CONTENTS

Preface . . . . . page 2

EXECUTIVE SUMMARY. . . . . page 4

Chapter 1 - AN OVERVIEW . . . . . page 5

Chapter 2 - DEATH CERTIFICATION . . . . . page 17

Chapter 3 - POST-MORTEMS. . . . . page 26

Chapter 4 - THE JUDICIAL INVESTIGATION OF DEATHS. . . . . page 32

Chapter 5 - THE PUBLIC INQUEST . . . . . page 39

Chapter 6 - SOME ISSUES OF STRUCTURE . . . . . page 49

Appendix A - Composition of the Reference Groups :

England and Wales . . . . . page 53

Northern Ireland . . . . . page 55

Appendix B - Text of our response to the Retained Organs

Commission Consultation . . . . . page 56

TERMS OF REFERENCE

In respect of England, Wales and Northern Ireland:

- To consider the most effective arrangements for identifying the deceased and for ascertaining and certifying the medical cause of death for public health and public record purposes, having regard to proposals for a system of medical examiners.

- To consider the extent to which the public interest may require deaths to be subject to further independent investigation, having regard to existing criminal and other statutory and non-statutory investigative procedures.

- To consider the qualifications and experience required, and the necessary supporting organisations and structures, for those appointed to undertake the duties for ascertaining, certifying and investigating deaths.

- To consider arrangements for the provision of post-mortem services for the investigation of deaths.

- To consider the consequences of any changes arising from the above for the registration service and the role of coroners under the Treasure Act 1996, and to consider where Departmental responsibilities for the arrangements should be located, having regard both to coherence for bereavement services and effective accountability.

MEMBERSHIP

Tom Luce, former Head of Social Care Policy Department of Health (Chair)
Mrs Elizabeth Hodder, former Deputy Chair Equal Opportunities Commission
Mrs Deirdre McAuley LLB, Citizens Advice Bureau Advisor
Professor Sir Colin Berry,
former Professor of Morbid Anatomy University of London
Anthony Heaton-Armstrong, Barrister-at-Law
Iqbal A K M Sacranie OBE, Secretary of the Muslim Council of Britain

PREFACE

In summer 2001 we were appointed by the Government to review and report on the death certification and investigation processes in England, Wales and Northern Ireland. Our full terms of reference are opposite.

Our review is financed by the Home Office and the Northern Ireland Courts Service but is independent of the Government. They have emphasised that it should be fundamental. We expect to report in March 2003.

We have been in contact with all the key professional bodies whose members work within the death certification and coroner systems - the various medical and legal organisations and the Coroners' Society for England and Wales and its counterpart in Northern Ireland.

But we have spent at least as much time in contact with voluntary bodies, support groups and private individuals with relevant experiences and perspectives. We have asked a number of the people and groups who have been especially helpful so far to join a Reference Group so that we can remain in contact with them for the remainder of our work. A separate group has been formed for Northern Ireland. Reference Group members are given in Appendix A.

Many of these contacts have been on visits to Northern Ireland, Wales and the regions in England. We have so far visited Northern Ireland three times, and have visited Wales and all the English regions. On these visits we set out to meet private individuals and families, and people working in the services at ground level - hospital doctors, general practitioners, coroners and their officers, police, pathologists, public health specialists, local support groups such as RoadPeace and Support After Murder and Manslaughter, local solicitors working in the personal injury and occupational disease fields and religious groups, for example. Each of the visits has lasted the inside of a working week, representing in all some two to three months spent in direct contact with front-line professionals, registrars, funeral directors and families, listening to their experiences and views.

We have commissioned three surveys, which are still in progress:-

- of relevant specialist literature and some professional practice issues in death certification. This is being done by the London School of Hygiene and Tropical Medicine.

- of the work coroners do and the support they have to do it, by Peter Jordan an operational researcher.

- and of public attitudes to death certification and the coroner services. This is being done by the Omnibus Survey team of the Office for National Statistics in England and Wales and by their counterpart in Northern Ireland.

The survey reports will be made available with our report, next year.

The main purpose of this consultation paper is to help our Reference Group colleagues, and the other groups and bodies whom we will continue to consult, to know the range of our review agenda and the particular questions we are addressing. That does not in any way inhibit them or others from raising other issues. Indeed one of the main purposes of this consultation is to ensure that we cover all the main points that cause people concern.

This is a consultation paper, not an interim report. It covers most issues in a summary way. Our full analysis will be made in our report which will reflect amongst other things the responses to this consultation. Where we outline specific proposals for change it is of course without commitment. The purpose is to engage people - professionals within the systems, families and private individuals - in a process of constructive comment so that they can influence our recommendations.

Responses should be sent by the 22nd of November or sooner if possible. They can be sent by e-mail to sophyosborn@coronersreview.org.uk or in writing to Sophy Osborn at The Review of Coroner Services, 100 Pall Mall, St James's, London SW1Y 5HP.

Please do not be inhibited by the wide range of issues raised in this document. We wish to hear from as many people as possible.

Elizabeth Hodder
Deirdre McAuley
Colin Berry
Anthony Heaton-Armstrong
Tom Luce (Chair)
Iqbal Sacranie

EXECUTIVE SUMMARY

Our main aims are to create new death certification and investigation systems which serve the needs of the modern public, are adaptable to change, give bereaved families better rights, and provide professional workers within the systems with better support.

Our overall diagnosis is in Chapter 1.We would like to know if people agree with it, and with the more detailed aims for future services outlined in paragraph 22 on page 15.

