CHAPTER SIX

Registration of Deaths

The Registration Service

6.1 The registration service is organised within 172 local authority areas in England and Wales. Registrars of births and deaths ('registrars') are statutory office-holders who have no employer and no line manager. Their duties are prescribed by statute and regulations. They are appointed by the local authority, but may be removed from office only by the Registrar General, to whom they are accountable for the performance of their statutory duties. All registrars must appoint at least one deputy. In large urban areas, several full-time registrars may be based at one register office, together with deputies, some of whom work part-time. In sparsely populated rural areas, there may be a part-time registrar and one deputy, also part-time. In those circumstances, a deputy registrar may work very infrequently.

6.2 Registrars need no specific qualifications and those entering the service come from a variety of employment backgrounds. They have no medical expertise; indeed, medical practitioners are one of the classes of person at present disqualified from holding the office of registrar. In the past, the General Register Office (GRO), which is the office of the Registrar General and forms part of the Office for National Statistics (ONS), provided residential training courses for registrars (but not deputies), covering all aspects of their work, including death registration. In recent years, however, the policy has changed, probably for financial reasons. Now, the onus is on the appointing authorities to organise local training. The GRO will provide assistance with the content of that training. The GRO also holds seminars and distributes written information, explaining important changes in registration law and practice. It provides a distance-learning package and produces the Handbook for Registration Officers, which contains instructions to registrars in carrying out their functions; the Handbook is up-dated frequently.

6.3 In 1994, the GRO, in collaboration with local authorities, introduced an examination of registration law and practice, which tests candidates' knowledge of the law and practice relating to registration, and includes a practical examination. The examination is not compulsory. The GRO also carries out periodic inspections of the work of registrars and register offices.

6.4 Local authorities in some areas (Lincolnshire is one) have developed excellent training programmes for registrars and deputies. In other areas (for example, Manchester), there is little or no training provision and very limited opportunity for contact between registrars working in different register offices. As a consequence, practices within local register offices vary significantly and registrars can experience a degree of isolation.

6.5 The GRO provides an advice line, offering assistance to registrars who have queries about registration matters. So far as the registration of deaths is concerned, the majority of queries relate to the cause of death. A registrar might not understand the cause of death that appears on the MCCD or might be uncertain as to whether s/he should report the death to the coroner. Those employees of the General Section of the GRO who deal with

such queries have no medical qualification or specific training for the task and are reliant upon medical reference books and notes of past advice that has been received or given. As I shall explain in due course, these notes are not always helpful. In the event of a particularly complex medical query, it is open to the staff to seek the advice of medical epidemiologists employed by the ONS. However, the evidence given to the Inquiry strongly suggested that most questions are resolved by members of the staff within the General Section, without recourse to medical advice.

The Registration of a Death

6.6 The Births and Deaths Registration Act 1953 governs the registration of deaths. In order to register a death, the informant must attend personally before the registrar to give information. The only exception to the requirement for personal attendance before the registrar arises where an inquest is held. In that event, the coroner provides the particulars necessary for registration after the inquest has been concluded and no signature in the register (other than that of the registrar) is required. In other cases, the informant must attend the register office before the expiration of five days from the date of death or finding of the body; however, if the informant sends to the registrar written notice of the death, together with notice from the doctor that the MCCD has been signed within the five-day period, that period is extended to 14 days.

6.7 The registrar must enter particulars of the death in a register, from which a certified copy of any entry identified in the index may thereafter be supplied on request, upon payment of a fee. The Registration of Births, Deaths and Marriages Regulations 1968 prescribe the particulars which must be recorded in the register of deaths: a blank entry can be seen at Appendix C to this Report. Information about the date and place of death, the name, occupation, sex and usual address of the deceased and details of the informant must be recorded. The cause of death must be recorded precisely as it appears on the MCCD or coroner's certificate. The name and qualification of the medical practitioner who completed the MCCD must be entered in the register. The registrar will also ask the informant a number of questions, the answers to which are not recorded in the register but are sent to the Registrar General, to be used for statistical purposes.

6.8 If the MCCD appears, on its face, to have been fully and correctly completed and contains an acceptable cause of death, and if the registrar is not aware of any circumstance requiring that the death be reported to the coroner, the registrar will proceed to register the death in reliance upon the MCCD. If the registrar proceeds to registration, the relevant particulars are entered in the register and signed by the informant. The registrar will then issue at least one certified copy of the entry in the register (often known as the 'death certificate', although that term is also used, incorrectly, to describe an MCCD) and will issue a disposal certificate, certifying that the death has been registered. A copy of a blank disposal certificate can be seen at Appendix C to this Report.

