CHAPTER NINE

Coroners' Investigations and Inquests

Introduction

9.1 In Chapter Seven, I discussed the ways in which deaths are reported to the coroner. I also considered the ways in which (and the material upon which) the decision as to whether the coroner has jurisdiction over the death is taken. I shall now go on to consider the quality of the investigations carried out by and on behalf of the coroner once the decision has been taken that the death comes within the coroner's jurisdiction.

9.2 I have already mentioned that standards within coroners' offices in England and Wales appear to be very variable. I have no doubt that there are districts where investigations, both medical and circumstantial, are careful and thorough. However, even in those districts, the way in which investigations are undertaken is necessarily constrained by the legal framework within which coroners operate. I shall explain the reason for that constraint, and the respects in which it is undesirable, shortly.

9.3 I have already explained in Chapter One that, because Shipman's practice in Hyde fell within the coronial District of Greater Manchester South, it was necessary for the Inquiry to examine in detail the practices and procedures in operation within the office of Mr John Pollard, the Coroner for that District.

9.4 Disregarding the investigations and inquests which took place after Shipman's arrest, only a small number of deaths among those 508 cases for which I provided a decision in my First Report or for which Shipman was convicted, were reported to the Coroner. Even fewer were followed by an autopsy and/or inquest. Of those deaths where Shipman had killed the deceased, autopsies were performed only in the cases of Mrs Renate Overton and Mr Charles Barlow and, in both cases, the Coroner certified the cause of death on the basis of the autopsy findings, using the Form 100B procedure. Consideration by the Inquiry of the cases of Mrs Overton and Mr Barlow revealed cause for concern that the investigations in those cases had not been carried out with a sufficient degree of care or thoroughness.

9.5 Mrs Overton's death, in April 1995, was reported by Dr Rachel Pyburn, a doctor working at Tameside General Hospital, where Mrs Overton had been an in-patient for 14 months following an overdose of diamorphine (or possibly, morphine), administered by Shipman in February 1994. She had been in a persistent vegetative state throughout that period. Following an autopsy, the pathologist reported that the cause of death was hypoxic cerebral degeneration and expressed the view that the death was due to 'natural causes'. The then Coroner, Mr Peter Revington, decided not to hold an inquest and certified the cause of death (using the Form 100B procedure) on the basis of the autopsy report. Despite the fact that Dr Pyburn had alerted the coroner's officer to the possibility that the underlying cause of death was the administration of morphine in association with an asthma attack, there was no investigation or explanation as to how Mrs Overton came to be in a persistent vegetative state. Her death was wrongly attributed to 'natural causes'. I shall recount Mrs Overton's history in detail in Chapter Thirteen of this Report.

9.6 Shipman killed Mr Barlow in November 1995 and, most unusually, reported the death to the Coroner. When he telephoned the coroner's office, I suspect that he hoped to be given permission to certify the cause of death. He probably decided that it was prudent for him to seek the 'approval' of the coroner because Mr Barlow had had a hernia operation only 17 days before his death and had recently been discharged home. I suspect that Shipman told the coroner's officer when reporting the death that it had not been connected to the operation. Whatever Shipman said during the telephone call, the coroner's officer must have decided that Shipman could not issue an MCCD, so that an autopsy was necessary. A police officer attended the scene of the death on the Coroner's behalf. He completed the sudden death report Form 751. In it, he recorded little about the circumstances of the death. It may be that he did not understand that the purpose of his enquiry was to establish whether the recent operation had contributed to Mr Barlow's death.

9.7 Following the autopsy, the pathologist reported that the cause of death was bronchopneumonia due to tracheal compression due to a nodular thyroid goitre. Thereafter, Mr Pollard, the newly-appointed Coroner (he had then been in post for about four months), decided that an inquest was not necessary and certified the cause of death on the basis of the autopsy report. There was no investigation of the circumstances of the death and no detailed consideration of the autopsy findings, which were not confirmed by any histology. Investigation of the circumstances would have revealed that Mr Barlow had not been sufficiently ill when seen two hours before his death for him to have died of bronchopneumonia. Also, the goitre, said to be the underlying cause of death, had been present in an unchanged state for many years.

9.8 It was naturally a cause of some concern to the Inquiry that the Coroner's investigations in these significant cases had been to some extent defective and had missed evidence of unlawful killing. Unless these two cases were exceptional and the obvious shortcomings in their investigation attributable only to isolated individual failings, the possibility would exist that there might be deficiencies in the methods of investigation adopted by coroners elsewhere. As Stage Two of Phase Two of the Inquiry progressed, I began to realise that coroners' investigations are often superficial and I began to understand the reasons why that is so.

9.9 As I have explained, the Inquiry has concentrated upon the investigation of the procedures followed in the office of the Coroner for the Greater Manchester South District. The practices and procedures operated by Mr Pollard and his staff have come under close scrutiny. However, I have no reason to think that the practices and procedures followed in Mr Pollard's office are any different from those followed in many other coroner's offices throughout the country. Indeed, there is some evidence to suggest that they are typical. Accordingly, when I criticise these practices and procedures, I do not imply that the individuals who operated them should be singled out for personal criticism.

The Process of Investigation: the Autopsy

Deciding to Order an Autopsy

9.10 Some deaths are reported to the coroner because the circumstances are such that an inquest is required, even though the cause of death is clear. For example, there must be

an inquest into the death of a workman who suffers a crushing head injury in an industrial accident, because the factual circumstances in which the accident was sustained make the death unnatural. In such cases, an autopsy may not be necessary; in practice, one is almost always ordered.

9.11 However, a large number of deaths are reported to the coroner because the cause of death is not known with sufficient certainty. Until further enquiry as to the cause of death is made, it will not be clear whether or not an inquest will be necessary. If the medical causes of death are established by an autopsy and appear 'natural', there will not usually be an inquest.

9.12 In the Greater Manchester South District, until the year 2000, the decision to order an autopsy and the practical arrangements for its conduct were usually made by a coroner's officer, without any reference to the Coroner. The decision to order an autopsy was almost automatic. Although that practice has now stopped and the Coroner himself orders the autopsy, the result is the same; the decision is, in effect, automatic. There is no consideration as to whether an autopsy is necessary in a case where the cause of death is obvious from the appearance of the body and the reported circumstances of the death. Nor is there any consideration of whether the cause of death could be established without resorting to a full invasive autopsy.

9.13 This resort to autopsy comes about as a result of the legislation. Although a coroner could, in theory, undertake a wide range of investigations, including an examination of the scene of death, consideration of medical records and the taking of witness statements, there must seem to be little point in doing so. If the cause of death cannot be certified by a doctor issuing an MCCD, the only ways in which the coroner can certify the cause are, first (after ordering an autopsy under section 19 of the Coroners Act 1988), by relying on the cause of death provided by the pathologist (the Form 100B procedure) or, second, by holding an inquest. If an inquest is to be avoided, there must be an autopsy. It seems that most coroners consider that as, in virtually every case where there is to be an inquest, an autopsy will be necessary and, since the autopsy will almost always provide a medical cause of death, there is little point in undertaking any investigation other than the autopsy.

9.14 There are at least two reasons why I regard this practice as undesirable. First, an autopsy should really be conducted only when there is a positive reason to do so; the decision should not be taken 'by default'. Many people are deeply distressed by the thought that the body of a beloved relative is to be 'invaded'. They will accept it with reluctance if it is necessary, but not otherwise. Some religious and ethnic groups are strongly opposed to such procedures. Orthodox Jews are most anxious to avoid an autopsy, although they accept that, if and when the law so demands, it must be done. Muslims take a similar view. Second, an unnecessary autopsy is a waste of scarce resources. Although section 19 of the 1988 Act permits that the autopsy may be carried out by any legally qualified medical practitioner, in practice the examination is almost always performed by a consultant histopathologist. Almost all the histopathologists who perform autopsies for coroners are also employed on NHS contracts to carry out diagnostic work in connection with living patients at general or teaching hospitals. There is a shortage of suitably qualified histopathologists available to carry out NHS work. The demands of coroners place a strain on the available resources.

9.15 It follows that it would be preferable, in my view, if coroners had the power to certify the cause of a death after some preliminary investigations but without necessarily resorting to autopsy. There must be many cases in which a coroner with medical knowledge could, following examination of medical records and consideration of evidence of the circumstances of the death, reach a sufficiently confident conclusion about the cause of death to give a certificate without autopsy. Autopsy would still be necessary in some cases, but in fewer cases than at present.