We look at death certification in Chapter 2. We are disposed to recommend that the present "three-tier" certification process for cremations should not continue, and suggest for consideration a new Medical Auditor Service to support doctors certifying deaths and to ensure that certification is properly and safely done. The detailed questions on which we welcome comments are listed in paragraph 46 on page 25.

Chapter 3 covers post-mortems done for coroners. The main points on which we welcome views are summarised in paragraph 61 on page 31.

Chapters 4 and 5 look at the systems for the judicial investigation of deaths, and the use of the inquest. The main proposals are to create new coronial jurisdictions for England, Wales and Northern Ireland. These would be linked into the general judicial system, and include powers for superior courts to act as appeal or review bodies and conduct a small number of exceptionally complex or contentious inquests themselves. Issues are also raised about the use of public inquests, and the outcomes and purposes of judicial death investigation. Summaries of the key points are in paragraph 72 on page 35 and in paragraphs 81-91 on pages 40-42 and paragraph 102 on page 46.

The last chapter looks at some structural issues, in particular how a new Medical Audit Service and the judicial investigation of deaths might be linked, and what public authorities should resource and account for the new arrangements.

CHAPTER 1 - AN OVERVIEW

Systems and Key People

1. When someone dies, the death is registered by the Registrar of Births, Deaths and Marriages. This registration provides a permanent public record of the individual's death and of its cause. It is legally required before the body can be buried or cremated, and before the personal representatives and family of the person who has died can settle his or her affairs[1]. Before a death can be registered the Registrar must be provided with notification of the death and a certificate of the cause of death from a doctor or the coroner. Registration is not required where the death has occurred abroad, but a certificate of no liability to register is required where the body is to be buried or cremated in England or Wales.

2. Registered deaths provide the main input to the national mortality statistics regularly published by the Office for National Statistics. These statistics are essential for the monitoring of national and local health trends. The framework within which causes of death are classified, and the approach adopted in the form on which doctors give the cause of death, comply with World Health Organisation guidelines.

3. For most deaths the doctor who provided care during the last illness gives a certificate of the medical cause of death. This is taken to the local Registrar of Births, Deaths and Marriages who issues an authority for the disposal of the body. If the body is to be buried there are no further formalities.

4. If there is to be a cremation, there are further requirements: the family or personal representative completes a cremation application, the doctor who completed the main death certificate completes a further and fuller

[1] A body can be buried but not cremated before the death is registered. This happens occasionally where a speedy burial is required for religious reasons. It is possible for some of the affairs of the deceased to be settled on the basis of an interim certificate issued by the coroner before the issue of his certificate after inquest to allow the death to be registered.

certificate, and a second doctor completes another after seeing the body and talking to the first. These completed cremation forms then go to the Medical Referee at the Crematorium who checks through them and gives, or withholds, the final approval necessary for the cremation to occur.

5. For a significant minority of deaths there is a referral to the local coroner, a locally appointed judicial official, for further investigation. Most of these referrals are made by doctors because they do not fulfil the requirements of attendance for certifying the death or because they do not know its cause. The police and the Registration Service make others.

6. When a case is referred to the coroner, he decides whether he is satisfied with the nature of the death on the basis of the facts already available, whether to arrange for a post-mortem, and/or to hold an inquest which is a public judicial hearing to find the cause of death. Following the outcome of whichever of these routes is adopted, the coroner will then give a finding of the cause of death and notify the Registrar accordingly.

7. Of the 532,500 deaths in England and Wales in 2001:-

   - 322,200 (61%) were certified by doctors without reference to coroners.

   - 202,350 (38%) were reported to coroners who then arranged post-mortems in 121,100 cases, held inquests in 25,800, and notified the Registrar that no post-mortem or inquest was necessary in 55,450.

8. 23% of all deaths in England and Wales are the subject of coroners' post-mortems and inquests are held into nearly 5%. There are significant local variations around these averages partly due to local population characteristics. In Northern Ireland post-mortem and inquest rates are significantly lower.

9. Roughly 70% of deaths in England and Wales lead to cremations. In Northern Ireland the figure is much lower at 11%.

Key People and Structures

10. The key people are:-

- The nearest *relatives* of the person who has died or, if they are not present, other people in the premises where the death has occurred.

- *Local Registrars of Births, Deaths and Marriages* who hold statutory offices, and are subject to guidance and direction by the Registrar General for England and Wales, a senior official in the Office of National Statistics. They are appointed and resourced by the Local Authority where they work. In Northern Ireland registrars are appointed by the Local Authorities but the cost of employing them is recovered from central funds. They are part of the Northern Ireland Statistical and Research Agency which is part of the Northern Ireland Department of Finance and Personnel.

- *Doctors certifying deaths* do so as a statutory duty, and not as a condition of their employment in the NHS. Certification of death is not an NHS responsibility. In a similar way, the completion of cremation certificates is treated as an independent matter for which there is no answerability to the NHS or other employer. In these as in other matters doctors are subject to regulation of their professional conduct by the General Medical Council.

- The 138 *coroners* in England and Wales are appointed by Local Authorities to 129 districts, in some but not all, cases with the agreement of the Home Office. 23 are whole-time, the remainder part-time. In addition there are a number of deputy coroners and assistant deputy coroners appointed by the coroners themselves who bring the total number up to around 375. They must have medical or legal qualifications. They are judicial officials, who hold office until retirement. Like other members of the judiciary coroners can be dismissed only by the Lord Chancellor. The 7 Northern Ireland coroners (of whom 1 is full-time), are appointed by the Lord Chancellor, and all must be legally qualified.

- The several hundred *coroners' officers* who in England and Wales support coroners are employed by the police or Local Authorities. Many are serving or retired police, but people from other professional backgrounds are increasingly found. There are none in Northern Ireland where casework for the coroners is a police responsibility.

