have encountered many instances where there is lack of uniformity. In Chapter Four, I have mentioned geographical differences in practice concerning the removal of bodies to funeral directors' premises. In Chapter Six, I highlighted the differing practices of coroners concerning the issuing of Forms 100A and requiring reports by registrars on Form 52. I shall shortly deal with 'local rules' and the different lists that individual coroners issue, describing the categories of case that they expect to be reported to them. The Inquiry has heard about wide variations in the approach of different coroners towards autopsies, particularly relating to the use of histology and toxicology. There are also great differences in the way in which coroners run

their offices and in the way in which their staff work. In Chapter Eight, I will explain the great variation that exists in the tasks performed by coroner's officers working in different districts. The Coroner's Officers Association is concerned that the lack of uniformity is leading to a variation in the standard of service that is being provided to the public. I am sure there are other examples of differences in practice that I have not mentioned and it was not, of course, possible for the Inquiry to examine the practice in every district in the country.

7.38 That the system is variable can be demonstrated by consideration of the statistics produced by the Home Office. For example, in 2001, the proportion of cases reported to the coroner which resulted in an inquest varied very greatly. Although, typically, between 10% and 20% of all reported deaths were followed by inquests, the overall range was very wide. In North Tyneside, 53% of reported deaths were followed by inquest. In North Lancashire, the proportion was 2%. It is difficult to resist the inference that coroners are applying differing standards when reaching their decisions. Similarly, there was a wide variation between the proportion of reported deaths in which an autopsy was held. For example, in the District of North and East Cambridgeshire, an autopsy was held in 96% of all non-inquest deaths. In the adjacent District of South and West Cambridgeshire, the comparable figure was 45%. In the Scarsdale District of Derbyshire, the figure was 36%. There is also some variation in the proportion of inquest cases in which an autopsy is held. In most districts, there is an autopsy in virtually every inquest case but, in some, there is no autopsy in a significant proportion of cases. For example, in 2001, in Milton Keynes there was no autopsy in 26% of inquest cases. In Manchester West District, the figure was 29%. These disparities strongly suggest a wide variability of standards and practice.

7.39 Home Office Research Study 241 entitled 'Experiencing Inquests' was published in November 2002. The authors, members of Bristol University Law Department (including one professor), observed a total of 81 inquests in nine coroner's districts and interviewed 12 coroners and deputy coroners and 13 coroner's officers. Their Study confirmed the existence of a general variation in practice relating to inquests and highlighted considerable variation in the approach of coroners towards the calling of witnesses to give oral evidence and towards the airing of evidence relating to issues of culpability.

7.40 It seems to me that this variation of standards and practice is the result of two main features. The first is the lack of regulation, leadership, guidance and training provided for coroners. The second, which may flow from the first, is that coroners take different approaches to their statutory duties and to the ways in which they organise the work within their offices.

Lack of Regulation, Leadership, Guidance and Training

7.41 It has long been recognised that those taking judicial decisions must be – and must be seen to be – independent. Judges and coroners cannot be directed to take their decisions in a particular way. They cannot be 'managed' by an executive. However, there are many ways in which good practice can be fostered without any loss of judicial independence. That is exemplified by the training and guidance already given to other members of the judiciary. Unfortunately, no such advice or guidance has been given successfully and consistently to coroners. To a very large extent, coroners are left to their own devices.

7.42 One method of promoting consistency is by the imposition of statutory rules of procedure. The existing Coroners Rules are mainly procedural rules relating to conduct of autopsies and inquests. They do not seek to regulate, by stipulating relevant criteria, the way in which the coroner approaches his/her decisions. Moreover, they have not changed with changing times. There is no committee charged with regular review of the Rules.

7.43 There is no senior coroner who can give guidance to other coroners. Nor is there an appellate court by which unsatisfactory decisions can be set aside. The only supervision exercised over the decisions of coroners is by the High Court under the procedure of judicial review and for the limited purpose of directing that an inquest be held, under section 13 of the Coroners Act 1988. The grounds on which judicial review can succeed are very limited; the applicant must show that the decision under review is either unlawful or unreasonable. A poor decision or poor practice cannot be corrected. Applications for judicial review are rare, although they have increased in recent years. The judges have been able to offer some guidance on difficult points of law, but this has necessarily been limited to the issues that have arisen in the few cases where judicial review has been entertained.

7.44 The only circumstances in which coroners meet to discuss their work is through the medium of the Coroners' Society. Although, at present, all coroners are members of the Coroners' Society, membership is voluntary. Not all members attend meetings. Many coroners have little contact with what their colleagues are doing and operate in virtual isolation without the kind of peer support available to those holding other types of judicial office. The fact that most coroners are employed only part-time exacerbates the position. They have to fit their coronial duties around their professional and other commitments.

7.45 Until recently, there was virtually no training available for coroners. Prior to 1983, the Coroners' Society assumed sole responsibility for training but, since that time, the Home Office has also been involved. The extent of training was at first very limited and was not compulsory. About three years ago, however, the Coroners' Society urged the Government to allocate increased resources for training and matters have improved, but only slightly. Training is still not compulsory and, according to Mr Burgess, there are some senior coroners who never undertake the voluntary training that is available because they believe they know all that there is to know.

Different Approaches to Statutory Duties and the Organisation of Work

7.46 The second reason why standards and practice are so variable is that coroners interpret the statutory provisions in different ways. Because there is no appeal structure and judicial review applications are relatively rare, coroners are effectively free to develop their own responses to the legislative provisions. In the remainder of this Chapter, I shall provide several examples of the way in which these factors result in variability of practice between different coroner's districts.

Decisions about Jurisdiction

The Initial Report of a Death

7.47 The coroner's jurisdiction is dependent upon a report made by some person, either as the result of a statutory duty to report or as a voluntary act. As I have already explained, apart

from where a death occurs in custody (when there are special obligations to report the death), the registrar is the only class of person with a statutory duty to report a death to the coroner. Although it is little known, there is a common law duty on everyone to report to the coroner or to the police circumstances requiring the holding of an inquest.

7.48 There is no standard way of recording a report to the coroner. Most reports are made by telephone and a member of staff, usually a coroner's officer, will deal with the call. Whether or not the officer makes a note will depend on the nature of the report and the practice within the relevant office. If a note is made, the amount of information recorded will vary from office to office; for example, far more information is recorded in the office of the Nottinghamshire Coroner than in that of the Coroner for Greater Manchester South District. Each office devises a method thought to be suitable to its own needs and the resources available. In some offices, a written or computerised record is made of every telephone call received by the office in connection with a death. In others, no record at all is made of calls from doctors seeking to 'discuss' a death when the discussion results in 'permission' being given to a doctor to issue an MCCD; a record is made only if the case gives rise to a need for the issue of a Form 100A.

7.49 Most reports to the coroner are made by doctors. They rely mainly on the guidance printed in the books of MCCDs issued to them by the General Register Office. This reproduces regulation 41 of the Registration of Births and Deaths Regulations 1987, which sets out a list of criteria identifying those categories of death where a duty is imposed on the registrar to report the death to the coroner. This regulation is set out in paragraph 6.12. The list of criteria in regulation 41 does not replicate the list of categories of deaths in which the coroner is required to hold an inquest contained in section 8 of the Coroners Act 1988; it is longer and more detailed. Although it incorporates all those types of death in respect of which the coroner is required to hold an inquest, it also specifically identifies a number of factual circumstances which would bring a case within the section 8 categories. For example, it refers to deaths occurring during an operation and deaths which appear to have been due to industrial disease or industrial poisoning. Both types of death might potentially fall within the 'unnatural' categorisation. I find it strange that the regulation 41 list and the section 8 list are not the same, but it is not perhaps surprising that it was felt necessary to specify some of the more common types of unnatural death for the assistance of registrars who are neither medically nor legally qualified.

7.50 Many coroners, however, consider that even the regulation 41 list is not sufficient and they issue (not only to registrars, but also to hospitals and doctors) their own lists of the types of case that they wish to have reported to them; such lists can, of course, have no legal status. Mr Dorries, who has written a well-respected textbook on coroners' law and practice[1], has circulated locally a list of the types and categories of deaths that he would like to be reported to him and a modified version of that list appears on page 46 of his textbook. As he says in introducing the list in the textbook:

> **'The present requirements for reporting deaths to the coroner are a muddle of legislation, common law and varying advice. This is most unsatisfactory and in an effort to provide doctors in his jurisdiction with**

[1] Dorries, CP (1999) 'Coroner's Courts – a guide to law and practice'. Chichester: John Wiley and Sons.

some clear guidance the author prepared the list set out ... in Table 3.2. With one or two minor amendments this has found a general measure of favour among coroners in the Yorkshire region.

