# RECOMMENDATIONS

## The Future of the Coronial System

1. The coronial system should be retained, but in a form entirely different from at present. There must be radical reform and a complete break with the past, as to organisation, philosophy, sense of purpose and mode of operation. (paragraphs 19.10–19.12)

## The Aim and Purposes of the New Coroner Service

2. The aim of the new Coroner Service should be to provide an independent, cohesive system of death investigation and certification, readily accessible to and understood by the public. It should seek to establish the cause of every death and to record the formal details accurately, for the purposes of registration and the collection of mortality statistics. It should seek to meet the needs and expectations of the bereaved. Its procedures should be designed to detect cases of homicide, medical error and neglect. It should provide a thorough and open investigation of all deaths giving rise to public concern. It should ensure that the knowledge gained from death investigation is applied for the prevention of avoidable death and injury in the future. (paragraphs 19.13–19.14)

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

3. The Coroner Service should provide leadership, training and guidance for coroners, with the aim of achieving consistency of practice and a high quality of service throughout the country. (paragraph 19.15)

4. The Coroner Service requires medical, legal and investigative expertise. (paragraph 19.16)

5. Many of the functions currently carried out by coroners (who, in the main, have a legal qualification only) require the exercise of medical judgement. Some of those functions (and others which I am recommending) require legal expertise. In the future, those functions should be carried out respectively by a medical coroner and a judicial coroner. Both the medical and judicial coroners should be independent office-holders under the Crown. (paragraphs 19.17–19.19)

6. The Coroner Service should have a corps of trained investigators, who would be the mainstays of the new system. The coroner's investigator would replace the coroner's officer but have a greatly enhanced role. More routine functions, at present performed by coroner's officers, would be performed instead by administrative staff. (paragraph 19.20)

## Structure and Organisation of the Coroner Service

### Central Organisation

7. The Coroner Service must be, and must be seen to be, independent of Government and of all other sectional interests. It should not be administered, therefore, from within a Government Department. Instead, it should be a body at 'arm's length' from Government,

that is an Executive Non-Departmental Public Body (ENDPB). Such bodies are formed in association with, but are independent of, the Government Department through which they are answerable to Parliament. Ideally, the Coroner Service should be associated with both the Department for Constitutional Affairs and the Department of Health (in Wales, the National Health Service Wales Department of the National Assembly for Wales).
(paragraphs 19.21–19.25)

8. The Coroner Service should be governed by a Board. Among the Board's responsibilities would be the formulation of policy, the strategic direction of the Service and the promotion of public education about such matters as the work of the Coroner Service and bereavement services. Three of the members of the Board would be the Chief Judicial Coroner, the Chief Medical Coroner and the Chief Coroner's Investigator, each of whom would be responsible for leading his/her respective branch of the Service.
(paragraphs 19.26–19.30)

9. The Service should also have an Advisory Council, the function of which would be to provide policy advice on all issues. (paragraph 19.31)

### Regional and District Organisation

10. The Coroner Service should be administered through a regional and district structure, with a regional medical coroner and at least one judicial coroner assigned to each region. There might also be a regional investigator. There would be ten regions in England and Wales, coinciding with the ten administrative regions. (paragraph 19.32)

11. Each region should be divided into between three and seven districts, each with a population of about a million. Each district office would have a medical coroner, one (possibly more than one) deputy medical coroner (who might work part-time), a team of coroner's investigators and a small administrative staff. The staff would operate a service outside the usual office hours. (paragraph 19.34)

12. The Coroner Service should have jurisdiction over every death that occurs in England and Wales and over every dead body brought within the boundaries. Jurisdiction should not depend upon a report being made or upon the need for an inquest. A death should be investigated in the district office most convenient in all the circumstances.
(paragraph 19.32)

## Death Certification

13. There should be one system of death certification applicable to all deaths, whether the death is to be followed by burial or cremation. (paragraph 19.36)

14. There should be a requirement that the fact that a death has occurred should be confirmed and certified. (paragraph 19.41)

### The New Forms

15. The basis for the certification system would be the completion of two forms. The first (Form 1) would provide an official record of the fact and circumstances of death. It would be

completed by the person (a doctor, an accredited nurse or paramedic or a trained and accredited coroner's investigator) who had confirmed the fact that death had occurred. The second form (Form 2) would be completed by the doctor who had treated the deceased person during the last illness or, if no doctor had treated the deceased in the recent past, by the deceased's usual medical practitioner. Form 2 would contain a brief summary of the deceased person's recent medical history and the chain of events leading to death. The doctor completing the form would have the option of expressing an opinion as to the cause of death. To be eligible to complete Form 2, a doctor should be registered in the UK and have been in practice for four years since qualification.