- *Pathologists* doing post-mortems for coroners are usually employed in the NHS or by universities, although their coroners' post-mortems are separately remunerated. Like other doctors they are subject to professional regulation by the General Medical Council. Most coroners' post-mortems are done in NHS mortuaries, where the technicians and other staff are NHS employees, though some are done in local authority mortuaries. In Northern Ireland, most coroners' post-mortems are done by pathologists in the State Pathology Service, which is the responsibility of the Northern Ireland Office and is located in the Royal Victoria Hospital Belfast.

- *Funeral directors* and their staff.

- The 220 crematoria in England and Wales each have a *medical referee* and one or more deputies nominated by the cremation authority (the local authority or private company) and approved by the Home Office. In Northern Ireland there is one crematorium and the medical referee role is carried out by hospital doctors.

- A wide range of *care and bereavement staff* who may support and help families.

11. Within government, the Home Office has a general responsibility for the coroner service and the policy responsibility for death certification and cremation. Responsibility for resourcing the coroner service lies with

independent local authorities and in their decisions on individual cases coroners have judicial independence. The Home Office also provides some training for coroners. The Lord Chancellor, as well as having responsibility for coronial discipline, makes the Coroners Rules which broadly regulate the conduct of inquests and some other coronial functions. He also has a power to direct the adjournment of an inquest where a public inquiry chaired by a judge is expected to fulfil the role of the inquest. The Attorney General has a limited power to allow applications to be made to the High Court for new inquests. The Department of Health is responsible for public health and health care. Government responsibility for the Office for National Statistics lies with Treasury Ministers, although the Registrar General, as the holder of a statutory office, is answerable to the courts. In Northern Ireland the general responsibility for the coronial service lies with the Northern Ireland Courts Service, as well as the responsibility for supporting the service administratively and financially.

Fitness for Purpose

12. The certification and coroners systems are both of considerable age. The certification process had its origins in the first half of the nineteenth century and was last the subject of significant change in the 1920s. The coroner system has its roots in the early Middle Ages. The current form of the office of coroner is largely a creation of the Coroners Act of 1887.

13. A review of the systems by the Brodrick Committee between 1966 and 1971 recommended some significant changes, but few were made[2]. A report on the coroner system by the Wright Committee in 1936[3] was also largely shelved.

14. Both systems are now under serious public challenge:-

- In 2000 Harold Shipman, a doctor in general practice in Hyde, Cheshire, was convicted of murdering 15 patients. A judicial inquiry

[2] Report of the Committee on Death Certification and Coroners, November 1971
[3] Report of the Departmental Committee on Coroners, 1936

by Dame Janet Smith, a High Court Judge, convened under a resolution of both Houses of Parliament pursuant to the Tribunals of Inquiry (Evidence) Act 1921, has looked at the deaths of many more of his patients. It has found that over 23 years he unlawfully killed a total of 215 patients (including the 15 in respect of which he had already been convicted) and that there is a real suspicion that he was responsible for the deaths of 45 more[4]. Of these, 6 of the 15 cases for which he was convicted had been certificated for cremation. 166 of the 200 cases where the Inquiry gave a finding of unlawful killing had also been certificated for cremation, and so had 36 of the 45 cases where there was a real suspicion of Shipman being responsible for the deaths. Dame Janet's inquiry continues to investigate the roles of systems and institutions in the failure to prevent these crimes as well as the role of responsible individuals.

- Other inquiries into multiple deaths have raised significant issues about the role and practice of coroners. These include the Allitt inquiry following the conviction in 1992 of a hospital nurse for the murder of 4 children in her care[5], the inquiries that took place in the late 1990s following the handling of the Marchioness disaster[6], the Bristol Inquiry into deaths of children following paediatric surgery[7], and the Alder Hey Inquiry[8] into the misuse of post-mortem tissues from children who had died at the hospital, and the poor quality of the response to their parent's enquiries about what happened.

- In Northern Ireland many individuals and groups, including Human Rights groups, have expressed serious concerns about the way in which the inquest system is working. A recent review of the

[4] The Shipman Inquiry, *First Report* July 2002
[5] The Allitt Inquiry: *Inquiry into deaths and injuries on the children's ward at Grantham and Kesteven General Hospital in 1991;* published 1994
[6] *Public inquiry into the identification of victims following Major Transport Accidents* by Lord Justice Clarke, March 2001
[7] *Learning from Bristol: Report into children's heart surgery at Bristol Royal Infirmary* by Ian Kennedy, July 2001
[8] The Royal Liverpool Children's Inquiry Report by Michael Redfern QC, January 2001

Criminal Justice System there recommended an independent review into the law and practice of inquests.[9] There are particular concerns in some quarters about non availability of verdicts, and generally how the process has handled deaths related to inter community conflicts.

15. Our own review has so far attracted a considerable response from private individuals, professional bodies and voluntary support and action groups. Their input and the work we have ourselves so far done in analysing and assessing the death certification and coroner systems lead us to conclude that neither the certification nor the investigation system is "fit for purpose" in the circumstances of modern society. Both need substantial reform.

16. We reach this conclusion without any disrespect to the generality of the people who work in these fields. Our work has not shown grounds for a general lack of public confidence in their professionalism or integrity. The prevailing impression we have is of people managing to give committed, professional, and compassionate service through obsolete and neglected structures which they themselves have little responsibility for or power to improve. The aim of our work is to enable the Government to modernise the systems, and to provide the people who work in them with better support.