9.16 There are other adverse consequences that flow from this automatic resort to autopsy. Some pathologists devote far less time to coroners' autopsies than they do to a 'hospital' autopsy (that is one undertaken for clinical and/or research purposes with the consent of the next of kin or the consent of the deceased, given in life), knowing, no doubt, that so long as they can identify some pathology capable of explaining the death, the cause they provide will be accepted. Another adverse consequence of the automatic resort to autopsy is that the autopsy report is usually considered by the coroner in isolation rather than in the context of other evidence. As a result, its reliability is much impaired. I shall expand upon this problem below.

Investigations Pending Receipt of the Autopsy Report

9.17 If, having decided that the circumstances of the death may require him/her to hold an inquest but will not necessarily do so (e.g. because there is uncertainty as to the medical cause of death), the coroner may order an autopsy under section 19 of the 1988 Act. He or she will provide some background information for the pathologist. It might be thought that the coroner would also want to gather other evidence to inform the decision that s/he will have to take when the autopsy report is available. In the Greater Manchester South District at least, any other evidence which will have been gathered by the time the autopsy report is available is likely to be very limited indeed.

9.18 When the Coroner for the Greater Manchester South District orders an autopsy in cases reported by a doctor, the only information usually available to him is the oral account of the reporting doctor. As that account is given to a coroner's officer who has no medical training or expertise, the amount of information recorded is usually very limited and contains little detail. If the death has been reported, or a preliminary investigation has been undertaken, by a uniformed police officer completing Forms 751 and 751A, the police officer will have usually recorded only brief details of what any person who happened to be available for interview has said. The medical information recorded on the form will usually be scanty and couched in 'lay' terms. The account of the circumstances of the death will often fill no more than a line or two. The police officer completing the forms will have no understanding of the purpose of the questions or of the issues which the Coroner and pathologist will have to decide, as was the case following the death of Mr Barlow. The police officer will not know what information is relevant. Upon receipt of the forms, the coroner's liaison officer (CLO) will check the forms and complete any boxes left blank. The CLO will speak to the deceased's next of kin to ensure that the particulars of the deceased, such as date of birth, are correct but will not interview anyone to find out about the circumstances of the death.

9.19 I have said that a coroner could, in theory, carry out a wider range of investigations in the period before the autopsy report is available. Certainly, the coroner could obtain witness statements from any relevant witness. At present, as I have said in Chapter Seven, s/he has no power to order the production of any documents or records, nor is there any power to enter premises or to seize any property relevant to the investigation. That is not to say that coroners are unable ever to obtain such records and material prior to the inquest. They can do so with the consent of the person having control of the premises, records or other material. However, in practice, the Coroner for the Greater Manchester South District does not (and I think most other coroners do not) conduct or authorise any such investigations before deciding, in the light of the autopsy report, whether to hold an inquest.

The Autopsy and the Report on the Cause of Death

9.20 Evidence received by the Inquiry has suggested reasons why the autopsy is not the definitive source of information it is often thought to be. The pathologist who is to conduct the autopsy may have only very limited information about the deceased and the circumstances of death before conducting the autopsy. He or she will usually have Form 751A or its local equivalent. If the death has occurred in hospital, and if the autopsy is taking place in the mortuary of the same hospital, the pathologist will usually receive the deceased person's clinical notes and records. If the death occurred in the community, or at a hospital other than the one where the autopsy is held, the pathologist will not usually have any medical records. Even if the autopsy is taking place in the hospital where the deceased died, the medical records are not always examined. Some coroners and their officers provide high quality information for pathologists and are prepared to make any further enquiries requested. However, others are less efficient. Coroner's officers may be office-bound, may have no investigative role and may be unable to identify or discover further information which could be of assistance to the pathologist. Remoteness and lack of communication, as between the coroner and the pathologist, can also be a problem, particularly with part-time coroners.

9.21 It frequently happens that a pathologist conducting autopsies for a coroner will have a long list of such procedures to be carried out in one session. Coroners' autopsies are additional to the pathologist's duties for the hospital trust for which s/he works. The evidence suggests that coroners' autopsies are sometimes conducted rather quickly and that best practice is not always followed. For example, to save time, the mortuary technician may be permitted to open the body and remove the organs before the pathologist has carried out an external examination. Insufficient time may mean that the pathologist has no opportunity to inspect the medical records carefully or discuss the case with clinicians.

9.22 It is not uncommon for a pathologist to feel under pressure to reach a conclusion on the cause of death without conducting the ancillary tests that should properly form part of the autopsy procedure. The Royal College of Pathologists (RCPath) advises that diagnostic or confirmatory histopathology should be done in all cases, subject to the requirements of the Human Tissue Act 1961 and the instructions of the coroner. The attitude of coroners to the taking of samples for histology varies widely. Some will permit tissue samples to be

taken for histology in only a few types of case. Such an attitude places the pathologist in considerable difficulty. Moreover, funding for histology can also be a problem. I shall discuss these issues further in Chapter Ten of this Report.

9.23 Some pathologists also report that they feel under pressure (whether self-imposed, imposed by the coroner or imposed by circumstances is not always clear) to find a natural cause of death, thereby avoiding the need for an inquest. I can understand how such pressures might arise. If there is to be an inquest, the pathologist will have to attend to give evidence. That will be time-consuming and possibly very inconvenient for him/her. The pathologist might think that the relatives of the deceased will feel relieved that a natural cause has been found and would rather not have to go through an inquest. The pathologist might also have the impression that the coroner would be pleased that a natural cause had been found. Inquests are very time-consuming for the coroner as well.

9.24 Professor Helen Whitwell, Head of the Forensic Pathology Department at the University of Sheffield, told the Inquiry that it is commonly recognised that, if a pathologist conducting a coroner's autopsy can find evidence of a condition which can account for the death, s/he is likely to attribute the death to that cause without undertaking histology to confirm that cause. Dr Martin Gillett, a consultant histopathologist who frequently carries out coroners' autopsies, agreed that further tests might not be ordered where there is pathology that could account for the death. Professor Whitwell explained that the reasons for this approach are partly financial and partly related to concerns about the retention of tissue. If this approach is prevalent, it is particularly likely to lead to mistaken diagnoses of the cause of death in the elderly, who will almost always have some condition that is capable of accounting for death. Mr Barlow's death is a case in point. The pathologist found macroscopic signs of bronchopneumonia and, without confirming them by histology, attributed the cause of death to that cause, citing, as an underlying cause, tracheal compression due to an enlarged goitre. As I have said, there was no reason to believe that Mr Barlow's goitre had changed in the weeks and months before his death. The pathologist did not know that. He found something that could account for the death and gave that cause as his opinion. Professor Whitwell said that the only reliable way to diagnose bronchopneumonia is by histological examination. Macroscopic examination is unreliable.

9.25 In addition to reaching a conclusion on the cause of death, the pathologist will, if s/he feels able to do so, express an opinion as to whether or not the cause of death is 'natural'; this is really a question for the coroner to determine. Some findings at autopsy are most likely to be consistent only with a natural cause; signs of an aortic aneurysm are a good example. Some findings, such as a stab wound to the heart, are consistent only with an unnatural death. However, there are many findings which could be consistent with either a natural or an unnatural underlying cause of death. Sometimes, if the pathologist has been provided with reliable background information about the circumstances of the death or has access to the medical records or can discuss the medical history and autopsy findings with a doctor who has treated the deceased, s/he may be able to reach a safe conclusion as to the underlying cause of death. If s/he can, so much the better.

9.26 Sometimes, a pathologist might express a conclusion about the underlying cause of death, or say that the cause of death was natural, without any proper basis for such a

conclusion. The death of Mrs Overton is a case in point. At the time of her death, Mrs Overton had been in a persistent vegetative state for 14 months. The findings at autopsy of cerebral hypoxic degeneration were wholly predictable. However, such findings could throw no light on what had happened to cause that condition. The degeneration could have been caused by a natural event, such as an acute attack of asthma leading to respiratory arrest, or it could have been due to an unnatural event, such as near drowning, near suffocation or – as in fact it was – drug overdose. In such circumstances, only by finding out what had happened to cause Mrs Overton's respiratory arrest could a safe conclusion be reached as to the underlying cause of death. No such information was available to the pathologist. Nonetheless, the pathologist expressed his opinion that her death was due to natural causes. As I shall explain in Chapter Thirteen, that conclusion was not well founded on evidence and went well beyond the limit of the pathologist's expertise. What the pathologist ought to do in those circumstances is to tell the coroner that s/he cannot tell what is the real or underlying cause of death from the autopsy findings and that other enquiries must be made.