(paragraphs 19.40–19.48)

**The Duties of Doctors**

16. A statutory duty to complete Form 2 should be imposed:

- in the case of a death occurring in hospital, upon the consultant responsible for the care of the deceased at the time of the death. The duty would be satisfied if the form were completed by a suitably qualified member of the consultant's clinical team or firm; and
- in the case of a death occurring other than in a hospital, upon the general practitioner with whom the deceased had been registered. The duty would be satisfied if the form were completed by another principal in the practice. If, in the future, patients were to be registered with a general practice (rather than an individual general practitioner), the statutory duty would lie upon all principals in the practice until fulfilled by one of them. (paragraph 19.49)

17. The General Medical Council should impose upon doctors a professional duty to co-operate with the death certification system, requiring them to provide an opinion as to the cause of death on Form 2 in cases where it is appropriate to do so. A failure to co-operate should be a disciplinary matter. (paragraph 19.51)

**The Role of the Coroner Service**

18. All deaths should be reported to the Coroner Service, which would take responsibility for certification of the death and for deciding whether further investigation was necessary. Deaths where the doctor completing Form 2 had expressed an opinion as to the cause of death would be considered for certification by a coroner's investigator after consultation with the deceased's family. All other deaths would go for further investigation by the medical coroner. (paragraphs 19.58–19.65)

19. The Coroner Service would take primary responsibility for all post-death procedures. It would relieve other agencies of some of the responsibilities that they presently carry in connection with those procedures. (paragraphs 19.66–19.69)

**Random and Targeted Checks**

20. A proportion of all deaths certified by a coroner's investigator on the basis of the opinion of the Form 2 doctor should be selected randomly for fuller investigation at the discretion of the medical coroner. This process of random investigations would itself be the subject

of audit. In addition, the Coroner Service should have the power to undertake targeted investigations, both prospective and retrospective. (paragraphs 19.70–19.73)

## Registration

21. A new certificate of cause of death should be designed for completion by a coroner's investigator or, where an investigation has been undertaken, by the medical coroner. If, in the future, it becomes possible to register a death on-line, registration could on many occasions be effected by the informant (with assistance) direct from the district coroner's office. (paragraphs 19.79–19.81)

## Further Investigation

### Criteria for Investigation

22. Coroner's investigators should be trained to recognise the type of circumstances which make it appropriate for a death to be investigated by the medical coroner. The guidance given to investigators should permit flexibility and should be kept under constant review. (paragraphs 19.83–19.86)

### The End Product of Further Investigation

23. In general, there should be an inquest only in a case in which the public interest requires a public investigation for reasons connected with the facts and circumstances of the individual case. There should be a few quite narrow categories in which an inquest would be mandatory. Otherwise, the decision whether the public interest required an inquest would be for the judicial coroner and would be subject to appeal. I agree with many of the views expressed in the recent Report of the Coroners Review relating to the outcome, scope and conduct of inquests. (paragraph 19.87)

24. In other cases, the product of the further investigation of a death would be a report (written by the medical or judicial coroner, occasionally by them both jointly) explaining how and why the deceased died. The report should be primarily for the benefit of the family of the deceased person, but should also be provided to any party or public body with a proper interest in its receipt. (paragraph 19.88)

25. Any recommendation made by a judicial or medical coroner, whether in the course of an inquest or a written report, should be submitted to the Chief Coroners. If they ratified it, they would then be responsible for taking it forward at a high level, first by submitting it to the appropriate body and then by pursuing that body until a satisfactory response had been received and action taken. (paragraph 19.91)

### Procedures for Investigation

26. The framework for the investigative procedures to be followed once a death had been identified as requiring investigation would be for the Board of the Coroner Service to determine. In any individual case, the course to be followed would be a matter for the individual medical or judicial coroner to decide. (paragraph 19.92)