6.9 There are circumstances in which the registrar will have further documentation to consider, in addition to the MCCD. Before the death comes to the registrar, it may have been reported to the coroner, probably by the deceased's treating doctor. If the coroner has completed his/her enquiries into the death, no post-mortem examination has been

held and the coroner does not intend to take any further action in connection with the death, the coroner's office will usually send to the registrar a Form 100A, signed by the coroner, confirming that no post-mortem examination has been held and the coroner does not consider it necessary to hold an inquest. There is no legal requirement on the coroner to issue a Form 100A and the form is not prescribed by statute. Copies of the form are supplied by the Registrar General for use by coroners. A blank Form 100A can be seen at Appendix C of this Report. The cause of the deceased's death will usually (although not always) be recorded on Form 100A. However, the instructions on the reverse of the form direct the registrar to rely on the cause of death that appears on the MCCD when making the entry in the register of deaths. In practice, the coroner's staff will usually ensure that the cause of death on Form 100A is the same as that which appears on the MCCD. However, if there is inconsistency, it is the information on the MCCD upon which the registrar must rely.

6.10 If the death has been reported to the coroner and s/he has directed a post-mortem examination and is satisfied, as a result of that examination, that no inquest is necessary, the coroner's office will send to the registrar a Form 100B, signed by the coroner, confirming that the coroner does not consider it necessary to hold an inquest. Under the provisions of section 19(3) of the Coroners Act 1988, a coroner is required, when satisfied as a result of a post-mortem examination that an inquest is unnecessary, to send to the registrar a certificate stating the cause of death as disclosed by the report of the examination. The form of the certificate is not prescribed by statute and Form 100B is provided by the Registrar General for this purpose. A blank Form 100B can be seen at Appendix C of this Report. The instructions on the reverse of the form direct the registrar to enter the cause of death which appears on Form 100B in the register of deaths. In practice, it is highly unlikely that the registrar will have received an MCCD in a case where a post-mortem examination has been undertaken, so that there will be no alternative source from which the registrar could take the cause of death.

6.11 If the death has been reported to the coroner and an inquest is held, the death cannot be registered until the conclusion of the inquest. The coroner is then required by section 11(7) of the Coroners Act 1988 to send to the registrar a certificate giving various details about the death and the inquest. That certificate must specify the particulars to be registered, including the cause of death. The form of the certificate is not prescribed by statute and Form 99 is provided by the Registrar General for this purpose. A blank Form 99 can be seen at Appendix C of this Report.

The Duty of a Registrar to Report a Death to the Coroner

6.12 In certain circumstances, a registrar will not register the death, but will instead report it to the coroner. Regulation 41 of the Registration of Births and Deaths Regulations 1987 provides:

> **'(1) Where the relevant registrar is informed of the death of any person he shall ... report the death to the coroner on an approved form if the death is one:**
>
> **(a) in respect of which the deceased was not attended during his last illness by a registered medical practitioner; or**

(b) in respect of which the registrar:

(i) has been unable to obtain a duly completed certificate of cause of death; or

(ii) has received such a certificate with respect to which it appears to him, from the particulars contained in the certificate or otherwise, that the deceased was not seen by the certifying medical practitioner either after death or within 14 days before death; or

(c) the cause of which appears to be unknown; or

(d) which the registrar has reason to believe to have been unnatural or to have been caused by violence or neglect or by abortion or to have been attended by suspicious circumstances; or

(e) which appears to the registrar to have occurred during an operation or before recovery from the effect of an anaesthetic; or

(f) which appears to the registrar from the contents of any medical certificate of cause of death to have been due to industrial disease or industrial poisoning.'

6.13 In practice, registrars report deaths to the coroner comparatively infrequently. Indeed, in 2001 (the last year for which ONS statistics are available), reports from registrars accounted for only about 4% of all deaths referred to the coroner. Usually, the attending doctor will have recognised that the death is one which should be reported and will have taken the step of reporting the death before the stage of registration has been reached. It is obviously preferable, where a death must be reported for one of the reasons set out above, that this is done as soon as possible. This enables the coroner to begin his/her enquiries earlier than would be the case if the death were reported at the registration stage, with less delay to the funeral arrangements. In 2001, 95.7% of coroners' referrals were made by doctors. There is, as I have said, in Chapter Five, no statutory duty upon a doctor to make such a referral. However, doctors are encouraged by their professional associations and by the GRO (in the guidance notes contained in books of MCCDs) to report to the coroner any death which they judge would need to be referred to the coroner by the registrar. The remaining referrals to the coroner (less than 1% in 2001) were made by the police and other agencies.

6.14 In general, if a registrar communicates with the coroner's office about a death, it is because one of the following circumstances has arisen:

(a) The doctor completing the MCCD has indicated that s/he has reported **'this death to the Coroner for further action'**. If that has been done, the registrar cannot register the death without ensuring that the coroner has completed his/her enquiries into the death. The coroner will usually give notice that s/he has completed his/her enquiries and intends to take no further action by issuing a Form 100A: see paragraph 6.9.

(b) The cause of death (or certain words used to describe the cause of death), as certified by the doctor, is one which the registrar has been instructed should be referred to the coroner. This might arise, for example, if the word 'dehydration' (which

might suggest an element of neglect) or 'fracture' (which might mean that the death was due to an accident and, therefore, violent or unnatural) appears within the causes of death stated. Another example would arise if the registrar took the view that the cause of death certified amounted to a 'mode of dying', rather than a cause of death.