9.27 The result of the practices and pressures I have described is that the coroner's autopsy is not the 'gold standard' means of ascertaining the cause of death that it is sometimes thought to be. In September 2002, the RCPath published a document, 'Guidelines on autopsy practice', to which I shall refer further in Chapter Ten. One of the recommendations made is that adequate background information about the death should be made available to the pathologist. I have no doubt that a thorough autopsy, conducted to the high standards recommended by the RCPath and viewed in the context of the background circumstances, provides the best basis for a decision as to the cause of death. However, the confident reliance presently placed on hurried and inadequate autopsies is ill founded especially when such reliance may result in the coroner's failing to apply his/her mind to the underlying cause of death; this is what may well have happened in the case of Mrs Overton.

9.28 The problem is compounded by the lack of any audit or quality assurance of coroners' autopsies. Concern has been expressed by organisations such as the National Confidential Enquiry into Perioperative Deaths about the quality, not only of autopsies, but also of autopsy reports. Some auditing of the reports of forensic pathologists has been introduced. However, there is no such system in place for coroners' autopsies performed by consultant histopathologists. Professor Whitwell reported that, where attempts at audit have been made in the past, some coroners would not consent to reports on their behalf being used for audit purposes. It would of course have been possible for the reports to be anonymised so as to protect the confidentiality of patients. It seems that the coroners concerned did not appreciate the value and importance of the audit process.

Certifying the Cause of Death on the Basis of the Autopsy Report

9.29 When the coroner receives the pathologist's report containing the medical cause of death, s/he is almost bound to accept it at face value. He or she will have no wider evidential background against which to consider it. Nor do most coroners have the medical expertise necessary to subject the report to any critical examination. If, in a case where the coroner has decided to order an autopsy under the provisions of section 19 of the

Coroners Act 1988, the pathologist furnishes a medical cause of death (particularly if s/he expresses the view that the death was due to 'natural causes'), the coroner is likely to decide not to hold an inquest and will probably certify the cause of death in accordance with the pathologist's opinion.

9.30 The cases of Mrs Overton and Mr Barlow illustrate the effects of this practice. In Mrs Overton's case, the pathologist reported the immediate cause of death and, without any proper justification, ascribed the death to 'natural causes'. The Coroner had very little other evidence available to him and, on seeing the autopsy report in isolation, accepted it, apparently without realising that the autopsy had been unable to provide any explanation as to how Mrs Overton had come to be in a persistent vegetative state. If the Coroner had obtained evidence from the doctor who had reported the death, had examined the hospital medical records and had had the medical knowledge necessary to understand their significance, he would have realised that an inquest was necessary and that his investigation ought to focus on whether Mrs Overton had been given a single dose of 20mg morphine and, if so, in what circumstances. Reliance on the autopsy report and on a pathologist's opinion that went beyond what was justified by his findings resulted in the Coroner's failure to discover the true cause of death.

9.31 Similarly with Mr Barlow, the Coroner relied on the pathologist's view that death was due to bronchopneumonia. If he had had the advantage of a witness statement from Mr Norman Newton, a neighbour and friend of Mr Barlow who saw him daily, he would have learned that Mr Barlow was sitting in his chair drinking a cup of coffee only two hours before his death. Provided that the Coroner had sufficient medical knowledge, he would then have realised that Mr Barlow's condition two hours before death was not consistent with a death from bronchopneumonia. He would also have learned that Mr Barlow's enlarged goitre had not, so far as anyone knew, changed for a long time. The cause of death suggested by the pathologist would then have seemed an unlikely one. The Coroner would have realised that an inquest was necessary. Further investigations would have been required and might have revealed the truth.

9.32 These two cases suggest, first, that the results of an autopsy should be seen in the context of the surrounding evidence and not in isolation. The coroner's uncritical acceptance of a pathologist's opinion, given without knowledge or understanding of the background circumstances, is a recipe for an erroneous decision. Second, if the coroner is to scrutinise an autopsy report and test it in the light of the surrounding evidence, s/he needs some medical knowledge. If s/he cannot carry out such a scrutiny, s/he is wholly dependent on the pathologist. In effect, the decision is that of the pathologist, rather than the coroner.

9.33 My overall impression of the coroners and some of the pathologists about whose practices I heard is that there is in their minds an expectation that, if a death is not immediately identified as 'suspicious', it will be found to be due to natural causes; this is certainly the case in respect of many of the deaths referred to the coroner because the treating doctor does not know the cause of death. This expectation seems to lead to the attitude that it will be to everyone's satisfaction if a cause of death can be found that will enable the coroner to certify the cause of death without further delay, cost or inconvenience. It is easy to see how this attitude can become entrenched. The great majority of deaths will, in fact, be

natural. However, if a coroner's investigation is to be effective, there must be an ever-present readiness to keep in mind the possibility that the death might not have been natural. Quite apart from any question of homicide, the coroner should bear in mind the possibility that neglect, accident or medical error might have caused or contributed to the death. Dr James Young, Chief Coroner for the Province of Ontario, Canada, said that his coronial investigators are trained to 'think dirty', by which he meant that they are trained to approach each death not with the expectation that there will be 'something wrong' but keeping in mind the worst possibility. It seems to me that such an approach would be appropriate for coroners and pathologists, as well as investigators. Otherwise, the expectation that the death will be 'natural' may become a self-fulfilling prophecy.

The Process of Investigation: Preparation for the Inquest

9.34 As I have explained, in some cases it will be clear from the outset that there must be an inquest. In others, the coroner will decide, in the light of the results of the autopsy, that an inquest is necessary.

9.35 In a case in which there is an autopsy under the provisions of section 19, the inquest will be opened and adjourned soon after the receipt of the autopsy report. In many districts, it is then that the investigation begins. Sometimes, in an inquest case, the police or some other investigatory body such as the Health and Safety Executive, will have commenced an investigation immediately after the death. In this Chapter, I am concerned only with investigations carried out under the direction of the coroner.

9.36 As I have explained in Chapter Eight, the arrangements about who carries out the investigations on behalf of the coroner in preparation for an inquest vary from district to district. In some districts, the coroner's officers undertake no investigations at all; all investigatory work is carried out by the police. In other districts (and Greater Manchester South is one), some investigatory work is carried out by the CLOs and some by police officers, but the coroner's officers, who work only in the coroner's office, do none.

The Practice in Greater Manchester South District

9.37 Mr Christopher Gaines, one of the District CLOs, described the formal opening of an inquest in the Greater Manchester South District. He said that he attends Mr Pollard. Mr Pollard declares the inquest open and Mr Gaines then swears to his belief in the truth of the information then available (essentially, that contained in Forms 751 and 751A and a statement of identification). Mr Pollard then adjourns the inquest to some future time. Mr Pollard said that he regards the formal opening as a public occasion, although the public is not given notice of the event beforehand and it takes place in his room.

9.38 Upon adjourning the inquest, Mr Pollard issues instructions to Mr Gaines as to the investigations required. These might entail interviewing witnesses and possibly inspecting the scene of the death, albeit several days after the death has occurred. Typically, Mr Gaines would be asked to obtain an 'antecedents statement', meaning a statement of the life history of the deceased. This would usually be obtained from the next of kin or a close relative of the deceased. I have seen examples of such statements and

they are often very detailed in the background history they provide. However, such statements as I have seen are not always well focussed on the issues likely to arise at the inquest.

9.39 In addition, Mr Gaines might be asked to take a statement from a nurse or carer from the nursing home or elderly persons' home in which the deceased had died. I have the impression that, although Mr Gaines conducts his enquiries conscientiously, he does not see his role as a proactive one; he simply records what the witness tells him about the death, rather than asking searching questions, for example probing why the carer had done what s/he had done or why the system in the home was as it was. I do not attribute this to any lack of interest on his behalf. Rather, I believe that it is explained by his lack of any medical or nursing background or training and by the fact that, even when in the police force, he was mainly engaged on uniformed patrol work, rather than investigative duties.