**The Necessary Powers**

27. The judicial coroner should be given powers to order entry and search of premises and seizure of property and documents relevant to a death investigation. The medical coroner should be given powers to order the seizure of medical records and drugs. The judicial coroner should hear appeals from decisions of the medical coroner in relation to those powers of seizure. (paragraph 19.95)

**Investigation of the Medical Cause of Death**

28. In cases where the medical cause of death is to be investigated, there should not be an automatic resort to autopsy. The medical coroner, who would have responsibility for establishing the cause of death, would have a variety of investigative tools at his/her disposal. If the medical coroner were considering ordering an autopsy, the family of the deceased person would be informed and an explanation of why the autopsy was considered necessary would be given to them. There should be an opportunity for family members to advance objections. If the medical coroner were to decide nevertheless that an autopsy was necessary, the family should have a right to appeal the decision to the judicial coroner. In a case where the medical coroner concludes that the cause of death has been established and no further investigation is required, but the family is of the view that there should be an autopsy, there should be a right to make representations to the medical coroner and to appeal to the judicial coroner. (paragraphs 19.96–19.97)

29. In general, the medical coroner should seek to establish the cause of death to a high degree of confidence. However, in an appropriate case, it should be open to a medical coroner, provided that s/he has satisfied him/herself that there is no other reason why the death should be investigated further, to certify the cause of death on the balance of probabilities. In some cases, it might be appropriate for the medical coroner to certify that the death was due to 'unascertained natural disease process'. However, such a cause should not be certified without toxicological screening of a blood or urine sample. The medical coroner should be permitted, in an appropriate case, to certify that a death was due to 'old age'. (paragraphs 19.98–19.100)

30. Disposal of the body of a deceased person whose death is being investigated by the Coroner Service should be permitted as soon as the body has been identified and a decision has been taken that it will not be required for further investigations. If the medical coroner is satisfied that the cause of death is known, but the investigation into the death is not yet complete in other respects, s/he should inform the family and the register office of that cause of death. If there remains any uncertainty about the cause of death, and that uncertainty cannot be resolved until the circumstances have been fully investigated, the medical coroner should, where possible, provide the register office with a provisional cause of death. (paragraph 19.102).

**Investigation by the Judicial Coroner**

31. Judicial coroners who have to conduct inquests should be relieved of the day-to-day responsibility for the pre-inquest investigation. They should direct the investigation, but responsibility for the collection of evidence should devolve onto a legally qualified person

in the regional office. The judicial coroner should also have the assistance of that person or, in the more complex cases, counsel to the inquest, who would present the evidence and call the witnesses. (paragraph 19.105)

**Criminal Cases and Deaths Investigated by Other Agencies**

32. If criminal proceedings have been commenced, there should be no need for an inquest to be opened and adjourned, as is the present practice. If the proceedings resulted in a conviction, the medical coroner would usually need to do no more than write a report recording the fact of the conviction, the cause of death and the brief circumstances of the death. In a rare case, a public interest issue might arise, in which case an inquest would be appropriate. If the proceedings led to acquittal, the death would be referred to the judicial coroner for inquest. (paragraph 19.106)

33. If any other agency (such as the Health and Safety Executive) were to investigate a death, the medical coroner would take no action, other than that necessary to establish the cause of death. When the other agency's investigation was complete, its report, together with the result of the medical coroner's investigation into the cause of death, would be sent to the judicial coroner. The judicial coroner would then decide whether any further investigation was required or whether an inquest should be held. If no inquest were to be held, the judicial coroner would write a report. (paragraph 19.107)

**Deaths Arising from Medical Error or Neglect**

34. Deaths which were, or might be, caused or contributed to by medical error or neglect should be investigated by the Coroner Service. Doctors should not be treated any differently from others whose errors lead to death. At present, it appears that many cases of medical error and neglect are not reported to or investigated by coroners. The coroner's conclusions would not be determinative of civil liability. The Coroner Service should study the system of identifying and investigating cases of potential medical error being developed in Victoria, Australia, with a view to introducing something of a similar nature in this country. (paragraphs 19.108–19.109)

35. Cases of possible medical error or neglect should be investigated initially by the medical coroner. If, following that investigation, it appeared to him/her that the death might have been caused or contributed to by medical error or neglect, the case should be referred to the regional coroner's office for investigation by the regional medical coroner and judicial coroner. (paragraph 19.110)