It should be clearly explained that the list is merely the author's own interpretation of statute and (hopefully) common sense combined. It is, of course, possible to find exceptions or arguments in many of the categories.'

7.51 Inevitably, as Mr Dorries acknowledges, the drawing up of an illustrative list will always be vulnerable to criticism on the grounds of unwarranted inclusion or exclusion of certain types of death. Some coroners regard the practice of circulating lists of criteria with local variations as undesirable. Those who issue them wish to extend the range of deaths reported to them, expecting that this will improve their chances of catching more of the deaths that warrant the holding of an inquest. This practice, adopted no doubt with the best of intentions, is bound to lead to some variability of practice. It explains, at least in part, the difficulties many doctors have in recognising reportable deaths. Indeed, local lists may actually exacerbate those difficulties. During the course of the Inquiry, as I considered the lists set out in section 8 and regulation 41 and the various lists of 'reportable deaths' issued by different coroners, I became gradually less surprised that doctors should have difficulty in making reliable decisions about whether an individual death ought to be reported, as the research I mentioned in Chapter Five shows that they do. Those doctors who move from one district to another during their early years will no doubt observe the variation in coroner's practice.

7.52 The evidence suggests that some doctors do not know which of the requirements imposed in their district are based on regulation 41 and which are imposed by the local coroner or are based on local custom and practice. Registrars are not always informed of local rules; for example, Mr Pollard did not tell the Tameside registrars that he had imposed a local rule requiring the reporting of deaths occurring within 24 hours of admission to hospital.

The Criteria for the Decision about Jurisdiction following the Report of a Death – Was the Death Violent or Unnatural?

7.53 As I have said, section 8 of the 1988 Act requires the coroner to accept jurisdiction in respect of any death reported to him/her if there is reasonable cause to suspect that the death was violent or unnatural or was sudden and of unknown cause or if it occurred in prison or in other circumstances in which an inquest is required by statute. If none of those criteria is satisfied, the coroner has no power to conduct an inquest or to order an autopsy and has therefore no jurisdiction. If any one or more of them is satisfied, s/he has jurisdiction and must hold an inquest, unless an autopsy has disclosed the cause of a sudden death not meeting any of the other criteria.

7.54 Decisions as to whether there is a reasonable suspicion that the death was violent are not usually difficult; in general, the circumstances in which the death or injury came to the attention of the reporting doctor will suggest a history of violence or the body will show

signs of violence. However, determining whether or not there is reasonable cause to suspect that the death was unnatural may not be as straightforward.

7.55 There are two aspects to such decisions. First, there is the practical problem of receiving sufficient reliable information on which to base a decision. There can be no doubt that the coroner is entitled to undertake preliminary enquiries in order to reach a decision. The coroner has no power to call for documents, such as medical records, although I heard evidence that some coroners, or their officers, do so. Some also make enquiries of a member of the deceased's family. However, I have the clear impression that most initial decisions are based solely upon the information received from the person making the report, usually a doctor. That information might or might not be accurate and reliable; the person receiving the information might or might not make a full and accurate record of it.

7.56 Second, the question of whether a death is or is not 'natural' involves very difficult questions of law. Much light has been thrown on this issue by recent decisions of the Court of Appeal such as R v Inner London North Coroner, ex parte Touche[2] and R v Poplar Coroner, ex parte Thomas[3]. Even so, the issue is not always simple. It is now established that, where a death appears to have been due to natural causes, but contributed to by human failure or neglect, the failure or neglect must be of an obvious nature in order for there to be reasonable cause to suspect that the death was unnatural. There will also be cases which fall outside the category of 'neglect' and yet call for an inquest on the basis that the death, though in part resulting from 'natural causes', was wholly unexpected and would not have occurred but for some culpable human failure and was therefore in all the circumstances unnatural. However, the coroner is not expected to hold an inquest simply because there may be some question of negligence: see R v HM Coroner for North Humberside and Scunthorpe, ex parte Jamieson[4] and the case of Touche referred to above.

7.57 An illustration of this second problem would be the common occurrence of the death of an elderly person following a fall. Some doctors regard a frail elderly person's propensity to fall as a natural consequence of the ageing process. So, if a fall results in an injury (often a hip fracture) which causes immobilisation leading to bronchopneumonia and death, they would say that the death is natural. A coroner might accept that view. Other doctors and coroners would say that any fall, even a spontaneous fall, is a traumatic and unnatural event and, if it is part of the chain of causation leading to death, the death is unnatural. Some coroners would say that, if the fall were spontaneous, the death is natural but if it were caused, say, by a defective carpet, then the death is unnatural. Finally, some coroners might regard such a death as violent and, therefore, as requiring an inquest. So, coroners will reach different conclusions about the need for an inquest in such a case.

7.58 Accepted learning about what amounts to a natural or unnatural death is not always logical or satisfactory. It appears to be generally accepted that a death due to smoking is a 'natural' death. It is also accepted that a death due to lung cancer caused by the inhalation of asbestos fibres is an 'unnatural' death. Both are due to the inhalation of a known

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[2] [2001] QB 1206.
[3] [1993] QB 610.
[4] [1995] QB 1.

carcinogen. If the death might be due to exposure during employment, it will be treated as unnatural. Regulation 41 requires registrars to report a death which appears to have been due to industrial disease or industrial poisoning. This is presumably because such a death is to be regarded as 'unnatural' and therefore falling within section 8 of the Coroners Act 1988. The distinction conventionally drawn between a cancer death due to asbestos and one due to cigarette smoking does not appear rational.

7.59 There was some evidence before the Inquiry that coroners' decisions on whether there is a reasonable suspicion that the death was unnatural are not always satisfactory. Dr Gordon Pledger, Medical Referee at the Newcastle-upon-Tyne crematorium, told the Inquiry of a case that had caused him concern. When reading a cremation Form B, he had noticed that the deceased was said to have died as a result of a head injury sustained in a road traffic accident two years before. There was no reference to the coroner on the Form B so Dr Pledger, being of the view that the death plainly called for an inquest, telephoned the coroner's office. He was told that the coroner was aware of the case and had decided not to hold an inquest. Yet, a death caused by injuries sustained in a road traffic accident would be regarded by most coroners as plainly 'unnatural'. It may be that the time which had elapsed since the accident explains the coroner's decision. However, the nature of the cause of the death is unaffected by time.

7.60 I heard evidence that, sometimes, a coroner's officer will reject a report on the basis that 'the coroner is not interested in that' and that no inquest will thus be held. For example, a Tameside registrar who attempted to report a death due to 'e-coli' was told that the coroner would not 'accept it', but would do so if any further deaths from that cause came to light. I do not see how the coroner could conclude that there was no reasonable cause to suspect that the death was due to neglect (e.g. by lack of proper hygiene precautions) without making some preliminary enquiries. The information given by the registrar, limited to the mere cause of death, could not be a sufficient basis for decision. Furthermore, the suggestion that a second death from the same cause would be treated differently by the coroner's office made no sense at all.

7.61 Similarly, there was evidence that one coroner would not accept a death due to tuberculosis. Such a death is to be regarded as 'unnatural' (and therefore requires an inquest) if it had resulted from occupational exposure to infection, for example, of a nurse in an isolation hospital. It is listed on the reverse side of the MCCD as an infectious disease which may be of industrial origin. Its causes are said to include **'contact at work'**. The Tameside registrar reporting it did not know how the disease had been contracted. The Coroner for Greater Manchester South District declined to hold an inquest, saying that tuberculosis was a naturally occurring disease. In evidence, it was apparent that he had not appreciated that, in some circumstances, such a death might be related to the deceased's occupation and therefore regarded as 'unnatural'.

7.62 On another occasion, a Tameside registrar telephoned the coroner's office to report a case in which the word **'dehydration'** appeared on the MCCD. Registrars are instructed that, if the word **'dehydration'** appears within the causes of death given on an MCCD, they must report the death to the coroner. The registrar completed Form 52 stating that dehydration was a reportable cause of death. The note made at the coroner's office was

that the registrar was **'Unable to accept dehydration without clearance'**. The reason why registrars are instructed to report cases of dehydration is that they may result from some form of neglect, so that the death may not have been natural. In the event, the registrar was given 'clearance' by the coroner's office by means of a Form 100A without any further enquiries being made. Thus, the coroner's office never discovered whether the dehydration resulted from neglect, or was the result of a natural disease process; instead, the report was treated merely as a procedural exercise. This defeated the whole purpose of the rule that such a death should be reported and of the intention that this should lead to an enquiry as to whether there had been any form of neglect.