(c) The informant or another member of the deceased's family gives the registrar information that suggests that the death might fall into one of the categories referred to in regulation 41. The Inquiry was told that this most commonly occurs in the case of industrial disease; for example, when the deceased dies of a respiratory condition and the family tells the registrar that s/he was in receipt of a pension relating to byssinosis contracted when working in the cotton industry. Such cases should result in an autopsy and inquest.

(d) There is disclosed on the face of the MCCD information that suggests that the death should have been reported to the coroner by reason of the statutory requirements or because of a 'local rule' operated by the coroner. Regulation 41(1)(b)(ii) requires that a death must be reported to the coroner, if the certifying doctor did not see the deceased either after death or within 14 days before the death (the 'either/or rule'). However, many coroners have a 'local rule' whereby all deaths where the certifying doctor did not see the deceased during the 14 days before death must be reported, irrespective of whether the doctor saw the deceased after death. Another common local rule requires deaths occurring within a certain period (usually 24 hours) after admission to hospital to be reported.

6.15 Regulation 41 provides for the registrar to report to the coroner deaths within the categories specified in the regulation on an approved form. The approved form is known as Form 52; it is not prescribed by statute, but is produced by the Registrar General for the use of registrars. A blank Form 52 can be seen at Appendix C to this Report.

6.16 In the case of a death which the registrar has reported to the coroner, or which s/he knows has been notified to the coroner, or which s/he knows it is the duty of some other person or authority to report to the coroner, the registrar must refrain from registering the death until s/he has received either a coroner's certificate after an inquest (Form 99) or a notification (usually on Form 100A or Form 100B, but sometimes oral) that the coroner does not intend to hold an inquest. Receipt of such notification enables the registrar to proceed to register the death.

The Process of Registration

Meeting the Informant

6.17 The registration service rightly lays considerable stress on the need for accurate information about the deceased. Hitherto, personal attendance by the person likely to have the best knowledge about the deceased has been seen as the only way to ensure the accuracy of information. However, changes have been proposed recently which would make personal attendance optional. I shall refer to those proposed changes later

in this Chapter. Many registrars consider that a face to face meeting between the registrar and the informant is helpful to bereaved relatives. They believe that families welcome the opportunity to take a formal part in the process of registration. Under the present system, the visit to the register office often constitutes the only contact with 'the authorities' during the post-death procedures and may be welcomed by some as a practical task in which they can be involved in the aftermath of the death. For others, it must be an inconvenience, even an ordeal. In many other jurisdictions, personal attendance is not required in order to register a death. I have the impression that registrars are very considerate of the bereaved and make every effort to ensure that the process of registration causes as little distress as possible.

6.18 As I have said in Chapter Five, the doctor usually hands over the MCCD to the informant or another member of the deceased's family in a sealed envelope; some doctors do not tell that person the cause of death before handing over the certificate. Registrars report that it is quite common for the relatives of the deceased to be unaware of the cause of death when they present the certificate at the register office. Registrars say that relatives sometimes bring the MCCD without its envelope or they find that the envelope has been opened; it appears that the family has looked at the MCCD. The registrar does not challenge the family about this, unless it appears that the certificate has been tampered with. However, often, when the envelope has not been opened, the relatives ask to see the certificate when the registrar has opened it. The registrar allows them to do so and the relatives are sometimes puzzled, distressed or even angry when they find out the cause of death that the doctor has given. Registrars often have to try to explain the cause of death to the deceased's relatives and are ill equipped to do this. A relative might be distressed to see that a cause of death such as 'alcoholism' appears on the certificate. Sometimes, the relative will challenge what the doctor has put, asserting that the deceased certainly did not suffer from the condition to which the doctor has attributed the death. The registrars say that they try to do what they can to help the relatives in these difficult and distressing circumstances but feel that this is more than should be expected of them, as administrators of the system. They consider that the informant should be told of the cause of death by someone with medical knowledge before registration takes place. Obviously, it is highly desirable that this should be done by the doctor who completes the MCCD at the time the certificate is handed over.

Obtaining Information from the Informant

6.19 There is certain information that a registrar must seek from the informant in the course of their meeting. He or she must obtain the details to be recorded in the register of death and must seek other information required for statistical purposes. The registrar must also find out whether the deceased is to be buried or cremated. He or she must find out how many certified copies of the entry in the register of deaths are required by the informant. However, there is no requirement for the registrar formally to seek information relating to the circumstances surrounding the death. Nor is the registrar required to confirm information given by the doctor who has issued the MCCD. If it appears to the registrar that there are circumstances that suggest that the death is reportable to the coroner under the provisions of regulation 41, his/her duty is to make the report. However, the registrar

is not required to make direct enquiries of the informant, with a view to ascertaining whether or not such a report is necessary.

6.20 Sometimes, the informant will volunteer information during the course of the meeting (e.g. about a recent fall suffered by the deceased which might have had a bearing on the death) that will alert the registrar to the need to report the death. Sometimes also, in the course of general conversation, it will become evident that there are differences between the facts as stated by the doctor on the MCCD and as given by the informant. In those cases, the registrar might make further enquiries or might report the death to the coroner.