36. Cases of medical error or neglect transferred to the regional coroner's office would be investigated under the direction of a legally qualified person. There should be a small team of coroner's investigators at every regional office who can develop expertise in medical cases. Appropriate expert opinions would be obtained. Further ideas for the investigation of more complex medical cases should be considered with a view to a proper system of investigation being devised. (paragraph 19.111)

## Pathology Services

### Autopsies

37. All autopsies should be carried out to the standards recommended by the Royal College of Pathologists in its document 'Guidelines on autopsy practice', published in September 2002. The content of a properly conducted autopsy should be formally recognised, possibly by the production of a code of practice with statutory force. Pathologists should be provided with improved background information about the deceased person's medical history and the circumstances of the death so that they can interpret their findings in context. They should be free to carry out whatever special examinations they consider necessary for the completion of a thorough and accurate autopsy report, provided that there is proper medical justification for the conduct of those examinations. (paragraph 19.119)

### Toxicology

38. Greater use should be made of toxicology in the investigation of deaths of which the cause is not immediately apparent. It should be the aim of medical coroners to move towards the use of toxicology in virtually all autopsies and in some cases where no autopsy is conducted. (paragraph 19.120)

### Partial Autopsy

39. It should be possible for a medical coroner to authorise a partial autopsy. Any limitation would have to be very clearly defined and would have to be subject to the stipulation that, if the pathologist needs to go beyond what has been authorised, in order to reach a satisfactory conclusion as to the cause of death, s/he should be free to do so. (paragraph 19.121)

### Retention of Organs and Tissues

40. Guidance on the issue of retention of organs and tissues following a coroner's autopsy will have to be provided for coroners by the Coroner Service. The medical coroner must have the power to order retention of organs and tissues if such retention is necessary for the purpose of his/her investigation. Families should have the same rights to object and appeal as in respect of an autopsy. (paragraph 19.123)

### The Provision of a Unified Pathology Service

41. There are strong arguments to suggest that the criminal justice system and the Coroner Service would both be well served by a pathology service (including both forensic pathologists and those histopathologists who conduct most coroners' autopsies) which operated under the auspices of a Special Health Authority. If such a pathology service were to establish regional 'centres of excellence', this would fit well with the Inquiry's proposal for regional coroner's offices. (paragraphs 19.124–19.125)

## A Statutory Duty to Report Concerns about a Death

42. There should be a statutory duty on any 'qualified' or 'responsible' person to report to the Coroner Service any concern relevant to the cause or circumstances of a death of which

s/he becomes aware in the course of his/her duties. The duty should be to report as soon as practicable any information relating to a death believed by that person to be true and which, if true, might amount to evidence of crime, malpractice or neglect.
(paragraph 19.126)

43. All relevant employers should encourage their employees to report any concerns relating to the cause or circumstances of a death of which they become aware in the course of their duties. Employers should ensure that such reports as are made to them are passed on to the appropriate quarter without delay and without any possibility of the reporter being subject to criticism or reprisal. (paragraph 19.127)

## Public Education

44. The Coroner Service should seek to educate the public about the functions of the Service and, at the same time, encourage members of the public to report any concerns about a death. (paragraph 19.128)

## Audit and Appeal

45. There should be systematic audit of every function of the medical and judicial coroners and their investigators, save for those relating to the correctness of the decisions reached by the coroners. (paragraphs 19.129–19.131)

46. Any decision made by a medical or judicial coroner would be subject to judicial review. However, a quicker and cheaper means of appeal should be provided, whereby decisions of the coroners that are wrong in law, plainly wrong on the facts, fail to set out the facts found or fail to give reasons for the conclusions can be set aside. The Chief Judicial Coroner should decide such appeals, if appropriate with the Chief Medical Coroner acting as medical adviser. From his/her decision, there should be a statutory right of appeal to the Divisional Court on a point of law only. (paragraph 19.132)

## Transitional Arrangements

47. In the short term, changes to existing systems should be made. In particular, the cremation certification procedures should be strengthened. A variety of steps could be taken to improve practices in coroner's offices. (paragraphs 19.134–19.140)

## The Future

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