7.63 Another case concerned two daughters of a deceased person who were concerned about his death. They expressed their concern to the registrar and said that they did not wish to register the death. The registrar telephoned the coroner's office to report the death. The deceased had, according to his daughters, appeared to be making good progress after a stroke and was about to be discharged from hospital, when he died suddenly. His daughters wanted an explanation as to why he had died so suddenly. The cause of death was certified by a doctor as bronchopneumonia resulting from a stroke. A member of the coroner's staff spoke to the certifying doctor, who said that he was **'quite happy with the cause of death'**. At that stage, neither the coroner nor any member of his staff spoke to a member of the deceased's family to ascertain the detailed reasons for their concern. On the basis of what the doctor had said, the coroner directed that a Form 100A should be issued, notifying the registrar that he did not consider it necessary to hold an inquest. One of the coroner's staff telephoned one of the deceased's daughters and informed her that the coroner was **'happy with'** the cause of death the doctor had given and would not order an autopsy. The daughter was not satisfied and wanted an autopsy. She was offered an opportunity to speak to the coroner personally but declined, saying that if he had made that decision, she did not want to speak to him but would take the matter further from there. In the event, she made a complaint through the hospital complaints procedure. In oral evidence, the coroner told this Inquiry that he had a report of a natural cause of death from the doctor and did not regard it as necessary to speak to the family, in order to ascertain the nature of their concerns, before taking a decision. He said that, where there was a conflict between the view of the doctor and the view of the family, he had to take the view of the professional. It may be that, in this instance, the professional's view was indeed correct. But until the coroner had informed himself of the family's concerns, he was not in a position to judge whether there was a reasonable cause to suspect that the death was unnatural.

7.64 These cases suggest that the bases upon which some coroners decide whether or not to accept jurisdiction in respect of a particular death are variable and of doubtful validity.

The Criteria for the Decision about Jurisdiction following the Report of a Death – Is the Cause of Death Known?

7.65 Under section 8(1)(b) of the 1988 Act, the coroner has to determine whether there is **'reasonable cause to suspect that the deceased ... has died a sudden death of which the cause is unknown'**. It should be noted that the requirement is for suddenness and an unknown cause. The words suggest that there is no need for the coroner's intervention if

the death is slow and expected (i.e. not sudden) but of unknown cause. I do not think that that can have been the intention of Parliament. Assuming that the intention of Parliament was that there should be an enquiry into all deaths of which the cause is unknown, the wording of this sub-section seems to presuppose that all deaths that are not sudden are of known cause. I very much doubt that that is always the case.

7.66 It seems clear to me that what the provision is really driving at must be whether or not the cause of death is sufficiently known. The expression **'reasonable cause to suspect that the deceased ... has died a sudden death of which the cause is unknown'** is an unfortunate one. Whether or not something is sufficiently 'known' cannot be a matter of suspicion; the question should be whether the cause of death is known to a sufficient degree of confidence. It is to be hoped that coroners understand that that is the issue that governs this aspect of their jurisdiction.

7.67 If a deceased's doctor says that s/he does not know the cause of death and there is no other doctor qualified to issue an MCCD who has the necessary knowledge, the case falls within section 8(1)(b) and the coroner must either order an autopsy under section 19 or hold an inquest.

7.68 More difficult cases arise where the doctor is uncertain whether or not s/he is sufficiently confident of the cause of death to certify or is uncertain as to whether the condition s/he believes caused the death of itself gives rise to a duty to report the death. The doctor may then telephone the coroner's office for advice. Assuming that the proposed cause of death is not of itself such as to require the opening of an inquest, the issue for the coroner (or his/her officer) is whether it appears from the information available that the cause of death is known with a sufficient degree of confidence, such that there is no reason to suspect that the cause of death is unknown. Even if the doctor him/herself expresses confidence in the cause of death, that is not necessarily the end of the matter. The coroner (or his/her officer) may conclude that, in the circumstances (e.g. because the doctor has not seen the deceased recently and is not therefore in a position to diagnose the cause of death), there is still reason to suspect that the cause of death is unknown. It is for the coroner or the coroner's officer to judge whether the cause of death is known with sufficient confidence to avoid jurisdiction arising under section 8(1)(b).

7.69 Even where the deceased's doctor was in regular attendance on the deceased to the end of his/her life, is confident that s/he knows the cause of death and the coroner has no reason to doubt the doctor's word, difficulties can arise. As is made clear in the judgement of Simon Brown LJ in the Touche case cited above, it is quite likely that there will in many cases be several causes of death. In that case, the deceased had died shortly after giving birth by caesarean section. The medical causes of death, as recorded in the autopsy report and accepted by the coroner, were **'Ia. Brain swelling and tonsillar herniation b. Intra cerebral haemorrhage II. Recent pregnancy'**. These were undoubtedly accurate statements of the medical cause of death but provided an incomplete explanation for the death. Why had the deceased suffered an intra-cerebral haemorrhage? When the whole picture was later considered, it became clear that the underlying cause of Mrs Touche's death was that she must have developed very high blood pressure in the post-operative phase. This was a well-recognised complication; yet

the hospital had failed to monitor her blood pressure and treat it if it rose. That failure was a contributory cause of the death. The current system by which coroners or their officers decide whether or not jurisdiction arises seems to me to require the person receiving the report of death to be very astute to the potential significance of underlying or contributory causes; yet these reports are very often received by untrained staff and, to the extent that they may be considered by coroners in person, there is wide variation in the approaches taken. That doctors and coroners may focus on the immediate medical cause without considering the relevant wider picture is evidenced by the case in which death took place some time after a road traffic accident (see paragraph 7.59) and also by the death of Mrs Renate Overton, whose case I shall deal with in Chapter Thirteen.

7.70 As I have intimated, many reports or 'requests for advice' from doctors to the coroner, relating to uncertainty over the cause of death, are taken by coroner's officers. In Greater Manchester South District, at least until recently, decisions about whether or not the Coroner would 'accept' the case were taken by coroner's officers. I had the clear impression that these officers did not realise that they were making decisions about jurisdiction on the Coroner's behalf. That is not intended as a personal criticism of them; they have had no formal training. Although they knew that, if the doctor did not know the cause of death, the case had to be 'accepted', I do not think they had any idea of where to draw the line in a case of doubt. They said that, if in doubt, they would consult the Coroner. I had the impression that they did so only occasionally. In any event, I think they would often have been unable to equip themselves with the information needed to enable the Coroner to reach a well informed decision. The coroner's officers frequently gave 'advice' to doctors to issue an MCCD, which advice, in effect, amounted to a decision, made on the Coroner's behalf, to decline jurisdiction. I do not think they ever realised that that is what they were doing. I think it is inappropriate that they were allowed to do so, although I am sure that the practice is not unique to that office.

7.71 Even in cases where it is the coroner personally who takes the decision, some further difficulty might well arise because it is not clear what level of confidence is required before s/he should decide that no inquest is needed and should encourage the treating doctor to certify the cause of death. Some coroners appear to apply a much higher standard of confidence than others. There is little guidance in the statute as to what standard is to be applied. The use in section 8(1) of the 1988 Act of the words **'reasonable cause to suspect'**, inappropriate though those words are, suggests a fairly low threshold before an inquest must be held and the need for a fairly high degree of confidence in the accuracy of the cause of death before the treating doctor should be encouraged to certify. It might be thought that good practice and the satisfactory operation of the death certification and coronial systems should require a high degree of confidence in the accuracy of the cause of death.