6.21 There appears to be some confusion among registrars about the ambit of the questions that the registrar is required to ask the informant. One witness, a deputy registrar, stated in her Inquiry statement that it was a requirement of the registration process to ask the informant when the doctor last saw the deceased. It is clear from the evidence of Miss Ceinwen Lloyd, Branch Manager Births and Deaths Registration at the GRO, that this is not in fact the case. At a register office that I visited personally, for the purpose of seeing registrars at work, some registrars believed that it was obligatory for them to ask an informant whether the deceased had suffered any fall or other accident prior to death. They always did so. One of their colleagues, however, said that he never asked this question. He was unaware of any requirement that he should do so and Miss Lloyd's evidence makes it clear that no such requirement in fact exists. Within the Tameside register office, it is clear from the evidence that different registrars had differing practices in relation to the questions asked of informants.

The Registrar's Duty to Scrutinise the Medical Certificate of Cause of Death

Has the Correct Form Been Used?

6.22 The registrar must first check that the correct form has been used; there are separate forms for neonatal deaths and stillbirths. Then, s/he must scrutinise the MCCD to ascertain whether it appears to be 'valid' and 'acceptable'.

Is the Doctor Qualified?

6.23 The first stage is to ascertain that the form has been signed by a doctor who was qualified to sign it. If the form is not signed, or the doctor who has signed it was not qualified to do so, the MCCD is invalid. There are two necessary ingredients to qualification. First, the signatory must be a registered medical practitioner. Usually, this is easy to check. The registrar becomes familiar with the names and the writing of the doctors working in the district, although there will be a twice-yearly influx of new house officers at hospitals. The task of the registrar would be made easier if the doctor were required to print his/her name and to add his/her General Medical Council registration number.

6.24 Second, the doctor must have attended the deceased during the last illness. As I have said in Chapter Five, the meaning of this phrase is not defined. The certifying doctor states in the declaration contained on the MCCD that s/he was in medical attendance during the deceased's last illness. When considering whether the doctor is qualified in this respect,

the registrar is wholly dependent on the doctor's assertion. The registrars who gave evidence to the Inquiry said that they did not understand it to be their task to ask the informant questions designed to check the truth of statements made by the certifying doctor. If, however, the informant, or anyone accompanying the informant, were to volunteer information that cast doubt on an assertion made by the doctor (as, for example, by remarking that the deceased had not seen a doctor for months), the registrar should heed that and should report the death to the coroner.

Application of the 'Either/Or Rule'

6.25 If the registrar is satisfied that the certificate is 'valid', s/he must then consider whether it is 'acceptable'. The registrar will check to see if the doctor has recorded that s/he saw the deceased within 14 days before death or has seen the body after death. The registrar is not required to check with the informant when the certifying doctor last saw the deceased. In this, as in other matters, the registrar is dependent on the word of the doctor. If the doctor has stated that s/he has seen the deceased's body after death but had not seen the deceased for, say, several months before death, the registrar may wonder whether the doctor is sufficiently certain of the cause of death. There is no official guidance available to a registrar on this issue.

The 'Spearing Box'

6.26 Next, the registrar will look at the 'Spearing box' where the doctor should state whether s/he has any reason to believe that the death was or might have been caused by the employment followed at some time by the deceased. When that box has been ticked, the death must be reported to the coroner, if that has not already been done. Several registrars told the Inquiry that doctors frequently fail to tick this box when it would obviously have been appropriate for them to do so. As the registrar has to ask the informant about the deceased's former occupation, there is an opportunity to discover whether the death might have resulted from exposure to an industrial hazard. Questions about pensions may also lead to relevant information being given. Mr Christopher Dorries and Mr John Pollard, HM Coroners for South Yorkshire (West) and Greater Manchester South respectively, said that, in their experience, the most common reason for a registrar to report a death to the coroner was the discovery of a possible connection between the deceased's former occupation and the cause of death. Some registrars, on seeing a death from lung disease (particularly lung cancer) make a practice of asking questions designed to discover whether the death might have been occupational in origin. However, it does not seem that the practice is universal.

Scrutiny of the Cause of Death

6.27 The registrar will then examine the cause of death. It is this process which gives rise to the registrar's main difficulty. Registrars have no medical training. Some registrars told the Inquiry that they felt ill equipped to undertake this task and thought that it should be undertaken by someone with a medical qualification.

6.28 Various difficulties arise. Sometimes, the problem is only that the doctor's writing is difficult to read. Sometimes, the registrar is not familiar with, and does not understand, the medical terminology used in stating the cause of death. Not having any medical training, the registrar is seeking to 'recognise' the terms used by the doctor to describe the cause of death, but will frequently not understand them. Experienced registrars become familiar with the most common causes of death but, from time to time, the registrar is faced with a cause of death of which s/he has never heard. It has not been thought practicable to provide registrars with a list of acceptable causes of death. I can understand why. The list of possibilities would be almost endless. If in difficulty, the registrar might telephone the doctor to ask what the cause of death means. But s/he might hesitate to do so for a variety of reasons. In any event, s/he cannot assess the validity or reliability of the answer. Alternatively, the registrar might telephone the GRO advice line. Depending on the experience of the individuals concerned, a member of the GRO staff might have a wider knowledge of medical terminology than the registrar. However, like the registrars, the GRO staff are not medically qualified. The evidence strongly suggests that they do not often refer queries from registrars to one of the medical epidemiologists employed by the ONS. This situation is not satisfactory and it would be manifestly better for the scrutiny of the cause of death to be carried out by someone who understands the terminology employed and has immediate access to medical expertise, if required.