9.40 Mr Gaines was asked about the way in which he would investigate a death that might have resulted from industrial disease. He said that he would obtain the antecedent history from the next of kin. This would include an attempt to discover whether the deceased had been exposed to the substance thought to have caused the death. Mr Gaines might discover that, during his/her lifetime, the deceased had consulted a solicitor in connection with a claim for damages. In that event, the solicitor would probably hold a statement made by the deceased, dealing with his/her working life and exposure to the dangerous substance. However, if no such statement existed, Mr Gaines might obtain very little information. He would not attempt to contact a former employer to confirm the fact or circumstances of the deceased's employment. The only evidence of employment might be based on the recollections of, say, the middle-aged daughter of the deceased, trying to remember what her father had told her about his work when she was a child, 40 years earlier. Mr Gaines would not know anything about the medical evidence that might tend to confirm or refute the suggestion that the deceased had been exposed to a dangerous substance at work.

9.41 Mr Gaines also described what would happen when he investigated a case of suspected suicide. Usually, the police would be involved until they were satisfied that no third person had been involved. If a third person had been involved, there would be a suspicion of criminality. Once that had been excluded, Mr Gaines would take over and would obtain witness statements. In this, he would be left to his own devices although, if the Coroner wanted further statements when the file had been submitted to him, these would be obtained. Mr Gaines would not know what the medical evidence was and, in a drug-related case, might not have any knowledge of the effect of the drugs the deceased was suspected of taking.

9.42 As a rule, Mr Pollard would himself conduct any investigation of the medical aspect of a death. If evidence were needed from a doctor, whether a hospital clinician or a general practitioner, Mr Pollard would obtain it. Usually, if the death had occurred in hospital, he would write to the hospital administrator, asking for a report on the circumstances of the death from the appropriate consultant. In making such a request, he uses a *proforma* letter; he does not ask specific questions or refer to specific issues. Thus, the statement, when provided, would not be targeted at the issues to be decided at the inquest.

9.43 The overall impression that I gained was that investigations were unfocussed and lacked co-ordination by a person who understood the issues and had access to all the available information.

Deaths Possibly Caused or Contributed to by Medical Error or Neglect

9.44 As I mentioned in Chapter Eight, Mr Michael Burgess, HM Coroner for Surrey, said that the number of deaths reported to his office requiring some form of investigation into a medical mishap or nursing care was increasing. As with cases of other kinds, the practice relating to the investigation of this type of case varies from district to district.

Who Should Investigate Such Cases for the Coroner?

9.45 In some districts, possibly most, investigations involving a 'medical element' are carried out by the police, even though there is no suggestion that the medical error or neglect might amount to a criminal offence. There was general agreement among the witnesses at the Inquiry and the participants at the Inquiry's seminars that the police were not well placed to conduct such investigations. They did not have, and could not be expected to have, the necessary medical knowledge or expertise. Also, it seems to me that the involvement of the police in such a case would tend to raise to an unnecessary level the anxiety felt by any professional whose conduct or competence comes under scrutiny. In my view, such investigations should not be undertaken by the police unless there is a suspicion of criminality. If the investigation discovered facts suggesting that there had been neglect or error serious enough to warrant the consideration of criminal proceedings, the coroner could always refer the case to the police at that stage.

9.46 If such investigations are not to be conducted by the police, who should be responsible for them? In Greater Manchester South District, Mr Pollard does not usually involve the police in the investigation of allegations of medical error or neglect. As I have already said, he undertakes the investigation himself. The unsatisfactory nature of that process is illustrated by the following two cases, which were noticed by the Inquiry team on examining some of Mr Pollard's inquest files. In commenting upon the conduct of these two investigations, I do not wish it to be thought that I am being critical of Mr Pollard individually. I describe these investigations and their shortcomings to illustrate that the task of enquiring into a death which might have resulted from a medical error or neglect is very difficult to perform satisfactorily within the current legal framework and requires expertise which neither a police officer nor a legally qualified coroner with very limited medical knowledge is likely to have. They are further examples of the variability of practice and procedure noted by the Coroners Review and observed first-hand by the authors of Home Office Research Study 241, to which I have already referred in Chapter Seven.

The Case of Mr X

9.47 Mr X died at the age of 80. Two months before his death, he had undergone a right below-knee amputation; he suffered from severe peripheral vascular disease and had a history of problems with his right foot. Nine days after the operation, he was discharged to the nursing home where he had been living previously. While at the nursing home, he

developed an infection of the stump. He was re-admitted to hospital two weeks before his death. Following the death, a doctor from the clinical team responsible for Mr X's hospital care contacted the coroner's office and indicated that he was prepared to certify the cause of death, if the coroner agreed. However, Mr Pollard decided to order an autopsy. Mr X's family was informed of the decision and expressed concern about the standard of care he had received at the nursing home. The autopsy result was faxed to the coroner's office four days after the death; the cause of death was said to be bilateral lobar pneumonia due to an infected right amputation stump. Mr Pollard opened and adjourned an inquest.

9.48 The autopsy report that followed recorded, as part of the history, that the deceased had been admitted to hospital two weeks before his death with general deterioration and dehydration. Mr X was said to have sacral pressure sores and an unhealthy gaping wound at the amputation site. The clinical impression was that he had a urinary tract infection. It was also recorded that Mr X had a past history of diabetes mellitus, dementia and peripheral vascular disease resulting in bilateral below-knee amputations.

9.49 The autopsy report did not mention whether or not the pathologist had found any sacral pressure sores. The principal finding was of bilateral lobar pneumonia. The flap over the right amputation stump was said to show an open wound. There was said to be no evidence of urinary tract infection at the time of death. The cause of death was given as stated above. The pathologist cited congestive cardiac failure, ischaemic heart disease and bilateral amputations for peripheral vascular disease as conditions that had contributed to the death, though not related to the disease or condition causing it.

9.50 Six days after the death, Mr Pollard wrote to the hospital asking for a report on their care of Mr X. The letter was in standard form and did not ask any specific questions. Neither Mr Pollard's CLOs nor his coroner's officers had any role in the enquiries that took place; nor did any police officer.

9.51 A month later, a member of the family wrote to the Coroner, enclosing a lengthy statement in which she set out in detail the concerns felt by the family about Mr X's medical treatment and care. These concerns can be summarised as follows:

(a) The family suggested that, in several respects, Mr X had not received proper care in the nursing home. It was suggested that, before the amputation, the staff had failed to keep his troublesome right foot dry, despite the fact that the hospital consultant had given instructions to that effect. They had failed to ensure that Mr X was taking his medication.

(b) Mr X had been discharged from hospital only nine days after his amputation. He had deteriorated quickly after discharge. The family was concerned that he had been discharged too soon.

(c) Staff in the nursing home had removed Mr X's catheter immediately on his return there, although the family had understood that it was to remain in situ for four weeks after the operation. They had also failed to ensure that Mr X was receiving adequate nourishment, particularly in the light of the fact that he had an impaired swallow reflex.

(d) The family had been told by the nursing home staff, three days before his re-admission to hospital, that a **'wound specialist'** had seen Mr X and had not been unduly worried by his condition. Nonetheless, only three days later, Mr X had developed pressure sores that were so badly infected as to warrant re-admission.

9.52 It is clear that, if these concerns were found to be true, they were capable of amounting to gross neglect, certainly so far as the nursing home was concerned. Mr Pollard responded to the family's expression of concern by saying that, at the inquest, he would permit such questioning as was needed to establish how, when and where the death had occurred. In oral evidence to the Inquiry, he explained that his perception was that the death could reasonably be regarded as being due to natural causes if the treatment was adequate. He did not undertake to investigate the family's concerns, but indicated only that the family could ask questions within the limits he had defined. It must have been extremely difficult for the family to understand the parameters Mr Pollard set on the inquest, how they would operate at the inquest, and the legal basis for setting those parameters.