7.72 However, if a coroner imposes too high a standard of confidence, the result is neither sensible nor practicable. If the coroner, on receiving the report of the death, decides that the cause of death is unknown, s/he is virtually bound, under the present system, to order an autopsy, as that is necessary if s/he is to certify the cause of death without an inquest. Although the coroner could speak to the deceased's family and to witnesses with knowledge of the circumstances of the death and could examine any medical records

made available voluntarily, in practice s/he moves straight to the autopsy as the first tool of investigation. Autopsies are expensive and a drain on resources. Moreover, they cause distress to many families who are upset to think that the body of a loved one is to be (as they see it) invaded. For some religious and ethnic minorities, there are very strong and deep-rooted objections. Coroners know this only too well. Mr Dorries, who, I think, requires a high degree of confidence about the cause of death before he will allow a treating doctor to issue an MCCD, told the Inquiry that, in cases where he is sure that the death was natural but the precise cause cannot be identified with confidence, he often wishes that he could certify that state of affairs, rather than being obliged to order an autopsy. However, not all coroners require so high a degree of confidence and I am sure there are many who, faced with that situation, take the view that they can and should tell the doctor that s/he may issue an MCCD.

7.73 It might be thought that a high standard of confidence would be desirable despite the fact that this might lead to a large number of autopsies. If the autopsy produced a high degree of certainty about the cause of death, the effect would be beneficial to the system, even though unpopular with the public. However, as I shall explain in Chapter Nine, that is not the case. The coroner's autopsy often does not provide the 'gold standard' cause of death which some believe it provides. It reveals the conditions with which the deceased has died, but not necessarily the condition which actually caused the death. It may also reveal one or more of several causes of death but it will not necessarily result in the identification of the true cause of death.

Concerns about the Soundness of Decisions on Jurisdiction

Decisions Taken for Inappropriate Reasons

7.74 On the basis of the evidence received by the Inquiry, it appears to me that there are grounds for concern about the soundness of the decisions of some coroners and coroner's staff on jurisdiction. Although I have no doubt that many coroners understand and apply the correct statutory tests when making decisions under section 8 of the 1988 Act, there is also evidence that some either do not understand the criteria or are influenced, deliberately or not, by extraneous matters. On occasions, it appears that decisions are taken for frankly improper reasons. I give below some examples of practices reported to the Inquiry by doctors. I acknowledge that the evidence is fragmented. The Inquiry has not conducted any research of the wider position but my overall impression from the evidence I have received is that the practices in question are likely to be general and widespread, rather than specific and local, features of the coroner service.

7.75 The experience of the doctors who gave evidence to the Inquiry was variable. Dr Alan Banks, a former general practitioner, later Assistant Director of Primary Care and Medical Adviser to the West Pennine Health Authority, gave evidence in Stage One of Phase Two. He said that, when working as a general practitioner in East Anglia, he used to talk to the coroner when he was unsure whether the available medical evidence was sufficient to enable him to certify the cause of death. Dr Banks plainly found the experience of discussing a death in this way to be helpful. Many doctors do. Dr Frances Cranfield, a general practitioner who gave evidence in Stage One, said that, on occasions, she would

discuss a death with the Coroner so that she would be able to indicate that she had done so on the back of the MCCD. The Coroner would contribute little or nothing to her thinking on the cause of death but the process of registration would be facilitated. Dr Banks appears to have been luckier than many, in that he at least seems to have been able to speak directly to the coroner. The experience of Dr Ian Morgan, a general practitioner and medical referee from the West Midlands, was less satisfactory. He said that, in 15 years, he had never spoken directly to the coroner, save when he had attended an inquest.

7.76 Dr Rachel Pyburn, now a consultant geriatrician at Hope Hospital, Salford, said that, in the past, while working in the North East, she had had some very unsatisfactory experiences. She had been put under pressure to issue an MCCD when she had telephoned the coroner's office with the intention of reporting the death, because she did not feel confident that she knew the cause. One general practitioner from Yorkshire told the Inquiry that he and colleagues are sometimes asked by a coroner's officer whether they could not put 'bronchopneumonia' on the MCCD, because the coroner's office has a backlog of autopsies to deal with. Another general practitioner, again from Yorkshire, told the Inquiry that the coroner's officer, a police officer, usually advises the doctor to certify the cause of death if at all possible, even if there is uncertainty about it, so long as it is fairly clear that the death was due to natural causes. A clinical epidemiologist told the Inquiry that he had had conversations with a coroner about the certification of deaths following a fracture of the neck of the femur. This coroner wished doctors to avoid mentioning such fractures on MCCDs, even where the patient had died in the immediate period following a fracture as, if this were done, he would be obliged to intervene, presumably because it would appear that the death had resulted from a fall and was, therefore, unnatural. Quite apart from any other consideration, this sort of action has the effect, as the epidemiologist pointed out, of rendering completely unreliable statistics for excess mortality following a fractured femur.

7.77 I can see how such poor practices might arise. If a coroner is overworked or understaffed, s/he or the coroner's officer might be tempted to keep to a minimum the number of cases in which the coroner assumes jurisdiction for reasons which are, in fact, inappropriate. There will be less work to do and more deaths will be certified by the attending doctor. Fewer autopsies and fewer inquests will be held. Costs will be reduced. By and large, the population in the area will be content, as, in general, people do not want the bodies of their loved ones to be invasively examined. However, such a policy reduces the efficacy of the system to detect concealed homicide, malpractice or neglect and to provide information which might improve knowledge on health matters. It also produces a high level of distress and disappointment among those who are unsuccessful in securing the death investigation that they seek.

7.78 These are important concerns. The decision of a coroner to order an autopsy or hold an inquest is very important; yet it is not subject to any review. Indeed, the coroner does not even have to give reasons, unless (very occasionally) required to do so for the purpose of judicial review.

The Adequacy of the Information on which Decisions Are Taken

7.79 Even if the decision as to whether to order an autopsy or hold an inquest is taken in completely good faith, as I accept it usually is, there is reason to believe that the evidential

basis is incomplete and unreliable. The decision is usually taken in an informal way and without any independent investigation of the death. The usual procedure is that the doctor wishing to report the death telephones the coroner's office and tells the coroner's officer about the death. The coroner's officer may take down some details and indicate what the decision is likely to be or else promises to put the facts before the coroner for decision. Some coroners will speak directly to the doctor but my impression is that that is very unusual.

7.80 The informality of the process, in which the doctor provides only a verbal account of the medical history and circumstances of death, is quite likely to result in the coroner's officer having an incomplete and imperfect understanding of the case. Not all doctors are good historians. Most coroner's officers do not have the medical expertise necessary to probe the doctor's account. The doctor might not tell the truth or the whole truth. The coroner's officer will know nothing about the doctor. He or she can check to ensure that the doctor is properly registered but that is all; s/he will not be privy to any other information and will not know, for example, whether or not the doctor has been the subject of disciplinary action or is under the supervision of the General Medical Council. He or she will often have no independent knowledge of the deceased's medical history or about the circumstances of the death, although in some areas, such as Cheshire, the coroner's officer might discuss these matters with the family before putting the information before the coroner.

7.81 In some cases, the doctor will have an underlying wish to issue an MCCD, possibly to save the relatives the distress of an autopsy or inquest. In that event, s/he might well present his/her view of the cause of death in a more confident light than the facts warrant. Alternatively, the coroner's officer might have a preconceived view. He or she might know that the office has a backlog of work or that the coroner is not particularly 'interested in' certain types of case. In such circumstances, the coroner's officer might well suggest to the doctor that it appears that s/he could issue an MCCD. The giving and recording of a complete and accurate account will not be helped by the existence of any preconceived attitudes on the part of either the doctor or the coroner's officer.

7.82 In my view, a single conversation with the reporting doctor is an inadequate basis for the important decision that is to be taken. The Coroners Act 1988 and the Coroners Rules 1984 do not deal with the way in which coroners should set about investigating deaths reported to them, nor the sources from which they should seek information. No power is given to coroners at that stage to enter and search premises, inspect documents or seize documents or other property relating to a death, although there is nothing to prevent a coroner from doing so, provided s/he has the consent of the person with control of the relevant premises, documents or property.

7.83 I consider that it would be far better if the coroner undertook some preliminary independent investigations before making his/her decision on jurisdiction. I accept that it would not be practicable for extensive investigations to be made at this stage. However, it seems to me highly desirable that someone from the coroner's office should obtain information from relatives of the deceased, those who had care of the deceased or those who had seen him/her recently before the death. Such a practice is usual in Nottinghamshire and Cheshire and is clearly quite practicable. Mr Dorries introduced this

practice shortly before he gave evidence to the Inquiry and it appeared that he had found it helpful. The cases referred to in oral evidence by Mrs Christine Hurst, senior coroner's officer for Cheshire, suggested that the arrangements in her District work well. When he gave evidence to the Inquiry in November and December 2002, Mr Pollard had not yet introduced the practice of speaking to relatives and others with knowledge of the deceased in the Greater Manchester South District, despite his acknowledgement that the present arrangements depend heavily on the integrity of the reporting doctor and his detailed knowledge of Shipman's dishonesty.