6.29 The GRO issues guidance to registrars about causes of death that, if they appear on the MCCD, should be reported to the coroner. For example, the Handbook for Registration Officers states that tetanus is almost always the result of an injury and, when it appears on the MCCD, should be reported. Registrars are also advised that blood poisoning and septicaemia should be reported if they appear alone on the MCCD and if they appear in association with an injury. The Handbook also advises that modes of dying do not, on their own, positively identify a cause of death. If all the information recorded in Part I of the cause of death takes the form of a mode of dying, rather than a cause of death, the death should be regarded as one where the cause is not known and should be reported to the coroner. Examples of statements implying a mode of dying include 'respiratory arrest', 'respiratory failure', 'cardiac arrest' and similar expressions. If, however, the mode of dying is supported by a cause of death that would not of itself be reportable, that is acceptable. For example, 'cardiac arrest' in Part I(a), without more, would not be acceptable. However, if the immediate cause were given as I(a) cardiac arrest due to I(b) myocardial infarction and I(c) ischaemic heart disease, the MCCD would be acceptable. Sometimes, a doctor will place the diseases or conditions causing death in the wrong order, for example with the immediate cause at I(c) instead of at I(a). An experienced registrar will learn to recognise this and will see that the certificate does not make 'medical sense'.

6.30 Since 1985, 'old age' has been acceptable to the registration service as the sole cause of death, provided that the deceased was aged 70 or over. The Inquiry was told that the decision to accept 'old age' was made because it was thought that conditions such as 'bronchopneumonia' were being used by certifying doctors in order to avoid referrals to the coroner in cases where frail and elderly persons died without having any specific

disease diagnosed or treated. Until 1996, the guidance to certifying doctors about the use of 'old age' was as follows:

> **'In some elderly persons, there may be no specific condition identified as the patient gradually fails. If such circumstances gradually lead to deterioration and ultimate death, 'old age' or 'senility' is perfectly acceptable as the sole cause of death for persons aged 70 and over.'**

6.31 This guidance is closer to, although not as stringent as, the criteria which Dr John Grenville, a general practitioner, advised the Inquiry should be applied before a doctor could properly certify a death as being due to 'old age'. In his oral evidence, given during Phase One of the Inquiry, Dr Grenville said:

> **'It** [*old age*] **is an appropriate thing to put where an elderly patient has been suffering for some time with generalised degenerative disease involving several organs, the elderly patient has been ill for a significant period of time, usually weeks or months, with multiple organ failure and the death is fully expected. It may be difficult in those circumstances to determine exactly which organ it was that ultimately failed and brought about the death. So, in that situation, the diagnosis of old age or senility is acceptable.'**

6.32 The description given by Dr Grenville amounts, in effect, to a positive diagnosis of 'old age' as the cause of death, not merely a default cause to be used in the absence of any other possibility.

6.33 In 1996, the guidance to certifying doctors was amended under the supervision of the Deputy Chief Medical Statistician and the ONS Death Certification Supervisory Group to state:

> **'... do 'not' use 'old age' or 'senility' as the *only* cause of death in Part I unless a more specific cause of death cannot be given and the deceased was aged 70 or over'**.

6.34 The references to gradual failure and deterioration, which appeared in the earlier guidance, were not reproduced in the later version. In my view, the effect of the more recent guidance is this. If a doctor does not know the cause of a patient's death but is confident that the death was natural, s/he can certify that the death was due to 'old age', provided that the patient was 70 or over. The average life expectancy in England and Wales is now about 75 years for men and 80 for women. About two-thirds of male deaths and four-fifths of female deaths occur at age 70 or over. There is, therefore, a general feeling that 70 is very young to be certified as having died of 'old age'. The ONS shares this view. Its response to the Inquiry's Discussion Paper said that the reason the age limit was not changed when the guidance was last up-dated was that **'it was considered impractical to ensure that a revised age limit would be made widely known'**. Not surprisingly, some registrars are unhappy about the use of 'old age' as the sole cause of death, fearing that it may be a cover for the fact that the doctor does not really know the cause of death.