9.53 Mr Pollard had not at that time received any evidence from the hospital. In due course, he received a report from Dr P of the Cardiology Department of the hospital, who said that he was the consultant responsible for Mr X's care during his last admission. This report described Mr X's poor condition on re-admission to hospital and explained the treatment provided – rehydration, intravenous antibiotics, debridement of the infected tissue of the stump and pain relief. Despite such treatment, Mr X's condition had deteriorated and he had died two weeks later. This report did not, and could not, have been expected to, address any of the concerns raised by the family; those concerns had not been communicated by Mr Pollard to the hospital. Yet, having by now received the family's detailed account of their concerns, Mr Pollard did not contact the hospital again, to ask questions specifically relating to the possible lack of care by the nursing home staff or to Mr X's post-operative discharge. Nor did Mr Pollard direct that any evidence should be obtained from the nursing home; in particular, he did not arrange for any nursing notes kept by the nursing home to be produced at the inquest. The management of the nursing home was not even notified that an inquest was to take place.

9.54 As a result, no evidence was obtained which would have allowed proper exploration of the issues raised by the family or the general adequacy of Mr X's medical treatment and nursing care.

9.55 At the adjourned inquest, which was not conducted by Mr Pollard, the only witness to give oral evidence was the pathologist. A verdict of natural causes was entered. That might have been correct; I cannot say. The papers contain no record of the evidence given orally, nor any note of the Coroner's reasons.

9.56 However, it is apparent that the family was not satisfied that there had been an adequate investigation of the death. After the inquest, the family wrote, asking for the notes of evidence of the inquest. Mr Pollard replied, enclosing copies of the 'depositions' which apparently comprised five sheets of paper. It appears that these were the autopsy report and the report of Dr P. The family then wrote again, asking why a verdict of natural causes had been entered. The Coroner who had conducted the inquest replied that, at the

inquest, the pathologist had been questioned very closely as to the cause of death. The pathologist had said that the cause was a natural cause, as she had said in the autopsy report. The Coroner suggested that if the writer wanted any further explanation, she should consult her general practitioner, taking with her a copy of the autopsy report. The family must have been deeply disappointed that their concerns had not been subjected to closer scrutiny. They had been given no answers by the inquest process.

9.57 In evidence to the Inquiry, Mr Pollard explained that he had not sought further evidence from the hospital or any evidence from the nursing home because the pathologist had given him 'a cause of death' and would be able to answer questions related to the issues of how, when and where Mr X had died. He considered that the pathologist would have been able, at the hearing, to answer any questions raised by the family. He said that in every inquest that he holds it is possible to consider that further evidence should be obtained; however, according to Mr Pollard, a line has to be drawn somewhere and there is too great a delay at present in the hearing of inquests in his district. I find that answer disturbing for several reasons.

9.58 First, it suggests undue reliance on the fact that the pathologist has found a cause of death, essentially the medical cause of death, without seeking to enquire, as the family understandably wished, about any contributory causes – in this case the treatment, or lack of it, provided by the nursing home. The role of a coroner in such circumstances should be to enquire, proactively. This is particularly so if concerns of a sensible nature are raised about the circumstances of the death. Of course, I accept that a coroner cannot be expected to investigate fully every minor expression of concern about possible contributory factors that he receives from a bereaved family, some of which might have played no part in causing the death. However, the concerns in the case of Mr X were expressed clearly and in detail. They appeared to be sensible and Mr Pollard did not suggest that they were not. If there had been neglect, as the family suggested, it might have been sufficiently serious to have contributed to the cause of death. Yet, Mr Pollard considered that he had fulfilled his investigative function by obtaining a narrative history from the hospital and saying that appropriate questions could be asked of the pathologist at the inquest. It appears that the family relied upon the Coroner to ask questions. That was not an unreasonable expectation, as they had explained their concerns in detail in advance. In my view, there had not been an adequate investigation of the circumstances of the death and, as a result, the inquest could not fulfil its proper purpose.

9.59 Second, it is apparent that it was expected that the pathologist would be able to deal with all the issues that the family wished to raise. However, the pathologist could not know important elements in the history, such as what steps the nursing home staff had taken to keep the foot dry and when the foot had begun to show signs of infection. Nor could she know what steps the nursing home had taken to ensure that Mr X took his medication and received adequate nourishment and fluids. Nor could she know what had happened when the 'wound specialist' had seen Mr X. She would not know when the pressure sores developed or how they were treated. These matters were questions of fact, which could be answered only by the nursing staff involved and by production of the nursing records. It appears that the pathologist would have been able to say that the premature removal of the catheter had not contributed to the cause of death; there was no evidence of urinary

tract infection at autopsy. However, she would not have been able to say whether any possible failure of the nursing home staff (in the respects I have mentioned above) could have had any effect on the course of Mr X's decline. To do so would have been outside her area of expertise. It appears that it is common practice for coroners to rely on the evidence of a pathologist on matters lying far outside his/her expertise. Other pathologists told the Inquiry that they are often asked, at inquests, to deal with issues outside their expertise. They find themselves doing their best, out of a desire to assist the family and the coroner by providing answers and allowing the proceedings to be brought to a conclusion. This practice is to be deprecated. No expert should ever be asked to answer questions outside his/her field of expertise and indeed should not agree to do so, and yet the practice adopted seems not to be uncommon.

9.60 Third, Mr Pollard said that he did not think it appropriate to ask the pathologist in advance about the issues likely to be raised by the family at the hearing; he thought there was a danger that the family might suggest that he had 'primed' the witness. I think that such a suggestion could be avoided if the communication between the coroner and pathologist is set out in correspondence that the family can be shown. Otherwise, if the risk of such a suggestion is to be avoided and no communication is to take place between coroner and pathologist, not only may the pathologist be ill equipped to provide an opinion, by virtue of his/her lack of expertise in the area, but s/he will also be deprived of an opportunity to consider the issues in advance. The effect of Mr Pollard's practice is that he would begin the inquest hearing with no idea whether or not the pathologist would be able to deal with the issues raised. Mr Pollard said that he would be quite prepared to adjourn the hearing if it emerged that the pathologist could not deal with the issues. That, in my view, is not a proper approach to a hearing which the bereaved family has attended with anxieties and raised expectations. In any event, in Mr X's case, there should have been no question of the pathologist dealing with the issues, because of her lack of knowledge of the factual background.

9.61 Mr Pollard said that he did not have the time or the staff to deal with cases such as this in an appropriate way. That may well be the case but, if so, it is not a satisfactory state of affairs. However, I think that the real problem is not too large a caseload, but the lack of appropriate expertise. In my view, a legally qualified coroner, without a medically qualified colleague, might well find it difficult and time-consuming to analyse what is required for the proper investigation of such a case as this. A medically qualified coroner would be in a better position to do so. Moreover, it is obvious that, if proper enquiries were to be made at the nursing home, they would have to be undertaken by a coroner's officer with some medical or nursing background or knowledge and an understanding of the issues likely to be addressed at any future inquest.

The Case of Mrs Y

9.62 The second inquest case examined by the Inquiry concerned Mrs Y. She had attended an accident and emergency department late one evening, complaining of severe abdominal pain. She was admitted and underwent an operation at about midnight. It appeared to her family that she was making a reasonable recovery from her operation, but she died suddenly two days later. The death was reported to the Coroner, who ordered an autopsy.

9.63 The autopsy report described a perforated area 2cm in diameter in the lower third of the oesophagus. There was leakage of contents from the oesophagus into the right pleural space, where there was brown fluid and associated inflammation. The oesophagus appeared somewhat narrowed in the perforated area. The stomach was found to be unremarkable. In the duodenum, there was an area of oversewing of the anterior wall, which must have represented the site of the operation. The operative site appeared healthy. There was an ulcer 2cm in diameter on the wall of the duodenum but no evidence of leakage of the contents of the duodenum into the peritoneal cavity. All other findings were unremarkable.

9.64 The pathologist's conclusion was that the cause of death was a perforated oesophagus following surgery for a perforated duodenal ulcer. This conclusion was, to some extent, ambiguous. It rather sounded as though the pathologist was suggesting a causal connection between the perforated oesophagus, which was the immediate cause of death, and the previous surgery to repair the duodenal ulcer. However, from reading the body of the report, it appears that no such causal connection was believed to have existed, only a connection in time. The body of the report suggested that the perforation that had caused the death was in the oesophagus (from which leakage had been observed), and not in the duodenum, where there were signs of a successful operative repair. A further ulcer in the duodenum had not apparently perforated.