17. Other important reviews and developments are proceeding in parallel with our review, as well as the continued work of the Shipman Inquiry. They include that of the Retained Organs Commission which is reviewing policies, ethics and practices concerning the retention and disposal of human tissue after post-mortems, and a Home Office Review of the Forensic Pathology Service. The Department of Health and the Welsh Assembly have been reviewing the law on the retention and use of human organs and tissue and are currently seeking views on the scope and content of future legislation[10]. We are working with these reviews on issues of mutual interest. We have recently contributed to the Retained Organs Commission's consultation on proposals to improve safeguards. A copy of our response is at Appendix B.

[9] Review of the Criminal Justice System in Northern Ireland, March 2000, p.177
[10] *Human Bodies, Human Choices, the Removal, Retention and use of Human Tissue: the Law in England and Wales.* A report for consultation July 2002.

18. There has also been a Government review of the Registration Service. The White Paper *"Civil Registration: Vital Change"* of January 2002 described its outcome. Delivery of the service will remain with local authorities, but there will be national standards and a national inspectorate. It will be possible to register births and deaths by phone and on-line as well as in person. It is also intended that the registered cause of an individual death should become private information available to families and approved users and not, as now, to any member of the public who buys a certificate. This will be an important improvement in privacy. A similar review has been conducted in Northern Ireland and its findings, which are expected to be similar to those for England and Wales, will be made public shortly.

19. Also of critical importance is the evolving interpretation of Human Rights law as it affects the state's obligation to investigate deaths. Article 2 of the European Convention on Human Rights gives signatory states an obligation to protect the lives of their citizens:

> "Everyone's life shall be protected by law. No-one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law. Deprivation of life shall not be regarded as inflicted in contravention of this article when it results from the use of force which is no more than absolutely necessary:
>
> (a) in defence of any person from unlawful violence;
> (b) in order to effect a lawful arrest or to prevent escape of a person lawfully detained;
> (c) in action lawfully taken for the purpose of quelling a riot or insurrection"[11]

[11] The European Court of Human Rights set out its general principles in the case of *McKerr v. The United Kingdom (4 May 2001)*. It said there, amongst other things, that "In the light of the importance of the protection afforded by Article 2, the court must subject deprivations of life to the most careful scrutiny, taking into consideration not only the actions of state agents but also all the surrounding circumstances. Where the events in issue lie wholly, or in large part, within the exclusive knowledge of the authorities, as for example in the case of persons within their control in custody, strong presumptions of fact will arise in respect of injuries and death which occur. Indeed, the burden of proof may be regarded as resting on the authorities to provide a satisfactory and convincing explanation."

This duty has been interpreted by the courts as implying an obligation on the State in some circumstances to investigate deaths. A number of important judgements of the European Court of Human Rights and the domestic courts have significance for the style, and scope, support and type of outcome of some coroners' inquests. There are a number of relevant cases pending. We are taking independent specialist advice on these issues, which we plan to publish with our report.

Critical Systems Defects

20. At this point in our work we assess the critical defects in the death certification and investigation processes to be:-

1 **Fragmentation:** both systems are primarily built around the certification and investigation of individual deaths. They do not facilitate or require concern with patterns and trends and the public find it difficult to comprehend the links between them and the other services involved with death. The certification process is separate from the coronial process. The coroner has no information on or responsibility for deaths not reported to him. No public authority is properly tasked and resourced to see that the certification process is being properly done and that deaths which should be investigated further are appropriately referred.

2 **Lack of clear participation rights for bereaved people, and of standards and arrangements for their treatment and support.** They are largely excluded from the certification process, though not the registration process. They are not systematically or reliably given information and help about post-mortem processes or inquests. The evidence disclosure arrangements at inquests fall below modern judicial standards in openness, fairness and predictability.

3 **Lack of reliable and systematic response to minority community wishes and traditions for the disposal of the dead,** in spite of many successful local arrangements in recent years.

4 **Lack of medical skills to support and audit the death certification process.**

5 **A general lack of sustained and consistent training of coroners and their officers.**

6 **Lack of resources at coroners' inquests to deal effectively with the most complex or contentious cases; and of a clear relationship between the inquest and other statutory processes which may investigate deaths.**

7 **A general lack of quality assurance and support processes.**

8 **Lack of a clear modern legal base, and of mechanisms to monitor the effectiveness of the services and help them adapt to future change without infringing professional and judicial independence.**

21. Changes and other factors which we have identified as important include:-

- Mortality and general demographic trends. The population is forecast to continue to age, and the average age of death to rise. People are more likely, when they die, to have the complex pathologies characteristic of great age. Minority communities are also likely to account for an increasing proportion of deaths. Deaths from industrial disease are expected to increase.

- There has been a long-term trend away from dying at home, with more people dying in hospital. Many coroners say that the investigation of hospital deaths after the complex processes of modern medicine has become an increasingly important and sometimes contentious part of their work.

- The proportion of death occurring in care homes and hospices has also risen.

- Changes in general practitioners contractual terms and conditions, and the increased use of out-of-hours co-operatives and duty doctor services, have resulted in a steadily increasing proportion of deaths where the doctor who attends to confirm death is different from the doctor who would be responsible for completing the Medical Certificate of Cause of Death.

- There is concern about the investigation of the deaths of babies and very small children, from the perspectives of child protection and the support of bereaved parents.

- The grief of families at the loss of a child in young adulthood from accidents, violence or premature medical deaths from causes such as epilepsy or "Sudden Adult Death Syndrome", and the concern that preventive lessons are learnt from such premature deaths.