6.35 In practice, however, if a doctor certifies the death as being due to ‘old age’ and if the deceased person is 70 or over, the registrar is virtually bound to accept the MCCD. The deceased’s age is the only objective measure of the acceptability of ‘old age’ available to the registrar. He or she will in general have no information about any other medical condition(s) from which the deceased might have suffered and which might have caused the death. The registrar is left to rely on the doctor’s integrity and judgement as to whether ‘old age’ is appropriate in the particular case. The registrar is not required to ask questions designed to check on the validity of a cause of death given by a doctor. In practice, it appears that some registrars do ask such questions and, if they discover anything that suggests to them that ‘old age’ is not appropriate (e.g. that the deceased person was suffering from other conditions which might have caused the death), they will refer the death to the coroner. However, it is clear from the evidence given to the Inquiry that many registrars feel that such enquiries fall beyond their remit. One registrar told the Inquiry that, if the family told her that the deceased person had been up and about the week before being certified as dying of ‘old age’, she would not report the death to the coroner. She would advise the relatives to speak to the doctor if they had concerns and would then proceed to register the death. So far as she was concerned, she would have a viable MCCD with no reason to delay registration.

6.36 It is clear that, where a doctor gives ‘old age’ as the only cause of death in a person of 70 or over, the death is likely to be registered, and a disposal certificate issued, without any enquiry as to whether the deceased suffered the kind of gradual deterioration and decline that would warrant a diagnosis that death was caused by ‘old age’.

Reports to the Coroner

The Incidence of Reporting by Registrars

6.37 Although the registrar is under a duty to report to the coroner any death falling within the provisions of regulation 41, the number of cases in which a registrar makes a report is in fact limited. Most reportable cases have already been reported to the coroner by a doctor before they reach the registrar. Cases reported by a doctor will not usually come to the registrar until the coroner has considered the matter and issued a Form 100A, a Form 100B or a Form 99.

6.38 Another reason why the registrar makes very few reports to the coroner is that s/he has only a very limited opportunity to learn information that might result in the realisation that the death is reportable. As I have said, the registrars told me that they are not required to ask questions about the circumstances of the death. Both Mr Dorries and Mr Michael Burgess (HM Coroner for Surrey), believe that registrars do ask probing questions. Another coroner who provided evidence to the Inquiry spoke of families being questioned by the registrar, apparently with a view to eliciting any concerns they may have about the death. It may be that there is some misunderstanding of the extent of the registrars’ role. It may be that practice varies from place to place. However, I have the impression that, in general, very few questions are asked by registrars, other than those directly required by the process of registration. It is a remarkable anomaly within the present system that the only person who is under a statutory duty to report a death to the coroner (except for those

with a responsibility for persons who die in custody, to whom special requirements apply) has so little opportunity to investigate its circumstances and no training to equip him/her to do so.

Formal Reports

6.39 As I have said, regulation 41 requires a registrar to report deaths to the coroner on an approved form. That form is Form 52. An example of the form appears at Appendix C. The form requires the registrar to record the date and place of death, some details about the deceased, the cause of death (as given on the MCCD), the name of the certifying medical practitioner and the reason for reporting the death. Having completed and despatched the form, the registrar retains the counterfoil, on which s/he should record the date and place of death, the deceased's details, the cause of death, the name of the coroner to whom the death was reported and the date when it was reported. There is also space to record the date when the registrar received one of the various forms (e.g. Forms 100A, 100B or 99), advising him/her of the result of the coroner's enquiries.

6.40 Mrs Jane West, registrar for the Boston district and Training Officer for the Lincolnshire registration service, explained that there were a number of advantages in using Form 52 when making a report to the coroner. First, the counterfoil provides a written record of the report which the registrar can retain. This would be valuable in the event that any question were raised in the future about the registration of the death, or the validity of the MCCD upon which the registration was based.

6.41 Second, Mrs West said that receipt of a Form 52 means that the coroner's office has to respond to the report in some way, even if it is only to inform the registrar that no further action is to be taken and no form (i.e. no Form 100A or Form 100B) will be issued. When a registrar reports a death to the coroner, s/he expects to receive one of those forms, indicating that, after considering the death (and in the case of Form 100B holding an autopsy), the coroner has decided that no inquest is necessary. Alternatively, s/he would expect to receive a Form 99, signifying that an inquest has been held. The forms provide confirmation that the coroner's investigation has been completed and that the registrar is at liberty to register. The coroner has a legal obligation to send to the registrar Form 100B and Form 99 in the appropriate circumstances. However, no such duty exists in relation to Form 100A. Most coroners recognise the uncertainty in which the registrar is placed if s/he receives no documentation relating to a reported death and no notification of what decision has been taken in relation to the death. Such coroners, if they do not intend to order an autopsy, will send a Form 100A. However, Miss Lloyd told the Inquiry that she was aware that there were coroners who would never issue a Form 100A on the basis that they have no statutory duty to do so. She reported that this was less of a problem than it had been in the past, since there appeared to be a growing awareness that this type of inflexibility was inappropriate.