7.84 The form of any preliminary investigations might vary according to the circumstances of the death. Under the present provisions, the coroner might not only discuss the medical history and circumstances of death with the family or friends of the deceased or those who have cared for the deceased such as district nurses, s/he might also (with the consent of the next of kin) examine the deceased's hospital or general practitioner records. On some occasions, s/he might arrange to inspect the scene of the death. Any one or more of these steps might reveal evidence to show that there was or was not real cause to suspect that the death was violent or unnatural or might throw light on an uncertain cause of death. However, coroners do not generally undertake such preliminary investigations before reaching (or allowing an officer to reach) a decision on jurisdiction.

7.85 Whether this is because the coroner has no time for such enquiries or cannot fund them or does not undertake them because there is no statutory power to enforce the wish to undertake them, I do not know. No coroner told me that he wished to carry out such examinations but was thwarted, for example, by a lack of resources. All seemed prepared to accept the present system as it is, with all its limitations.

Decisions Taken by Coroner's Officers

7.86 Of particular concern was the evidence about the way in which coroner's officers – rather than coroners – take decisions on jurisdiction; these decisions should be taken only by coroners themselves. This practice is not universal, but, as I have already said, appears to be widespread. Dr Chapman claimed that he had some input into most of the decisions made or 'advice given' by his office. Mr Burgess permits his officers to give 'advice' to doctors. It was not clear to me which types of case call for 'advice' and which for a decision on jurisdiction. I suspect that the boundaries are blurred. Mr Burgess does not have any secretarial or administrative staff but sees no reason why, if he had, they should not 'give advice' to doctors. He says that all decisions taken by his officers are ultimately reported to him, although this might not occur until some time after the decision has been taken. His instructions about reporting decisions to him were recorded in writing for the first time in 2001.

7.87 In the Greater Manchester South District, until recently, any member of the coroner's staff (i.e. the first, second, or third coroner's officer or the clerk/typist) was authorised to deal with enquiries from doctors. They were authorised to take a decision about whether or not there should be an autopsy and about whether, if there was to be one, it should be conducted by a Home Office approved pathologist. Once the autopsy had been carried out, they were authorised to receive the results and decide whether to pass for certificates

(Form 100B and cremation Form E) to be prepared or arrange an inquest. In other words, they took decisions on all aspects of the Coroner's jurisdiction. Their 'entitlement' to take these decisions, without reference to the Coroner, was set out in their job descriptions until very recently. The evidence was that the staff did sometimes refer decisions to the Coroner, but it is clear that they often did not. In any event, the Coroner would often not be available, as he would be away conducting an inquest. I formed the view that, only if the officer thought the case was difficult or unusual, would it be referred to the Coroner. The junior members of staff would seek advice from the first officer if in doubt about the decision to take. Mrs Mary Evans, first coroner's officer from 1986 until 1999, said that a new clerk/typist would not be able to handle a query for a considerable time after appointment. She might take the details down but would not make a decision. However, Miss Michelle Kennerley (now Mrs Michelle Greenwood), who began work as a clerk/typist in the coroner's office in May 1998, told the police in August 1998 that she was dealing with simple queries, including giving clearance to doctors to issue MCCDs, within a short time of beginning her employment. She claimed that by the time she left, after seven months in the office, she had become more experienced and confident and able to deal with straightforward cases alone and without reference to others. It may be that Miss Kennerley was an unusually apt pupil; she had worked as a medical secretary and was used to speaking to doctors.

7.88 The job description of the coroner's first officer at that time appeared to entitle the post-holder to take a wider range of decisions on the Coroner's behalf. Her role was said to be to 'deputise' for the Coroner. The extent of her delegated powers was not defined. Plainly, she could not conduct an inquest or sign the various forms which the Coroner would issue but it seems likely that she could do anything else.

7.89 The practice of permitting a coroner's officer or clerk/typist to make decisions on the coroner's jurisdiction is plainly unsatisfactory, at least where, as in Greater Manchester South, the officers have no medical knowledge, investigative experience or formal training. They could not have had the knowledge necessary to ask the right questions, let alone evaluate the answers. This practice, the Inquiry has been told, has now ceased.

The Effect of the Decision on Jurisdiction

No Jurisdiction

7.90 If, following a conversation with the reporting doctor, the coroner or one of his/her staff decides that the cause of death is sufficiently known and that the other circumstances are not such as to require an autopsy or inquest, the doctor will normally proceed to issue an MCCD. I have explained in Chapter Five that the MCCD and counterfoil provide the doctor with the opportunity to state whether s/he has reported the case to the coroner **'for further action'** but, for various reasons, the fact that the conversation has taken place is not always recorded on the MCCD. Assuming that the MCCD is otherwise apparently in order, the registrar will proceed to register the death on production of the MCCD and may not be aware that there has been any earlier contact with the coroner. If, however, the registrar becomes aware that there has been a report to the coroner, for example, because the doctor indicates on the MCCD that s/he has reported the death, the registrar will require

a Form 100A (or, at least oral confirmation from the coroner that there is no intention to hold an inquest) before the death can be registered.

7.91 Form 100A is a notification that the coroner has been informed of the death and has decided not to hold an inquest. Its receipt provides official confirmation to the registrar that s/he can register the death. Some coroners issue a Form 100A in respect of any death of which they are informed, if they or an officer decide, for whatever reason but without an autopsy, not to hold an inquest. Others issue a Form 100A only in those cases that they regard as having been 'formally reported'. If the death has only been discussed with the coroner or 'informally reported', not only might the coroner not issue a Form 100A, but it is quite possible that no record at all will be kept of the referral. If a record is kept, it will probably be marked **'NFA'** (No Further Action). Here again, there is variability of practice. In some offices, the distinction between a formal report and 'discussions' and 'requests for advice' and 'informal referrals' is wholly unclear. Clearly, good practice requires that every contact with the coroner's office in respect of a death should be treated as a formal report, recorded as such and the outcome recognised as a decision on jurisdiction. Dr Chapman and Mr Dorries both operate such a system. In Mr Burgess' office, there is a distinction between formal and informal referrals, although a note is kept of all contacts. In Mr Pollard's office, the practice has recently changed so that every contact is treated as a referral and is considered by the Coroner. If jurisdiction is 'declined', a Form 100A is issued in every case. Previously, many conversations were dealt with by the staff on an informal basis and did not come to the attention of the Coroner. Many were not recorded; some were recorded and marked **'NFA'**. Forms 100A were frequently not issued. It was impossible to discern the criteria by which staff decided how to deal with any individual enquiry.

7.92 One of the effects of permitting a coroner's officer to take a decision without reference to the coroner is that the decision might have been acted upon before the coroner even knows of it. Mr Pollard agreed that, in the past, his staff made decisions on reports from doctors and, in a case in which jurisdiction was not accepted, and the doctor was told s/he could issue an MCCD, the doctor might well do so and give the certificate to the deceased's next of kin before he had seen the papers and issued a Form 100A. If the Coroner had disagreed with the officer's decision, that situation would have had to be set in reverse and it is likely that it would have caused considerable distress to the deceased's family. Mr Burgess said that 'he did not have a clue' whether doctors issued MCCDs before he had seen the papers and signed the Form 100A. It seems that the signing by coroners of Form 100A is, on occasions, no more than a 'rubber stamp' of previous decisions made by their officers.

7.93 It appears that, in some coroners' offices, Forms 100A pre-signed by the coroner are available to officers, who are then able to make a decision and put it fully into effect without reference to the coroner. In Mr Pollard's office, the staff used to keep a supply of such forms for use when Mr Pollard was away from the office. It was claimed that he gave permission before one was issued. Mrs Joan Collins, who was employed at the Coroner's office from 1985 until 2002 and was the first officer from 1999 until her retirement, said that only in exceptional circumstances would the staff use one without his prior knowledge. However, Mr Pollard agreed that he did not know whether staff used such forms without

his knowledge. There were no clear rules for their use and use was not audited. In my view, it is likely that, in the past, pre-signed forms were used without specific authorisation by the Coroner. That may well have been one of the respects in which Mrs Evans was permitted to 'deputise' for the Coroner. The practice of using pre-signed forms has now ceased.