22. Our aim is to make recommendations which would for England, for Wales and for Northern Ireland, lead to the creation of efficient death certification and investigation services which, in the differing circumstances of each country:-

    1 Meet public safety, public health, public confidence and human rights requirements.

    2 Ensure that information on preventable deaths is made fully available and has proper influence.

3 Respect individual, community and family wishes, feelings and expectations as far as possible, including community and family preferences and traditions relating to mourning and the disposal of the dead; and as far as possible respect individual and family privacy.

4 Encourage participation by families and bereaved people in the processes of certifying and where necessary investigating deaths, treating them sensitively and with dignity and helping them find further help where this is necessary.

5 Are suitably staffed to deal with medical and legal and judicial responsibilities, and properly and consistently trained for the specific tasks of the services.

6 Have full independence and proper accountability.

7 Work to known and auditable standards.

8 Contain processes encouraging change and adaptation to future challenges.

23. *We invite comment on our overall analysis, and the suggested aims for the new services in paragraph 22.*

CHAPTER 2 - DEATH CERTIFICATION

Public Health Issues

24. We shall be pursuing various public health aspects of the certification process further when we have the report from the London School of Hygiene and Tropical Medicine project. These will include:-

- The role and essential purposes of the national and local mortality statistics built up from death certification data, alongside other mortality data, such as the Confidential Enquiry series and other series from time to time commissioned to meet specific concerns[1].

- The implications for those essential purposes of what is said to be the high (perhaps 30% or more) error rates in death certificate causes of death that have been found in various studies comparing them with findings after post-mortem examinations. Questions include how far the errors represent mistakes of diagnosis or of certification, and how far they undermine or lessen the utility of the ONS series.

- How far changes in the structure or language of the forms, or in the guidance given on their completion might be more helpful to the doctors who complete them.

Certification of Individual Deaths

25. We have identified the following issues:-

- The lack of support for and supervision of the death certification process.

- The weak role allowed to families.

- Serious doubts about the effectiveness of the three-tier cremation certification process.

[1] These are Confidential Enquiries into Maternal Deaths, Stillbirths and Deaths in Infancy, Perioperative Deaths, and Suicide and Homicide by people with mental illness. They are financed and supported by the NHS National Institute for Clinical Excellence.

- The lack of standard arrangements for verifying the fact of death, rather than certifying the cause of death.

- The possible roles of other health care professions than doctors in these processes.

Audit and Support of Death Certification;

Consultative Proposal for a new Medical Auditor Service

26. The Registration Service registers all deaths but is primarily a service of record. There is no public authority tasked and resourced to support doctors in death certification, audit the standards to which it is done, and ensure that deaths which should be referred for further investigation are being properly referred. In-service training and education on death certification may be provided in hospitals to each new generation of house officers, and the pathology departments of some large hospitals have some informal quality control function, particularly in cremation cases where they provide the second signatories. Some but not all coroners give talks to local medical groups, as do local registrars.

27. We are considering whether to recommend the creation of a new **Medical Audit Service** which might in each region or locality be responsible for:-

    1 Providing training and general support in the certification process to doctors and other health care personnel, to police, funeral directors and their staffs, and to bereavement services.

    2 Periodically assessing the certification practices of doctors, medical practices and hospitals, investigating apparent departures from the norm in patterns of certification and referral to the coroner for further investigation, and perhaps on a sample basis examining individual cases in more depth.

3 Supporting local public health interests in the identification of local mortality patterns.

4 Providing the judicial death investigation process with independent medical advice.

5 Ensuring that particular types of death, notably those in care homes, and of very young children, are given proper attention in liaison for care homes with the National Care Standards Authority (which inspects and licences care homes and some home care services) and, for the deaths of children, with the full range of child protection services (The National Care Standards Authority does not extend to Northern Ireland where separate arrangements will be needed).

28. These might be its **core general support and monitoring functions.**

29. It is for consideration whether it might also have up to three others, relating to **individual deaths**:-

1 As the first point of advice and decision in cases where the doctor who attended the patient in the last illness is unable to certify the death or uncertain whether or how to do so. The medical auditor would thus become responsible for dealing in the first instance with deaths in which there is no ground to suspect criminality, and where the main issue appears to be what natural disease caused the death, and deciding how far investigation should go to establish that. Much of the casework now handled in coroners' offices would pass to the Medical Audit Service if it were introduced with this function. Deaths apparently requiring circumstantial investigation would continue to be referred to the coroner - directly in cases where this need was obvious from the beginning; or by the medical auditor if the need became apparent to him or her.

2 Following from that, the power to decide the purpose and scope of further medical investigation, including scrutiny of existing case notes and/or ordering post-mortems.

3 Overseeing second certification and accrediting second certificants if it were decided that the existing cremation certification process should be discontinued but that all deaths should be certified by two doctors.

Cremation Certification

30. Our consultation is not complete but we have so far encountered very few people who consider the three-tier cremation certification process an effective safeguard. The cremation forms require more information on the circumstances of the death than the basic cause of death certificate but:-

1. The second doctor is either chosen by the first, or by the funeral director, so is not necessarily independent.

2. The medical referee receives the papers at a late stage, usually the day before the cremation, sometimes on the same morning. By then all the pressures are to complete the disposal arrangements.

3. A refusal to approve the cremation by the referee does not necessarily stop the disposal of the body. The family will have the Registrar's certificate authorising disposal, so unless the medical referee has alerted the coroner or the police to serious anxieties, the family can arrange for burial rather than cremation, or can even try to gain the agreement to cremation from another crematorium referee.

31. We are disposed to recommend that the existing three-tier cremation certification process should not be continued and that the fuller information on the circumstances of death at present given in the cremation forms should be incorporated in revised documentation for a new certification process which would apply to all deaths whether the body is to be buried or cremated.