6.42 The third potential advantage of the Form 52 is that, if there are several conditions specified in the cause of death at Part I(a), (b) and (c) and Part II, it can be easier to understand them if they are seen in writing, in the order they appear on the MCCD, rather than relayed over the telephone. Mrs West's personal practice is to photocopy the MCCD

and send it to the coroner with Form 52. She always uses Form 52 when reporting a death to the coroner. Some coroners insist that Form 52 be used whenever a registrar reports a death to them. Mr Dorries does not require a Form 52 in all cases, but requests registrars to send him a copy of the MCCD. If the MCCD has been poorly completed, that enables him to take up the matter with the doctor concerned or, if the certifier is a hospital doctor, with one of his/her seniors. Miss Lloyd told the Inquiry that there were districts where the coroner makes it clear to registrars that s/he prefers telephone referrals and does not welcome reports by way of Form 52. Mrs West observed that that had been the case in her district in the past. However, the registrars insisted on reporting deaths by means of the correct procedure and that has now been accepted by the coroner's office.

Informal Reports

6.43 In some areas, however, registrars do not habitually use Form 52 when making a report to the coroner. Mr John Pollard told the Inquiry that, during 2001, his office had received a total of only 14 reports of deaths referred by way of Form 52 by registrars at the three register offices in his district. He was not able to say what proportion of the total deaths reported to him was reported by registrars. He could only say that it was a very small proportion. However, the evidence available to the Inquiry would suggest that the total number of deaths reported in a year by registrars at the three register offices would be significantly more than 14. Mr Burgess said that he received very few Forms 52. He estimated that he receives less than one a week from four register offices. He assumed that registrars preferred to use the telephone. Before attending to give evidence to the Inquiry, Mrs West carried out a survey of the Forms 52 issued by her. For some years, they have averaged one a month. It may be that, as well as adopting the practice of making all reports by means of Form 52, Mrs West is also more ready to report deaths to the coroner than are the registrars in South Manchester. There was also evidence that the frequency with which registrars report by using Form 52 has increased recently. The Tameside registrars have now adopted the practice of making all their reports to the coroner by means of a Form 52.

6.44 The fact that some registrars have not in the past habitually used Form 52 when making a report to the coroner may be because of the preference of staff at the coroner's office. It may be because the registrars themselves prefer to adopt the less formal procedure of telephoning the coroner's office to report a death. The perceived justification for this informality is speed. If the need to report a case to the coroner arises during the registration process, the informant (and, possibly, other members of the deceased's family) is already at the register office. Registrars are naturally anxious to avoid any delay in the registration process. They do not wish to distress or inconvenience the bereaved family. This is understandable and commendable. However, the effects of this informality are often undesirable and result in further loss of rigour in a system that is not inherently very rigorous. In any event, no time (save the very few minutes required to complete Form 52) need be lost in sending a Form 52 to the coroner's office. Mrs West's practice is to fax a copy to the coroner's office immediately and follow it up with a paper copy afterwards. A Form 52 could also be sent electronically, provided the necessary technology is available.

6.45 A registrar who telephones the coroner's office, saying that the MCCD which has been presented to him/her is or might not be acceptable, will sometimes be told by the coroner's officer that the coroner will not take over the case and will not issue a Form 100A. In that event, the registrar has little option but to proceed to register the death. Sometimes, registrars are made to feel that they are making a fuss about nothing. The outcome seems to depend on who is the stronger personality, the registrar or the coroner's officer. Such a conversation might well go unrecorded; it is likely to be treated as an informal request for 'advice'. If a more formal method of reporting were adopted, such informal conversations would not take place. Then if, as sometimes happens, the coroner (or the coroner's officer on his/her behalf) declines to accept jurisdiction, leaving the registrar no option but to accept the MCCD and register the death, at least there would have to be a record of the decision.

Conclusions

6.46 The registrar's role is essentially administrative. He or she is required to record details of births, marriages and deaths. The information recorded by registrars forms the basis of an important public record and is widely used for statistical and research purposes. It is vital that it is recorded meticulously and accurately. The main function of registrars is to ensure that that is done. Most of the information with which they are concerned is taken from members of the family affected by the registration concerned. Registrars also have the task of guiding members of the public through the formalities associated with the most important of all life events.

6.47 In the case of the registration of a death, registrars are also required to carry out a function of a completely different nature. They have to scrutinise a certificate written by a doctor and assess, insofar as they are able, whether it provides an acceptable medical explanation for the death. They have to be alert to circumstances that might be mentioned in, or evident from, the MCCD and which might make a report to the coroner appropriate. They have to do this with no background of medical knowledge, no training in the skills needed to question members of the public so as to elicit the correct information and no clear direction as to whether they should be doing this or not. All the while, they are conscious of their lack of medical knowledge and of the consequent difficulty of questioning the judgement of the certifying doctor.

6.48 My main concern is that registrars are not trained or equipped to provide the only form of scrutiny applied to MCCDs issued by medical practitioners. Unless they are encouraged to question the informant about the circumstances of the death, they cannot form any view as to whether the death ought to be reported to the coroner. Even if they do ask relevant questions (as, I believe, some do), they have not been trained in the enquiries which they should make. Nor are they in a position properly to evaluate the replies that they receive. Without medical expertise, they cannot effectively consider the cause of death given by the doctor. This is a not a criticism of the registrars, but of the system that imposes a statutory duty upon them, while not equipping them to fulfil it. In future, any information about cause of death provided by a doctor should be scrutinised by a person with a medical qualification, or at least someone with special training in medical matters and ready access to expert medical advice. That person should also have the opportunity to

cross-check the essential facts with a relative of the deceased or someone with knowledge of the circumstances of the death. In my view, the task of scrutinising the cause of death should no longer be that of the registrars. Theirs should be a purely administrative function.