Jurisdiction Accepted

7.94 If the decision is taken that the circumstances are such as to require an inquest to be held, the case will be 'taken over' by the coroner's office and the next stage will usually be to order an autopsy. I shall deal with what happens next in Chapter Nine.

Particular Examples of Decisions on Jurisdiction

'Old Age' as a Cause of Death

7.95 In Chapter Six, I explained that some registrars are unhappy about the use of 'old age' as a sole cause of death. However, if the deceased was aged 70 or over, and the MCCD is acceptable in other respects, the registrar is virtually bound to accept it and to register the death. Frequently, deaths where 'old age' is given as the cause of death will not be reported to the coroner. However, sometimes, doctors will contact the coroner to seek advice. Some coroners do not approve of 'old age' as a sole cause of death. Mr Dorries said that, if a doctor telephones his office to ask about certifying 'old age' as a cause of death, he will not approve it unless the deceased was over 80 and he is satisfied about the medical history. Deaths suggested as being due to 'old age' are not on Mr Dorries' list of reportable deaths and he admitted in oral evidence that he had no right to impose any conditions about use of the term. He is aware that at least some of the registrars in his district report cases of deaths due to 'old age' to him but he acknowledged in oral evidence that he did not get reports of all such cases. He said that, when doctors contacted his office to ask advice and he and his officers did not regard 'old age' as an appropriate cause of death, they would say so and the doctors would usually heed their advice. I have given detailed consideration to the use of 'old age' as a cause of death in Chapter Six.

7.96 According to Mr Pollard, the staff in the office of the Greater Manchester South District used themselves to make a judgement about the appropriateness of 'old age' as the cause of death in a case in which a doctor telephoned to ask advice. If in doubt, they would refer the decision to him. The staff who operated this system gave varying accounts of what happened in practice. Mrs Evans told the Inquiry that she would ask a series of questions, including how long the doctor had been treating the patient and whether the deceased had deteriorated gradually, as opposed to having died a sudden death. However, when making a statement for the police investigation of Mrs Kathleen Grundy's death in 1998, she said that **'... if a doctor had seen a patient within the required fourteen days and told us that they had died of old age having basically deteriorated over a period of time then we** [*i.e. the coroner's office*] **would not become involved'**. She said that such conversations lasted **'a couple of minutes'** only. Mrs Collins, who was employed in the office from 1985 until 2002, recalled that Mr Peter Revington, the Coroner

until 1995, would be happy for 'old age' to be used, so long as the deceased was over 80 and had deteriorated over time. She said that Mr Pollard asked for more information than that. Mrs Margaret Blake, the current first officer, said that the only question asked prior to 1998 was the age of the deceased; if that was 75 or over, old age was acceptable. Mrs Blake said that she had been told that this was the policy in the office. It is doubtful whether, prior to the enquiries about Mrs Grundy's death in 1998, the procedure was ever as extensive as Mrs Evans and Mrs Collins described. Mrs Blake's account seems most likely to be right. An internal office form dated 1985, recording a discussion with a doctor about the appropriateness of 'old age' as the cause of death, contained no details at all of the deceased's state of health. It is clear that, in the past, many discussions were of a superficial nature and could not have led to a fully informed decision. Mrs Collins said that, recently, Mr Pollard has begun to speak to doctors personally in 'old age' cases.

7.97 The importance of a sound decision is obvious. Once the coroner has given his/her approval to 'old age' as a cause of death, the doctor can tell the deceased's family, the registrar and the medical referee of that approval. If insufficient care is taken when making the decision, the coroner's *imprimatur* is attached to a certification that may be quite unsatisfactory, even dishonest. 'Old age' has the very real potential to be used as a cause of death when, in fact, no cause is known.

7.98 On at least one occasion, Shipman manipulated the Coroner's staff in order to obtain the apparent approval of the Coroner when he certified a death as being due to old age. In the case of Mrs Grundy, who, until her death at his hand, was a very fit and active woman of 81, Shipman wished to certify that her death was due to 'old age'. It would have been difficult for him to think of any specific disease process to account for the death, as those who knew Mrs Grundy were aware that she was very well. After the death was discovered, Shipman telephoned the coroner's office, apparently to seek approval for his proposed MCCD. The call lasted only 2 minutes 11 seconds. There is no record in the coroner's office as to who dealt with his call or what was said. It is possible that Shipman was asked only to state Mrs Grundy's age. If he was asked more detailed questions, it would seem likely that he gave false details about Mrs Grundy's previous state of health and of a decline leading to death. No doubt, his account would have been plausible. It appears that the member of staff must have indicated that the coroner would have no objection to the death being certified as due to 'old age'. In so doing, she would be doing no more than was common practice in that office at that time. Armed with the coroner's 'approval', Shipman's certification of Mrs Grundy's death would not be questioned by anyone in authority.

The 'Either/Or Rule'

7.99 Perhaps the most common reason why a doctor will wish to speak to the coroner before issuing an MCCD arises from the so-called 'either/or rule'. As I have already explained, regulation 41 of the Registration of Births and Deaths Regulations 1987 imposes on a registrar a duty to report to the coroner any death in which it appears that the medical practitioner who has submitted an MCCD had not either seen the deceased within 14 days before death or seen the body after death. I have called this the 'either/or rule'. The unsatisfactory effect of the rule is that, provided the doctor has seen the body after death,

it does not matter how long before death s/he last saw the patient alive. Some coroners, recognising that the 'either/or rule' is unsatisfactory, demand that, if a doctor has not seen the patient within 14 days before death, the death must be reported, regardless of whether the doctor has seen the body after death. As I observed in my First Report, it appears that Shipman believed that such a rule operated in the Greater Manchester South District. Indeed, I am satisfied that it did, although I have not been able to discover when it was introduced. It appears from the evidence of the coroner's officers (who were unaware of the existence of the 'either/or rule') that it must have been a rule of custom and practice dating back at least to the time of Mr Revington, the Coroner who preceded Mr Pollard, and possibly longer. It is clear that some coroners are uncertain about the 'either/or rule'.

7.100 Dr Morgan told the Inquiry that he did not regard himself as qualified to sign an MCCD unless he had seen the deceased within 14 days of death. He knows that that is not the law but regards the 'either/or rule' as illogical. It appears that many doctors believe that the law requires that a death should be reported to the coroner if they have not seen the deceased within 14 days before the death, regardless of whether or not they have seen the body after death. Mr Dorries said that, if this confusion did not exist, he would receive far fewer telephone calls from doctors concerned about their ability to certify. It is common practice for doctors who wish to certify the cause of a death, but who have not seen the deceased within 14 days before death, to telephone the coroner's office to seek 'permission' to do so. They believe that, if they state on an MCCD that they have not seen the deceased within 14 days before death, the registrar will refuse to accept the certificate, the death will be reported to the coroner and the relatives will be upset and inconvenienced. In fact, this fear may be misplaced as, if the doctor has seen the body after death, the registrar will accept the certificate, unless the doctor has not seen the deceased for a very long time before the death. There is no statutory provision and no other clear rule about how long this period of time is. However, many doctors do not realise this.

7.101 The response of the coroners to such a request for permission to certify varies. Some coroner's officers ask if the doctor has seen the body after death; if s/he has not, the coroner's officer advises the doctor to do so. Then, provided that the doctor says that s/he knows the cause of death and there is no other reason to report the death to the coroner, the doctor will be 'permitted' to issue an MCCD and the registrar will accept it. However, it appears that many coroners or coroner's officers do not enquire whether the doctor has seen the body but, on learning that the doctor has not seen the deceased within 14 days of death, engage in a discussion with the doctor about the medical history and circumstances of death and then either give or withhold 'permission' for the doctor to issue. Mr Dorries, who takes this approach, admits that, if the doctor has seen the body after death, he has no power to give or withhold permission to the doctor to issue. The doctor is qualified to issue and is under a duty to do so; it is a matter for his/her own judgement whether or not s/he feels sufficiently confident about the cause of death to state the cause in the unequivocal terms acceptable to the registrar. However, Mr Dorries takes the view that he should advise the doctor as to the appropriate course of action. If the advice is that the doctor should issue an MCCD, a Form 100A will be sent to the register office. In fact, provided the doctor does not record on the MCCD that s/he has reported

the death to the coroner **'for further action'**, there would be nothing on the face of the MCCD which would render it unacceptable to the registrar or prevent registration, so that a Form 100A would be unnecessary and not expected by the registrar.