One or Two Tiers of Certification

32. If this were done, there would be a choice between:

    1 Leaving the certification in the hands of one doctor, who would normally be the general practitioner or hospital doctor who had attended the individual during the last illness. This would mean relying on a general post-facto audit process of the kind outlined in paragraph 27 to ensure that the system was working properly, and that in most individual cases disposal of the body whether by cremation or burial could be authorised without any second opinion or check.

    2 Requiring a second level of certification by another doctor to ensure that proper checks were performed before there could be burial or cremation of the body.

33. There are substantial issues of professional practice, cost, practicality and public confidence involved in this choice. If the second tier were included in the process there would be a strong case for entrusting the function to doctors who were specifically contracted to and accredited by the local Medical Audit Service for performing the function and who had received appropriate training in its performance, rather than leaving the choice as now to the first certificant or the funeral director. This would ensure that the second certificant was independent of the first and should increase the prospect of scrutiny to consistent standards.

34. The functions of the second certificant might include wherever possible talking to or at the least being available to the family if they wished to give their perspective on the death.

Status of Medical Audit Service

35. If a Medical Audit Service on these lines were created, we consider that it should be provided by a public authority independent of the direct provision of health care. A key feature of the service would be the creation in each locality of a **Medical Auditor**. This office could be statutory, thus giving it clear legal status and professional independence. It would need to be given powers to obtain all medical records and other material necessary for its work; and might also be given powers and a responsibility to retain all case papers to facilitate any subsequent investigations.

36. There would need to be specific training in the legal, forensic and clinical aspects of the work, and on relations with the bereaved. There would need to be suitable statistical and public health support for the monitoring role, and for the casework responsibilities if they were included in the functions. Doctors from clinical, public health or pathology backgrounds might be considered for appointment.

37. There would need to be 365 day a year cover if the casework responsibilities were included in the service's functions and hence in each locality a roster of doctors to support and act for the medical auditor.

Particular Issues

38. Some particular points needing attention include:

- Whether the certifying doctor, or the second certificant if there are two, should see and examine the body. The cremation certification system requires the second doctor to do so, though some funeral directors say that these examinations are often very quickly done, and there are in any case those who question whether a visual examination is likely to be useful. On the other hand, it has been remarked that the United Kingdom is the only country in the world where burial can be authorised without the body being seen by a doctor[2].

[2] S. Leadbetter and B. Knight *"Anomalies and Ambiguities in the Disposal of the Dead"* article in Journal of the Royal College of Physicians of London" 1986 and in several articles since; Peter Franklin *"A Review of the Law of England and Wales Relating to Death"*, research thesis 1993; it also seems to have featured significantly in the concerns put to the Brodrick Committee by the BMA (section 5 of the *"Brodrick Report"*)

- How recently before death the attending doctor needs to have seen the patient, if certification can take place without reference to the coroner. In Northern Ireland the general rule is 28 days; the general rule in England and Wales is 14 days unless the doctor has seen the body after death. Whether or not the doctor has seen the body, though, some coroners require referral from the registrar for all deaths not attended by the certifying doctor within the last 14 days.

39. The present arrangements require families to pay doctors' fees for signing cremation certificates- the recommended fee for each certificant is £45.50 and there is a small fee payable to the medical referee. These fees total nearly £100 for each cremation, representing in England and Wales an overall cost to families of some £35 million per annum. It is conceivable that the new process could involve the payment of fees by families to meet its costs. Alternatively it might be regarded as a service akin to, and indeed a part of, the registration of deaths which in *"Civil Registration: Vital Change"* the Government says should remain free to the user. If so there would be a saving to families, but a charge on public finance.

40. We shall be assessing with particular care whether a Medical Audit Service as outlined could attract suitable doctors and could do so without damaging the development of services to living patients. We shall also be assessing the implications of negotiations for a new NHS general practitioner contract.

41. The prompt availability of the second tier of certification would need special attention, particularly in rural areas and particularly if there were a requirement to view the body. There do not appear to be serious problems of timing and availability over the present cremation arrangements, but the more substantial challenges might be in communities where the tradition is for the prompt disposal of the dead, and cremation is not practised:-

- In Northern Ireland, the tradition throughout the community is for burial within three days of death. Delays in authorising the disposal of the body would not be tolerated.

- Nor would they be acceptable to Islamic and Jewish communities who expect to inter within twenty-four hours at most, and preferably before sunset on the day of death.

These will be important issues in our further work.

Verifying the Fact of Death

42. The present statutory framework for death certification and registration covers the cause and registration of deaths but not the professional verification of the fact of death. There are significant variations of practice on this issue. Doctors are reported to be increasingly reluctant to attend to verify death in nursing homes, for example; and at scenes of accidents and in deaths in the home there can be delays while a doctor is awaited to verify death before a funeral director can be called and the body removed.

43. In some areas there are protocols under which certain specified personnel, in particular suitably qualified ambulance staff and paramedics, are able to certify the fact of death. The body can then be removed without waiting for the arrival of a doctor, and the police (if present) and the ambulance crew can move on to other urgent work.

44. Protocols to deal with the verification of death appear to have significant advantages, though they make training in recognising death and any special features at the scene of death of special importance.

45. We shall be exploring whether verification might generally be entrusted to nurses in nursing homes or in hospital, and if so under what conditions and safeguards: and whether nurses or other health care

personnel than doctors might have a role in the certification procedures, particularly, for example, in helping to document the circumstances of death. There are important contractual and liability matters to be addressed in these issues, as well as matters of suitability and policy.