9.65 On receipt of the autopsy report, Mr Pollard wrote to the hospital, using his standard letter, asking for a report on the treatment of Mrs Y. In due course, this was supplied. The report was written by the consultant surgeon nominally in charge of the patient's case. She had discussed the case with the junior doctors involved but had no personal knowledge of it. She described the findings on admission and the steps taken to diagnose the perforation of the duodenal ulcer. The report named the surgeon who had carried out the repair operation. After repair, the peritoneal cavity was washed out and a drain inserted. The post-operative care was described. Progress was said to be satisfactory for two days until Mrs Y died suddenly at 5.30am. Attempts at resuscitation failed. The consultant drew attention to the autopsy findings and the conclusion that the cause of death was a perforation of the oesophagus. She described Mrs Y's past medical history of oesophagitis and expressed her doubt that Mrs Y always took the medication prescribed for that condition. The writer then expressed the opinion that the perforation of the oesophagus had occurred shortly before the death. She suggested that the nursing chart provided a clue as to the time at which the perforation had occurred. There had been a sudden rise in the pulse rate to 130 beats per minute at about 10pm on the evening before death. However, this had fallen back to 110 beats per minute by 2am the next morning. The writer observed that no change had been observed in Mrs Y's general condition during this period and she had not complained of chest pain, which was said to be a **'cardinal symptom'** of an oesophageal perforation.

9.66 Apart from a brief statement taken from a member of Mrs Y's family, the only evidence obtained in advance of the inquest was the autopsy report and the consultant's letter. The family had not expressed any concern about Mrs Y's treatment at hospital. However, it would be normal for them to wish to know whether she had died as the result of error made in the treatment given in hospital or whether the death had been 'natural', and there is also

a wider public interest in knowing that information. Only the pathologist and a member of the family were asked to attend the inquest. Neither the consultant who had written the report, nor the surgeon who had repaired the duodenal ulcer, was asked to attend.

9.67 There is no record of the conduct of the inquest. Mr Pollard returned a verdict of misadventure. In evidence to the Inquiry, he explained that that verdict implies that the death was due to an unexpected result of a deliberate action; in other words, it was not due to natural causes. Mr Pollard agreed that, on the basis of the written materials, he could not explain how it was that he had come to the conclusion (as he apparently had) that Mrs Y's death had been due to something that had gone wrong during the operation on the duodenum. He thought it was probably connected with the fact that the site of the operative repair to the duodenum was not far from the site of the fatal perforation of the oesophagus. He said that oral evidence had been received from the pathologist that had drawn him to his conclusion. He had made no written record of that evidence and could not now remember what it was. There was no record of his reasons for reaching a verdict of misadventure. I was concerned and puzzled that the pathologist could have expressed the view that the oesophageal perforation (which had clearly caused the death) had somehow been caused at the time of the operation. If there were any signs observed at autopsy which had enabled him to reach that conclusion, one might have expected to see them recorded in the autopsy report.

9.68 Of further concern is the fact that the Coroner reached a conclusion which implied some degree of responsibility upon the surgeon who had performed the repair of the duodenum without giving that surgeon any notice that his conduct might be called into question or any opportunity to give evidence. The hospital authority had been given notice of the inquest, but not of the possibility of any criticism. The surgeon who performed the operation would have been an important witness. He had not even been asked to provide a statement. Mr Pollard's verdict might or might not have been correct. Whichever it was, I am left with a feeling of unease about the adequacy of the investigation and the accuracy and fairness of the inquest verdict.

Conclusions about Investigations

9.69 There is, in my view, an urgent need for a more focussed, professional and consistent approach to coroners' investigations; this is needed from the time that the death is reported, right up to the verdict. There needs to be clarity as to the purpose and scope of the enquiries that are made. Coroners themselves, who are to direct the conduct of an investigation, require training. Legal experience, particularly as a solicitor, should provide a sound basis for the conduct of an investigation into non-medical matters, but it is apparent, from the cases that I have described, that medical knowledge and experience is vital for the proper conduct of many investigations, as well as for the proper evaluation of evidence and the taking of decisions. Coroner's officers, who are, at present, almost wholly untrained, will require training, management and direction if they are to assume an effective investigative role.

9.70 The quality of information which comes into the coroner's office at the time of a death must be greatly improved. Instead of an oral account from the reporting doctor, there should

be a short written account of the deceased's medical history and a written account of the circumstances of the death, each to be provided on a prescribed form. Coroner's officers should always seek to obtain information from relatives or those with knowledge of the deceased in order to verify or expand upon the information provided by the health professionals who have completed the forms.

9.71 The coroner should have the power to seize or compel the production of documents, records and other material relevant to the investigation of a death. I agree with the recommendation of the Brodrick Committee which, as long ago as 1971, suggested that the coroner should have power to take possession of a body, to enter and inspect premises where a body has been found or has been moved from or where the deceased was prior to death, to inspect, receive and copy information from documents relating to the deceased and to seize any property material to the investigation.

9.72 The coroner should have the discretion to certify the cause of a death following investigation, without the need in every case to order an autopsy or hold an inquest. Instead of proceeding automatically to order an autopsy, coroners should make use of a variety of investigative methods; for example examining medical records, ordering an external (i.e. non-invasive) examination of the body and obtaining witness statements. If the coroner considers that an autopsy is necessary, the family should be notified in advance and the reasons for the decision should be explained to them. They should be able to make representations and should have the right to appeal the decision. I will discuss later where such an appeal should lie.

9.73 Coroners should be required to provide improved information for pathologists instructed to perform an autopsy. No pathologist should ever be expected to manage without the medical records of the deceased. Nor should a pathologist be denied the opportunity to conduct whatever ancillary tests s/he thinks appropriate for the proper investigation of the cause of death provided that there is proper medical justification for the carrying out of those tests. I endorse the recommendations of the RCPath in their drive to improve the conduct of autopsies.

9.74 Death investigations in which any issue of medical error or neglect arises require particular expertise. I shall suggest that, if there is any degree of complexity, such investigations should be conducted by a specialist team of investigators.

Inquests

9.75 In the light of the very limited number of inquests that were conducted into the deaths of Shipman's patients, it might be wondered why there is any need or justification for me to consider the topic of inquests. I do so because, in the course of the Inquiry, I became aware of the widespread concern felt about the number of inquests currently held and the way in which many inquests were conducted. Such concerns were apparent from the reports of legal cases I had to consider, as well as from responses to the Coroners Review Consultation Paper. They were confirmed by Home Office Research Study 241, 'Experiencing Inquests', to which I have already referred. As I intend to make recommendations about the jurisdiction of the coroner and the way in which the coronial

service should be organised, it seems sensible to include such views as I have been able to form about inquests. I shall not embark on a detailed consideration of the way inquests are conducted but will confine myself to consideration of the purposes of the coroner's investigation and the circumstances in which a public inquest should be held.

9.76 On other issues, I shall say little or nothing. I have read the Report of the Coroners Review, which has examined the issues relating to inquests in detail. I concur with the views expressed in Chapter 8 of the Review's Report on inquest outcomes (paragraphs 25(a), (b), (c) and (d)), evidential standards (paragraphs 30 and 31), implications of liability (paragraphs 32 to 40) and the scope of the inquest (paragraphs 53 to 59). In Chapter 9 of the Review's Report, which deals with the handling of inquests, I agree with the views expressed as to jurisdiction and support (paragraphs 1 to 13), the need for a Rules Committee (paragraphs 14 to 19), the pre-inquest hearing (paragraphs 20 and 21), disclosure (paragraphs 22 to 28), addresses as to the facts (paragraphs 29 to 31) and publicity (paragraphs 55 to 58). I say nothing about the questions of self-incrimination and juries, which I regard as particularly difficult subjects requiring detailed consideration.

The Purpose of Coronial Inquests

9.77 The purpose of an inquest in England and Wales is not currently defined by statute. Instead, section 8 of the Coroners Act 1988, to which I have already referred at paragraph 7.17, states the circumstances in which a coroner is under a duty to hold an inquest. Rule 36 of the Coroners Rules 1984 sets out the matters to be ascertained at the inquest and provides:

> **'(1) The proceedings and evidence at an inquest shall be directed solely to ascertaining the following matters, namely –**
>
> **(a) who the deceased was;**
>
> **(b) how, when and where the deceased came by his death;**
>
> **(c) the particulars for the time being required by the Registration Act to be registered concerning the death**
>
> **(2) Neither the coroner nor the jury shall express any opinion on any other matters.'**

9.78 It is possible to infer from section 8 and from rule 36 that the function of an inquest is to discover, in the case of a violent or unnatural death, a sudden death of which the cause is unknown or a death in prison, who the deceased was and how, when and where s/he came by his/her death. The inquest will also seek to establish the particulars required for the registration of the death. However, these provisions throw little light on why it is thought desirable to discover these facts in the deaths caught by section 8.