7.102 I have already expressed my concerns about the fact that decisions of this nature are often taken by a coroner who is not medically qualified, based on information taken by a coroner's officer who may have little experience of medical matters. Where the coroner is not involved in the decision, it may be taken entirely by an officer with no formal training or qualification. The Inquiry has come across cases where such decisions are or were taken by coroner's officers on a plainly inadequate basis. For many years, the staff in the office of the Coroner for Greater Manchester South District operated a 'rule of thumb', whereby the officer would say that the coroner would give 'permission' for the doctor to issue an MCCD, provided that the doctor had seen the deceased within 28 days before the death. Plainly, the notion that an important decision as to jurisdiction was being made was far from anyone's mind. No proper consideration was apparently given to the cause or circumstances of death or to whether, if a doctor had not seen the deceased for 28 days, s/he was able to be sufficiently confident of the cause of death.

7.103 It appears to me that the whole procedure relating to the 'either/or rule' is in a muddle, mainly because the rule is not properly understood, even by coroners and those who work for them. Many doctors telephone the coroner to obtain formal 'permission' even though, having seen the body after death and being, therefore, qualified to issue the MCCD, they do not need 'permission'. Many Forms 100A are issued quite unnecessarily for the same reason.

7.104 The position of the doctor who falls foul of the 'either/or rule', i.e. who has neither seen the deceased within 14 days before death nor seen the body after death, is not regarded by coroners as entirely clear. Mr Burgess said that this is a 'grey area'. Yet, the coroners who gave evidence to the Inquiry assumed (rightly, in my view) that they were entitled, depending on the circumstances, to 'give permission' to the doctor to issue an MCCD.

7.105 The doctor in that position cannot issue an MCCD that will be acceptable to the registrar. However, s/he may be qualified to complete the MCCD because s/he attended the deceased during the last illness; in that case s/he will be under a duty to issue the MCCD, stating the cause of death to the best of his/her knowledge and belief. However, as the doctor knows that the registrar would reject the MCCD, s/he will report the death directly to the coroner. If the coroner is satisfied that the doctor knows the cause of death, s/he has no legal power to order an autopsy or hold an inquest, since the death will not fall within section 8 of the 1988 Act (unless, of course, one of the other section 8 criteria is met). The coroner's task is to assess whether the cause of death is 'known'. The likelihood of the doctor knowing the cause of death will to some extent depend on when s/he last saw the deceased. If the doctor says, 'I know it was a heart attack', but has not seen the deceased for a year, the coroner would surely be entitled to say that s/he had reasonable cause to suspect that the cause of death was unknown. But in the situation where the coroner is satisfied that the doctor's professed knowledge is soundly based, the doctor should be permitted to complete an MCCD, Form 100A should be issued and the coroner's role should be at an end. In other words, the registrar is prohibited by the strict requirements

of regulation 41 from registering the death because the doctor has seen neither the deceased within 14 days before the death nor the body after death. Registration can, however, take place once the registrar has the coroner's 'permission' to register; that 'permission' is granted on the basis of what is said by the doctor to the coroner and is formally confirmed by the issue of Form 100A. The registrar will register the death as usual, relying on the cause of death given in the MCCD.

7.106 Although some doubt was expressed about the legality of this process, I have come to the conclusion that it is lawful. In my view, the only statutory requirement (save for the fact that the doctor must be registered) governing the capacity of the doctor to issue the MCCD is that s/he attended the deceased during the last illness. He or she is not disqualified from so doing by an inability to satisfy either of the requirements of the 'either/or rule'. That rule only requires the death to be reported by the registrar to the coroner. But if the coroner comes to the conclusion that the doctor did attend the deceased during the last illness and knows the cause of death to a satisfactory degree of confidence, then the doctor's certificate is good and the death can properly be registered in reliance upon it.

When the General Practitioner Is Not Available

7.107 As I have just said, the essential qualification for the doctor who is to issue an MCCD is that s/he must have attended the deceased during the last illness. However, it not infrequently happens that the general practitioner who has attended the deceased during the last illness is, for some reason, unable to certify the cause of death, even though s/he may know it. For example, s/he might have been taken ill or might be away on holiday. General practitioners who are going away on holiday at the time when they are expecting the death of a particular patient often arrange for a colleague to visit the patient whilst still alive so that, if the death occurs during the holiday, the colleague will be able to issue an MCCD. But the plans sometimes go astray and there is no doctor qualified to issue an MCCD. In these circumstances, the death must be reported to the coroner. This is often done by the another member of the practice, who has been called out to confirm the fact that death has occurred or has otherwise been informed of the death.

7.108 The coroner's position is unclear. On the one hand, it might be said that the coroner must accept jurisdiction because, if there is no MCCD, there must be **'reasonable cause to suspect'** that the cause of death is not known. In practice, if there is no MCCD, the only person who can certify the cause of death is the coroner, either on the basis of an autopsy report or after an inquest. If the coroner refuses jurisdiction and will not put him/herself in a position to certify the cause of death, the deceased's family is in difficulty. How is the death to be registered? On the other hand, it might be said the coroner is not bound to accept jurisdiction, which arises only if s/he has reasonable cause to suspect that the deceased **'has died a sudden death of which the cause is unknown'**. It sometimes happens that the member of the practice who has reported the death to the coroner has access to the deceased's medical records and has spoken to the deceased's family about the circumstances of the death. That doctor might be able to tell the coroner, quite properly, that s/he is confident that the death was not sudden and that s/he knows its cause. In those circumstances, some coroners decline jurisdiction and instruct the doctor to issue an MCCD based on his/her knowledge of the history and circumstances. The

coroner sends a Form 100A to the register office. Yet the legal position is that the MCCD is invalid and the Form 100A cannot make it valid. As a matter of law, the registrar should reject the certificate and refuse to register the death. However, registrars recognise that, if the coroner refuses jurisdiction, the family is in difficulty. Their practice is to register the death, giving the cause either as stated on Form 100A or, failing that, taking it from the informant, using the invalid MCCD as 'guidance'. Dr Cleone Rooney, medical epidemiologist at the ONS, described such deaths as 'legally uncertified'. Mr Dorries' practice is a variant on this. He asks the member of the practice to write a letter explaining the situation and giving his/her opinion as to the cause of death. No MCCD is completed. Mr Dorries' office issues a Form 100A, giving the cause of death contained in the letter. The registrar then registers the death, taking the cause of death from the Form 100A.

7.109 If the coroner accepts jurisdiction, s/he might order an autopsy. However, where the death was expected and the cause known, that course of action would seem hard on the relatives and a waste of scarce resources. Some coroners have a way round this problem. Mr Pollard's practice is to open and adjourn an inquest and allow disposal of the body on the basis of the information given by the treating doctor's colleague. By the time the inquest is resumed, he will have obtained a letter or statement from the treating doctor, which is then accepted in evidence and allows him to reach a verdict. If the treating doctor is not available then (because, for example, he is ill), Mr Pollard will take the evidence from the doctor's colleague. An alternative course is to conduct an inquest immediately, taking evidence from a doctor who knows the cause of death from perusal of the medical records. Both these solutions comply with the law. Something less cumbersome would be desirable.

Shipman's Practice of Reporting Deaths to the Coroner

7.110 Very few of the deaths of Shipman's patients were ever reported to the Coroner. As I explained in Chapter Five, Shipman was able to issue an MCCD for the patients he had killed and give false reassurance to the families that it was not necessary for the death to be reported to the Coroner. I pointed to the essential defect in the present system that allowed Shipman to avoid the coronial system almost entirely.

7.111 In a few cases (we do not know how many since records would not necessarily have been kept), Shipman discussed the death of one of his patients with a member of the coroner's staff and obtained 'permission' to issue an MCCD. In this way, he forestalled any possible query from the registrar, the deceased's family, the doctor who would complete cremation Form C or the medical referee about whether it was appropriate for him to certify the death. The relevant member of the coroner's staff never apparently doubted that permission should be given. It is clear that, even if Shipman had made more such telephone calls, in effect giving the coroner the opportunity to take jurisdiction in those cases, it is unlikely that the outcome would have been different. If Shipman gave a false history and asserted that he knew the cause of death, neither the coroner's staff, nor even the coroner himself, would have been able to discover that the death was sudden, unexpected and of unknown cause, unless enquiry had been made of an independent person, such as a relative of the deceased or some other person with knowledge of the circumstances of the death.