46. *We welcome comment on any aspect of this section, and in particular whether:*

1 There are other issues than those listed in paragraph 25 we should be addressing.

2 There should be a Medical Audit Service with core general functions suggested in paragraph 27.

3 A Medical Audit Service should also have some or all of the casework functions suggested in paragraph 29.

4 There should continue to be a special three-tier certification system for cremations.

5 If not, should there be a "one-tier" or a "two-tier" certification system for all deaths.

6 There should be standard processes for verifying deaths.

7 The roles of health care professions other than doctors might be developed as in paragraph 44.

CHAPTER 3 - POST-MORTEMS

47. A post-mortem examination is an internal examination of a dead body to find the underlying cause of death, and to investigate the processes and events that may have contributed to the death. An alternative term is autopsy. It is performed by a pathologist. In a full post-mortem examination, the chest and abdominal cavities and the skull are opened, and the main internal organs are removed for weighing and dissection to see if abnormalities are present. The organs are then placed back into the body (although not in their original positions) and the body is closed. Tissue samples from these organs are sometimes retained for histological analysis and, in some cases, toxicology.

48. Coroners have a legal right to order a post-mortem to help them find the cause of death. The consent of the family is not required as in practice it now is for "hospital" post-mortem examinations which are carried out under the 1961 Human Tissue Act. In England and Wales coroners choose the pathologists and make their own arrangements with them for the work to be done. The majority are done in NHS mortuaries by pathologists otherwise employed by the NHS or universities but their work for the coroner is separately remunerated. The coroner is charged for the use of the NHS mortuary. Some local authorities have mortuaries of their own, though the trend in recent years has been for NHS facilities to be used. Maintaining and managing a mortuary to proper standards is a demanding specialist task and, long term, the trend towards using NHS facilities seems sensible. In Northern Ireland the publicly funded State Pathologist's Department was created in 1985 as a service to coroners. The pathologists are salaried and the coroner asks the State Pathologist's Department to carry out a post-mortem for him. This provides a structure for quality control and consistency of approach, though we have had complaints from coroners of delay in providing reports.

49. Most of the coroners we have seen say that they are generally satisfied with the pathology services they get, though there are in some places shortages, in particular of paediatric pathologists, who should be used to do post-mortems on babies and young children alongside forensic pathologists in cases where there

are circumstantial issues needing assessment. Generally, pathology is a medical specialty in serious shortage.

50. There are nevertheless some issues of quality in this field, and, because of the nature of the current arrangements the NHS does not accept responsibility for the work done by pathologists for the coroner because the work is not part of the contract with any NHS Trust. The Confidential Enquiries, for example, into maternal and peri-operative deaths make some use of post-mortem reports done for coroners and, applying standards generally applied to hospital post-mortems done for other purposes, find a significant proportion of them to be below standard.

51. One approach would be to have a contract between the coroner and a NHS Health Trust, not with the individual pathologist. The Trust could then contract with the pathologist - it would be for settlement between them whether the coroner's work was fee-remunerated as now or included within the consultant's basic NHS contract. As part of the contract the NHS would accept a normal accountability for the quality of its work, and coroners' post-mortems done by the NHS would be subject along with other NHS pathology services to inspection by the Commission for Health Improvement.

52. Whether through this or other arrangements we see a need for a properly independent audit of post-mortems carried out for coroners, through processes for which there is ultimately a public accountability. We shall be pursuing the issue accordingly, and will take account of relevant work and recommendations of the Home Office review of Forensic Pathology Services.

Scale and Purposes of Coroners Post Mortems

53. The scale of coroners' post-mortems is considerable. 23% of deaths in England and Wales lead to these post-mortems, nearly one death in four. By international standards this is a high rate. The rate is considerably lower in Scotland, and, at 9%, lower still in Northern Ireland. Moreover, post-mortem rates vary considerably amongst different coroners jurisdictions.

54. If the equivalent of the 125,000 post-mortems done every year in England were surgical procedures carried out on living people, there would long ago have been an evidence base compiled to assess the utility and justification of the scale of practice. It is a consequence of the fragmentation of the coroner system that there seems to be no such evidence base. It is not, therefore, known in how many cases the post mortem is performed to find out if the death was natural, or to find out which natural disease caused death; or in how many cases the post-mortem revealed significant and unexpected results. Anecdotally, we are told that the number of cases where a coroner's post-mortem discloses or suggests previously unsuspected foul play is very small.

55. No-one we have so far consulted objects to the coroner's power to order a post-mortem to help decide if there has been foul play or something significantly untoward about a death. There are however doubts and objections about what seems to some a routine and unfocussed resort to the post-mortem, especially where the likely result is to discover which natural disease or condition caused the death, rather than to help in the assessment of whether there has been foul play.

56. Some families are uncomfortable with the idea of dissection after death and recent concerns about organ retention after post-mortem examination have served to heighten feelings on this matter. The objections are particularly strong in some religious faiths. Jewish and Muslim people believe, with some Christians, that the body should be returned to its Creator in as perfect a state as possible, without mutilation; and in Islam there is a belief that the soul stays with the body until the funerary and mourning rites are complete, and suffers distress if the body is mistreated. In Australia there are formal arrangements whereby the family can challenge the coroner's decision to order a post-mortem examination.

57. The Jewish community in Manchester has taken the initiative to develop and finance a scheme for conducting some post-mortem examinations using MRI scans instead of pathological dissection. Some coroners are willing to refer some cases to that scheme, and the Department of Health is looking at it in a wider review of the possibilities of non-intrusive post-mortem examination.