9.79 Historically, the purpose of the coroner's inquest was to determine whether there was criminal involvement in the death. That was plainly a 'public interest' purpose. Nowadays, such investigation is the province of the police. Today, the purpose of the public investigation of the deaths caught by section 8 is unclear. The coroners who gave evidence stressed the need for the purposes of the coronial inquest to be clearly stated

in future. I have the impression that they feel that the fact that the inquest has no defined purpose which the public can understand leads to difficulty and unrealistic expectations.

9.80 According to the author of the latest edition of Jervis on Coroners[1], the functions of an inquest are **'really to determine certain facts about the deceased, the cause of death, and the circumstances surrounding both death and that cause'**. In R v South London Coroner, ex parte Thompson[2], Lord Lane CJ observed that **'the function of an inquest is to seek out and record as many of the facts concerning the death as public interest requires'**. In R v HM Coroner for North Humberside and Scunthorpe, ex parte Jamieson[3] the Court of Appeal said that the main question to which evidence and inquiry are most often and most closely directed was how the deceased **'came by his death'**. That question was to be contrasted with the issue of **'how the deceased died'**, which might raise general and far-reaching issues. It has repeatedly been said that it is not the function of a coroner or his/her jury to determine, or appear to determine, any question of criminal or civil liability or to apportion guilt or attribute blame. The coroner is required to find out what happened, but not to attribute blame, even though the actions of someone involved might appear to warrant it. In short, the coroner has a difficult task with uncertain parameters.

9.81 These dicta, helpful though they are, only define the function of the inquest, not its purpose. For whose benefit is the inquest to be conducted? Lord Lane suggested that it is the public interest that is to be served. In 1971, the Brodrick Committee identified five grounds of public interest which they believed a coroner's inquiry should serve, namely:

> **'(i) to determine the medical cause of death;**
> **(ii) to allay rumours or suspicion;**
> **(iii) to draw attention to the existence of circumstances which, if unremedied, might lead to further deaths;**
> **(iv) to advance medical knowledge;**
> **(v) to preserve the legal interest of the deceased person's family, heirs, or other interested parties'**.

9.82 Parliament requires an inquest to be held in the cases covered by the provisions of section 8 of the 1988 Act, presumably because that section identifies deaths, such as violent or unnatural deaths, that might reasonably be expected to give rise to public concern if the circumstances remained unclear. I have already observed that it is not easy for coroners to decide whether a death falls within the provisions of section 8 and the results of their decisions often do not bear logical examination. Moreover, the general perception of those contributing to the Inquiry is that many deaths properly caught by section 8 do not give rise to any question of public interest or concern. Also, section 8 fails to catch some deaths that do give rise to public concern.

9.83 This issue was considered by Simon Brown LJ in the case of R v Inner London North Coroner, ex parte Touche[4]. In that case, the deceased had died as the result of a cerebral

[1] Matthews, P (2002) 'Jervis on Coroners', Twelfth edition. London: Thomson Sweet & Maxwell.
[2] [1982] 126 SJ 625.
[3] [1995] QB 1.
[4] [2001] QB 1206.

haemorrhage after developing high blood pressure following a caesarean section. This was a natural cause of death and the Coroner initially declined jurisdiction. On judicial review, the Coroner was ordered to hold an inquest. His appeal failed. In dismissing the appeal, Simon Brown LJ suggested that there was a powerful case for holding an inquest not only into 'unnatural' deaths but also **'whenever a wholly unexpected death, albeit from natural causes, results from some culpable human failure'**. He observed that such deaths caused understandable public concern which could be allayed by a coroner's investigation. The implied suggestion was that section 8 is not a satisfactory means of selecting deaths for public inquest. Simon Brown LJ also drew attention to the rather tortuous means which coroners sometimes have to adopt in order to bring a death within section 8. For example, some coroners who wished to conduct an inquest into deaths from legionnaire's disease (on the face of it a rare but natural cause of death) had been driven to reason that the mechanical spraying of infected water into the atmosphere (apparently a reference to the operation of an inadequately maintained air-conditioning system) made a death resulting from that spraying 'unnatural'.

9.84 In short, section 8 is not a satisfactory means of selecting those deaths where the public interest requires public investigation. In my view, in the modern era, the purposes of the public inquest should be:

- to conduct a public investigation into deaths which have or might have resulted from an unlawful act or unlawful acts
- to inform interested bodies and the public at large about deaths which give rise to issues relating to public safety, public health and the prevention of avoidable death and injury
- to provide public scrutiny of those deaths that occur in circumstances in which there exists the possibility of an abuse of power.

Do We Have Too Many Public Inquests?

9.85 In this country all inquests are conducted in public. Plainly that is appropriate if the inquest is to serve a public interest. If the public has no interest in a death, should there be a public inquest, merely because the death might be due to an unnatural cause such as suicide or an industrial disease? It might be more appropriate for the investigation of such deaths to take place in private.

9.86 The effect of section 8 of the Coroners Act 1988 is that a very large number of public inquests are held in England and Wales each year. In 2001 (the most recent year for which figures are available), inquests were held into nearly 25,800 deaths, which represents almost 13% of all deaths reported to coroners and nearly 5% of all registered deaths. Enquiries made by the Inquiry team suggest that inquests are held into a far greater proportion of deaths in England and Wales than in many other countries, where deaths are investigated (often more thoroughly than in England and Wales) and a written report is prepared.

9.87 Some jurisdictions have no provision at all for the conduct of an inquest. For example, in Maryland, USA, deaths are investigated by medical examiners and an expression of

opinion about the cause of the death is added to the autopsy report. This opinion will also contain information about the circumstances of the death. The report is a public document. Any person with a sufficient interest in the report can seek a review of the report, first by the Chief Medical Examiner, then, if leave is granted, by an administrative judge, from whom there is a final right of appeal to a circuit court judge. Information from the death investigation is harnessed for the purposes of improving public health and safety and is passed to a number of relevant bodies responsible for injury prevention and community health. Thus, the interests of the family in finding out what happened and the interests of the community are served without holding an inquest.

9.88 In Finland, there is no inquest or comparable proceeding. Deaths reported to the medical examiner are investigated by pathologists and often by the police, even where there is no suspicion of criminal involvement. A report into the death is produced and seen by relatives but is not a public document. Information from the investigation is provided to the authorities with responsibility for public health and safety.

9.89 In the state of Victoria, Australia, and the province of Ontario, Canada, inquests are held, but in far fewer cases than in England and Wales. In Victoria, 0.8% of total deaths are followed by a public inquest. Apart from a few circumstances in which an inquest is mandatory (for example for cases of homicide, deaths in custody or care, or cases where the body is unidentified), the conduct of an inquest is a matter for the coroner's discretion. This is usually exercised where there is a matter of public interest at stake. Deaths reported to the coroner, in which no inquest is held, are investigated and a report is prepared which becomes a public document.

9.90 In Ontario, there is a similar provision for mandatory inquests; otherwise, inquests are held in the pursuance of the public interest. The number held is small (only 72 inquests were held in 2002 out of about 20,000 deaths reported to the coroner) but the issues are examined in depth and the purpose of such inquests is the production of recommendations directed to the avoidance of death or injury in similar circumstances. Indeed, the motto of the Ontario Chief Coroner's Office is **'We Speak for the Dead to Protect the Living'**. It is quite common for a single inquest to be held into several deaths, all of which have arisen in similar circumstances or share a common cause. In deaths which are reported to the coroner where no inquest is held, a report on the death is prepared and provided for a defined class of family and associates of the deceased. The report is not a public document.

9.91 In Scotland, some classes of death are reported to the procurator fiscal, who will cause the police to investigate the circumstances and will direct such medical investigations as s/he thinks necessary to determine the cause of death. At the end of the investigation, the procurator fiscal is obliged to report certain categories of case to the Crown Office, and to make recommendations. The Lord Advocate, assisted by Crown counsel, will then decide whether further action is necessary, either by way of prosecution or by the conduct of a fatal accident inquiry.