6.49 One of the real problems created by the present arrangements is that the registrar is put in the position of having to make a 'snap' judgement. He or she sees the MCCD only when the informant arrives at the office. There is no opportunity to reflect on it. The informant expects to be able to register the death. The registrar is then under pressure, knowing that any delay will cause distress. The fact that the MCCD contains very little information means that the family may well give some additional, unexpected information in the course of a registration. That may cause a problem that the registrar will have to attempt to resolve there and then. If the person assessing the validity and acceptability of the certificate were able to consider its contents in advance of the face to face meeting, with the benefit of a great deal more information and medical advice on hand, there would be far greater opportunity to make a considered judgement. Moreover, the family could be prepared for any problems that might arise. Any such problems could then be resolved without the extreme pressure of time that characterises the present arrangements.

6.50 In the course of the Stage Two hearings, the Inquiry heard a considerable amount of evidence about practice at the Tameside register office. This was necessary, because it was there that the deaths of virtually all Shipman's patients were registered. The evidence showed that there were some practices in force at the Tameside register office that contrasted unfavourably with those operated, for example, in register offices in Lincolnshire, about which Mrs West gave evidence. I shall discuss those practices in Chapter Fourteen of this Report. Recent correspondence from the GRO has confirmed what I had believed to be the case, namely that the departures from best practice about which the Inquiry has heard are not confined to Tameside. Indeed, such is the concern of officials at the GRO about variations in practice throughout the country that, following a meeting with Home Office officials, they have written to all registrars and coroners, giving guidance about good practice in relation to a number of matters (including the need to use Form 52 whenever a report to the coroner is made) that have been explored in the course of evidence given to the Inquiry.

6.51 It is not surprising that variations in practice in different areas have grown up over the years. The uneven training provision and the relative isolation in which some registrars work make such variations virtually inevitable. Furthermore, as I shall discuss in due course, practice within coroners' offices is similarly variable, for similar reasons. The differing relationships between staff at local register offices and coroner's offices must also be a factor that has encouraged variations in practice to develop and flourish.

Future Changes to the Registration Process

6.52 In January 2002, following public consultation, the Government published a White Paper entitled 'Civil Registration: Vital Change. Birth Marriage and Death Registration in the 21st Century'. The document contains a number of important proposals for change.

6.53 It is proposed that responsibility for registration should be transferred entirely to local authorities. Registration officers would become employees of local authorities. Local authorities would have responsibility for their training, although the Registrar General would continue to provide some technical training, mainly via computer assisted learning, as at present. Services would be tailored to meet local needs.

6.54 It is also proposed that individuals would be able, on production of the appropriate evidence of identity, to register deaths remotely via the Internet or by telephone. There is no proposal at present to remove the option of registering in person. The document suggests that:

> **'... the giving of information to the registrar about a death is much more than a legal duty. It forms an integral part of the grieving process. A registrar is perceived as the person who can provide advice, reassurance and information at a time of great sadness.'**

However, it seems inevitable that the number of face to face registrations will reduce over time with the introduction of the new arrangements.

6.55 The facility for remote registration of deaths will be dependent on the introduction of electronic data exchange between doctors, coroners and registrars. This will enable information about cause of death, coroner's certificates and other documents to be transmitted electronically. Although the development and installation of the information technology necessary to put the proposals into practice will take some time, it seems likely that, within a few years, the system of registration of deaths in England and Wales will be very different from that which it is now. It may well be that, in time, the practice of personal attendance by the deceased's family to register a death will disappear altogether.

6.56 In the long term, it is proposed that death information will be capable of being viewed electronically, thus removing the need for a paper death certificate. The record of death registration would form part of a 'through life' record, which would link records of births, marriages and deaths. Access to 'through life' records would be restricted.

6.57 Historic records, i.e. those more than a hundred years old, would be open and fully available to the public. In the case of records less than a hundred years old, information such as addresses, occupations and cause of death would be treated as confidential and would not be released into the public domain. Access to such information would be available only to the deceased's family, those who were granted permission by the family and those agencies having legally prescribed access. There would be an additional form of death certificate, which would be acceptable for most administrative purposes. Such a certificate would omit the cause of death.

6.58 The document does not explain how, when dealing with remote registration, registrars would comply with their duty to report certain categories of death to the coroner. If regulation 41 were to remain in force, they would presumably continue to make such reports if there appeared reason to do so from the contents of the MCCD and any other information provided by the informant. In reality, however, their opportunity to identify the circumstances making a death reportable would be limited. I have already described the difficulties that registrars have in identifying those deaths that should be reported to the

coroner under the current system. The proposals for change, with the consequent advent of on-line and telephone registration, would compound those difficulties. This confirms my view that registrars should be relieved of their duties under regulation 41. In the future, their function in relation to the registration of deaths, as with other aspects of their work, should be purely administrative.