7.112 Thus, although I have drawn attention to a number of aspects of poor practice in coroners' offices, the fact is that, even if those aspects were remedied, there would still be no effective safeguard for those deaths about which a doctor chose to tell lies. If there is to be any protection against another Shipman, or any doctor who seeks to conceal a crime or medical error by him/herself or a colleague, all deaths must be subject to scrutiny by someone who is independent of the certifying doctor. Furthermore, the history on which that doctor relies must be independently verified.

Conclusions

General

7.113 The present function of the coroner is to investigate, on behalf of the state, deaths which occur otherwise than as the result of a natural disease process. This function constitutes an important safeguard for the ordinary citizen. It is important that the circumstances surrounding deaths that have or might have resulted from some outside agency (such as an accident or exposure to a noxious substance at work) are properly investigated. Under the present system, the coroner becomes aware only of those deaths reported to him/her. He or she has no knowledge of other deaths and no means of knowing whether, in the case of any individual death which has not been reported, there was in fact a need for an investigation. All the coroner can do is act upon information which is given to him/her.

7.114 The present arrangements by which deaths are reported to coroners are unsatisfactory. They vary from place to place. Doctors find them difficult to apply. The system largely depends on the willingness of doctors to report deaths. The Inquiry has heard that some doctors never report a death to the coroner. It seems unlikely that this is because no death certified by them should have been reported. It may be that they do not know when a death should be reported. It may be that the doctor has personal objections to the autopsy process. It is likely that in many cases the doctor is seeking to spare families the ordeal of a report to the coroner and a possible autopsy. Registrars are not well equipped to make a decision on whether a death should be reported. Shipman was able to evade the coronial system almost completely. A way must be found to ensure that all deaths receive a degree of scrutiny and investigation, appropriate to their facts and circumstances. Even some deaths that might currently be treated as 'natural' deaths might warrant detailed investigation. One example might be where it appears that there is an increasing prevalence of a particular illness in a particular district. Another is where, for example, an otherwise healthy individual succumbs to an illness that is not normally fatal. It may well be of interest to the family and the wider public at large to know why that individual succumbed and what, if anything, can be done to prevent the same thing happening again.

7.115 Under the current arrangements, once a death is reported, the coroner must first take a decision as to whether s/he has jurisdiction, i.e. jurisdiction to order an autopsy and/or hold an inquest. I have several concerns about the way decisions on jurisdiction are taken by coroners or their officers. First, the decisions are taken far too informally. The information on which the decision is based is taken down over the telephone by a coroner's officer who usually has no medical training and very little medical knowledge. If

the death raises issues of any medical complexity, there is obviously a danger that the full picture will not be captured. The doctor is not required to put anything in writing or to produce any extract from the medical records. Instead of an informal account provided over the telephone, the coroner should, in my view, receive written information about the circumstances of the death from the health professional who has certified the fact of death. He or she should also receive written information about the deceased's medical history from a doctor with recent knowledge of it.

7.116 Second, the amount of information obtained depends largely on the extent and nature of the coroner's officer's questions. In some coroner's offices, I am sure that the questioning is careful and detailed. Regrettably, in others, only scanty information is obtained.

7.117 Third, the decision as to jurisdiction is, in general, taken on the basis only of what the reporting doctor says. If the doctor chooses to give a false or incomplete account, the coroner's officer, or indeed the coroner, is unlikely to realise. The coroner takes what the doctor says completely on trust. Usually, there will be no attempt to verify the accuracy of the information given by the doctor with any other source. As I have said, the doctor will not be required to produce any part of the medical records. Nor will the coroner's officer usually attempt to speak to a relative of the deceased. In my view, it would be far better if such decisions were based upon a broader knowledge of the death than is usually available at present. Instead of relying solely on the account of one doctor, information provided by the doctor or other health professional should be cross-checked with a member of the deceased's family or some other person with recent knowledge of the deceased.

7.118 Of particular concern is the practice followed in some offices of delegating the decision on jurisdiction to a coroner's officer. In my view, this practice is of very doubtful legality under the present Act. In any event, even if lawful, I do not think it is appropriate to allow a coroner's officer with no formal training to take such a decision. I have no doubt that many coroner's officers are very experienced and take such decisions very conscientiously. But I am also satisfied that some are inexperienced and take decisions based on scanty information and sometimes by applying rules of practice or other considerations which do not reflect the criteria by which the decision should be taken.

7.119 In the main, such decisions entail a decision based on medical judgement. Even when the decision is taken by the coroner, as opposed to the coroner's officer, the legally qualified coroner may be ill equipped to take the decision. Dr Chapman, the only medically qualified coroner to give oral evidence to the Inquiry, described the way in which medical knowledge enables a coroner to take an informed part in discussions with doctors about deaths that may or may not fall within his/her jurisdiction. Some of the legally qualified coroners agreed that medical experience was required. For example, Mr Pollard said that it was not appropriate for him, as a lawyer, to take the decision to allow a doctor to certify the cause of death if the doctor told him that s/he could not say whether the death had been caused by one of two natural causes. His only option was to order an autopsy. He felt that this was often not appropriate. His powers were limited. He said that, if the coroner had more flexible powers and if there were a medically qualified person in the coroner's office, it would be possible to avoid unnecessary autopsies. I accept that some legally

qualified coroners do, after some years of experience, develop considerable expertise in medical matters. However, many do not. In my view, decisions of this kind should be taken by medically qualified coroners or, in the more straightforward cases, by coroner's officers with some medical background and ready access to expert medical advice.

7.120 There are substantial variations between the practices operated in different coroners' offices and much variability in the standard of service achieved. It would be desirable to achieve a measure of consistency of practice and of high standards. To achieve these ends, there is a need for leadership, organisation and structure in the work of coroners. Coroners must also receive continuing education and training.

Greater Manchester South District

7.121 Shipman's practice in Hyde fell within the coronial District of Greater Manchester South. Once his activities became known, there was some public disquiet that they had not earlier come to the knowledge of the Coroner for the District, Mr John Pollard. He had, in fact, first become aware of concern about Shipman in March 1998, when he was contacted by Dr Linda Reynolds, a local general practitioner. A police investigation followed, as described in my Second Report, and concluded that there was no substance in the concerns expressed by Dr Reynolds and others. No suspicions had previously been awakened within the coroner's office as a result of the deaths reported, or not reported, by Shipman. It was therefore necessary for the Inquiry to examine the practices within the coroner's office and to ascertain whether the absence of concern about Shipman's activities resulted from any fault on the part of the Coroner or his staff.

7.122 The procedures within Mr Pollard's office have been subjected to close scrutiny by the Inquiry. The Inquiry obtained a considerable amount of documentation relating to cases unconnected with Shipman, which had been dealt with by Mr Pollard and his staff. These cases, chosen at random, have thrown up concerns about decisions on jurisdiction made in Mr Pollard's office. I am not critical of individual members of staff, who had received no training and were no doubt doing their very best to discharge their duties in difficult circumstances. Nor am I very critical of Mr Pollard himself. He too had little training and suffered from the various problems which I have already described in this Chapter. Most significantly, I do not think that the practices within his office were any different from those in operation in many other coroner's offices up and down the country. It may be that, in some coroner's offices, the decision-making process is based on a sound understanding of the principles involved and the way in which those principles should be applied. However, the evidence available to the Inquiry suggests that this is certainly not always the case. I am confident that a close examination of the practices in operation in many other coroner's districts in England and Wales would reveal shortcomings similar to those which I have described in connection with Greater Manchester South District.

7.123 Most importantly, I doubt that the practices in operation in Mr Pollard's office had any effect on the outcome of those few deaths referred to him where Shipman had killed. In saying this, I exclude the case of Mrs Renate Overton, which I shall deal with in detail in Chapter Thirteen; in any event, Mrs Overton's death occurred during the time of

Mr Pollard's predecessor, Mr Revington. It is possible that, if the practices followed in Mr Pollard's office had been better, the outcome might have been different in those cases (we have no means of knowing how many, since no record would necessarily have been kept) where we know that Shipman spoke to the coroner's office to 'discuss' the death. For example, in the case of Mrs Grundy, a coroner's officer might have spoken to Mrs Grundy's daughter, Mrs Angela Woodruff, before giving 'permission' for Shipman to certify the death as due to 'old age'. However, the practice in the coroner's office can have had no effect on the vast majority of the killings, which never came to the Coroner's notice at all.