9.92 Fatal accident inquiries are conducted by sheriffs, the judicial equivalent of the circuit judge in England and Wales. A fatal accident inquiry is mandatory in deaths due to an accident in the course of employment and for deaths in custody. Otherwise, the decision

to hold a fatal accident inquiry is a matter of discretion for the Lord Advocate. Before the decision is made and the procurator fiscal makes his/her recommendations about the future conduct of the case, the family of the deceased will be consulted. The usual criteria are related to public interest and concern. A fatal accident inquiry is designed to find the facts relating to the death and not to allocate blame. Recommendations for the future avoidance of a similar occurrence, or relating to any aspect of public health or safety, are sent by the sheriff to the procurator fiscal who promulgates them to the appropriate body. Very few fatal accident inquiries are held; in the year 2001/2, only 64 were held out of a total of 13,625 deaths reported to the procurator fiscal. That figure represents less than 0.5% of the deaths reported to the procurator fiscal.

9.93 It is clear that other jurisdictions manage without any or without a large number of public inquests. I think that the inquest is so well entrenched in our legal system that its complete abolition would not be acceptable. The real question is whether the criteria for holding a public inquest should be changed. I think there are positive reasons to have inquests, provided that they are thorough and are well conducted. There are public health and public safety advantages. Also, where issues of public concern arise, an inquest can expose failings or engender confidence. However, if no such issues arise, the public inquest may be an unnecessary invasion of privacy.

Views Expressed at the Inquiry

9.94 At the Inquiry, there was a large measure of agreement with the suggestion advanced in the Inquiry's Discussion Paper that too many inquests are held in England and Wales. Of the four coroners who gave evidence, only Mr Christopher Dorries, HM Coroner for South Yorkshire (West) was of the view that the present arrangements were satisfactory and that the criteria for the holding of inquests in public were appropriate. He said that an inquest was 'a voyage of discovery' and often found out previously unsuspected facts and circumstances. He did not believe that the facts could be adequately discovered by a thorough investigation without an oral hearing. Moreover, he said that the relatives of the deceased welcomed an oral hearing as it gave them the opportunity to question the pathologist in a formal setting where the pathologist was obliged to provide answers to their questions.

9.95 When he gave evidence, Mr Burgess expressed the view that the number of inquests conducted was appropriate, although he thought that some should take place in private. By the time of the seminars, he had modified his view and agreed that too many hearings took place. He thought that the categories of deaths to be investigated should remain the same, but that many deaths could be properly investigated without a hearing. The result of the investigation could instead be set out in a written report.

9.96 Mr Pollard stressed the need for families to receive a written decision, so that they could know what had happened and why, but he thought there was no need for all inquests to be conducted in public. He agreed with Mr Dorries that families welcome the opportunity to question the pathologist, but he also agreed that, provided that opportunity were given, this need not take place in the formal setting of the court room.

9.97 Dr Nigel Chapman, HM Coroner for Nottinghamshire, would be content to see the number of inquests reduced and felt that the criterion for holding an inquest should be whether the death raised issues of public interest. He said that far too many inquests are held in public and that this is often distressing, and even harmful, to the relatives. He described an occasion when he had encouraged a widow to give limited (and misleading) evidence about the background reasons for her husband's suicide in order to avoid distressing facts going into the public domain.

9.98 Mrs Aline Warner, who represented the Coroner's Officers Association at the Inquiry's seminars, expressed the view that bereaved families needed to know what had happened and welcomed the idea that some investigations should not take place in public. She suggested that the result of any investigation should be made public, because this would allay any rumour or gossip about the death.

9.99 Dr Peter Acland, a forensic pathologist who represented the RCPath at one of the seminars, said that, in his view, there were too many inquests; he doubted whether they were of much benefit to relatives. He thought that a less formal way of conveying the results of an investigation to relatives would be preferable. Dr Anne Thorpe, a consultant histopathologist representing the British Medical Association, agreed with that view.

9.100 Professor Richard Baker, Director, Clinical Governance Research and Development Unit at the University of Leicester, speaking at the seminars, also agreed that there was no need for so many public inquests but stressed the need for the community to learn from the investigation of deaths. He considered that, in England and Wales, this feature of the coroner's inquest or investigation was neglected. There was general agreement that the knowledge gained from an inquest or investigation should be harnessed for the general good.

Conclusions about Inquests

9.101 In summary, the general view at the seminars was that there must be an investigation of all deaths to an appropriate depth. The results of the investigation must be fully explained to the relatives of the deceased. However, provided that any lessons learned from the investigation can be harnessed for the public good, there is, in many cases, no need for, and little benefit to be derived from, a public hearing. I agree with that general view.

9.102 In my view, coronial investigation is important for three reasons. It ensures that relatives of the deceased, and those with a personal interest in the death of the deceased, understand how and why the death has occurred. That will entail an understanding of the medical cause of death and, if necessary, clarification of the factual circumstances in which it occurred. Such understanding is a natural human need. It assists in coming to terms with the death and may avoid suspicion and resentment about the circumstances in the future. Second, an investigation is needed in the public interest so as to ensure that neglect or misconduct resulting in a death does not go undiscovered. Only by learning how and why a death has occurred is it possible to learn from errors and avoid the recurrence of an avoidable death. Third, the public also has a legitimate interest in the accurate diagnosis of the cause of death. This is of benefit

to the advancement of medical science and the proper use of the resources of the state in the prevention and treatment of illness.

9.103 All those important interests could, in most cases, be served by an investigation of the death (to whatever depth is appropriate in the circumstances), followed by the communication of the results to those with a private interest or with a duty to safeguard some aspect of the public interest. In many such cases, nothing is gained by the public airing of the evidence. Indeed, in many cases, such exposure amounts to an unwarranted invasion of privacy and only causes increased distress to the bereaved.

9.104 In my opinion, the public inquest should be limited to those deaths about which there is a real public 'need to know', as opposed to the theoretical public interest that section 8 of the 1988 Act is designed to identify. I would favour the abolition of the section 8 criteria for the holding of an inquest and would confine inquests to deaths where the particular circumstances are such that the public interest requires a public hearing. I suggest that, apart from a few types of situation in which an inquest should be mandatory (such as cases of homicide not followed by conviction and deaths in custody), the coroner should have discretion to decide (after consultation with interested parties) whether a public inquest should be held in that individual case or group of cases. The decision should be subject to an appeal, not only by relatives of the deceased, but also by anyone with a legitimate interest in the case. Coroners should receive guidance on the types of issue that will require a public investigation at inquest.

9.105 I realise that it appears that I have recommended a more limited set of circumstances that would call for a public inquest than has the Coroners Review. In one respect, I certainly have. I do not think that a public inquest is necessary in any case in which it is necessary to resolve a conflict of evidence. In my view, that could quite well be done in private, by the coroner calling the witnesses to give evidence on oath. Interested parties could be allowed to attend and ask questions if they wished. In other respects, I think the difference between what I suggest and what the Coroners Review has proposed may be almost semantic. The Review seeks to identify the types of circumstance in which a public interest will arise. I agree that the list contains appropriate categories. However, in my view, there may be many other types of circumstance in which a public interest can arise. It would be well nigh impossible to compile a complete list. In my view, just because the death fits into a particular category should not mean that there must be a public inquest. The facts of the individual case should be examined to see whether they do raise public interest issues.

9.106 Some obvious examples of cases in which there must be a public interest spring readily to mind. The public needs to know how and why fatalities have occurred on the public transport system, at an accident blackspot or because of a failure of design of a vehicle or piece of equipment. They need to know about a death at the hands of the police. If it appears that a death has been caused by the failure to carry out a proper procedure in a hospital such that others might be affected by a repetition of the failure, the public interest may demand a public hearing.

9.107 I also consider that the procedure by which coroners may make recommendations for future change should be continued, but strengthened. I shall return to this issue in Chapter Nineteen.

9.108 It is interesting to note that the Brodrick Committee recommended changes similar to those I have suggested. They suggested that the coroner should have complete discretion as to the type of investigation to be carried out. The existing categories of death in which an inquest had to be held should be swept away. Instead, the only circumstances in which an inquest should be mandatory would be deaths from suspected homicide, deaths of persons deprived of their liberty by society and deaths of persons whose bodies were unidentified. The Committee's view, expressed over 30 years ago, accords almost exactly with mine.