58. There are other perspectives on the issue. The post-mortem is a recognised and proven source of knowledge on disease prevalence at death although there are no systematic processes for capturing this information from coroners' post-mortems and using it beyond the individual case. Some families have a strong urge to know what has caused the death of the family member who has died, and would like a right to request a post-mortem. In addition, the point has been made to us that it is ageist to assume that there is no point in definitively establishing the medical cause of death in old and very old people, and wrong not to give their deaths the same attention as the deaths of young people.

59. Amongst the other issues raised with us are:-

1 Suggestions that families are still not always informed that there is to be a post-mortem. They may not be informed of its timing, location or purpose, or of their right to be represented at it by a doctor of their choice or to have it done by a pathologist independent of the hospital in which the death occurred.

2 Families do not as of right see the report of the post-mortem.

3 Whether it is necessary for a post-mortem to continue after it discloses a likely cause of death, in particular whether it is necessary, for example, to open the skull and dissect the brain after discovery of abnormalities in the chest or the abdomen sufficient to explain the death.

4 The absence of toxicology tests (of blood and other bodily fluids) in many coroners' post-mortems, in particular to investigate the possibility of accidental or deliberate overdosing with medical or other drugs; and of histology tests (laboratory tests on small tissue samples), which many pathologists feel are essential for a conclusive finding.

5 Very deep and enduring distress about what seems to be vagueness in the relative responsibilities of coroners, pathologists and hospitals for ensuring that organs and other tissues are not improperly retained after the post-mortem for research or teaching purposes without the knowledge or consent of the family. On this we consider that there is need for a much clearer and stronger statutory framework, including systems to monitor compliance. The Department of Health and the Welsh Assembly are currently consulting on changes to the law. We have sent our views to the Retained Organs Commission on its earlier consultation as they appear in the letter at Appendix B.

60. Subject to views expressed in this consultation we plan to work on a recommendation for a national protocol governing the use and arrangements for post-mortems for coroners and/or "medical auditors", allowing full scope for independent professional and judicial judgement, but having legal status and produced by a publicly accountable body after consultation with expert and family interests. It would:-

1 cover all the issues raised above about the sourcing, management and quality control purpose, scope of post-mortems done for coroners and reflect the best judgement possible at any given time about the scope for non-intrusive post-mortem examinations.

2 provide that post-mortems should not be "routinely" ordered, and that wherever practically possible there should be a

focussed approach, after proper consideration of the individual's medical history and other relevant circumstances; so far as practicalities allow, the background to the case, the existing clinical and circumstantial knowledge of the case, the main uncertainties to be explored in the examination should be defined in each case and the reason for holding a post-mortem should be identified.

3 reflect a presumption that families should see the post-mortem report, and that it should be made available to the family doctor and where appropriate the hospital doctor who had attended the person in life.

4 wherever possible, give families a formal right to request that a post-mortem should be avoided or should take place, though the decision would remain with the coroner or medical auditor taken on public interest grounds. There might be a review or appeal process in cases where the family wishes to challenge the decision to have, or not to have, a post-mortem.

The protocol should be linked with the framework of principles on the retention of organs and tissues likely to emerge from the work of the Retained Organs Commission, except where there are clear public interest grounds for difference.

61. *We would welcome views on:*

1 Whether the issues we have identified on pathology for coroners / medical auditors are the right ones.

2 The issues about quality control and possible audit mechanisms in paragraphs 50-58 above.

3 Whether there should be national protocols with legal status, giving scope for professional and judicial independence in deciding on post-mortem practice in individual cases, covering the issues outlined in paragraph 60 above.

CHAPTER 4 - THE JUDICIAL INVESTIGATION OF DEATHS

62. The coroner's inquest is a public judicial hearing into a death to determine the identity of the person who has died, the date and place of death, and "how the deceased came by his death". Statutory provision for inquests and the appointment of coroners is in the Coroners Act 1988, with more detail in the subordinate Coroners' Rules of 1984. In Northern Ireland the Coroners Act (Northern Ireland) 1959 is the main act, with the Coroners (Practice and Procedure) Rules (NI) 1963 containing more detailed provisions.

63. Inquests are normally held where a body is within a coroner's local territorial jurisdiction and there is reasonable cause to suspect that there has been a violent or unnatural death, or that the person has died a sudden death of which the cause is unknown, or the person has died in prison. Deaths in hospitals for the mentally ill or whilst the deceased was in police custody are not subject to a mandatory inquest, but the Home Office has asked coroners to deal with all deaths in legal custody as if they were deaths in prison for investigation purposes. The position in Northern Ireland is different in that the relevant legislation says that the coroner "may hold an inquest" thus giving the coroner a discretion, rather than a duty, other than in the case of a death in prison where the same statutory obligation to hold an inquest with a jury applies.

64. Each coroner in England is appointed to a defined territorial jurisdiction. In Wales coroners are appointed to an all-Wales jurisdiction, but in practice they work within local jurisdictions like their English colleagues. Appointments are made by local authorities, who also meet the coroners' costs and pay his or her salary. Those in Greater London, Berkshire and the Metropolitan Counties require the approval of the Home Secretary. In Northern Ireland appointments are by the Lord Chancellor, and the service is supported and financed by the Northern Ireland Courts Service. Of the 138 coroners in England and Wales, 23 are full-time - nearly all in large cities - and the remainder part-time. In Northern Ireland the Greater Belfast coroner is full-time and the other six part-time. Coroners may be removed from office only by the Lord Chancellor.

65. In England and Wales coroners may be doctors or lawyers of at least five years' standing. The majority are lawyers. In Northern Ireland the legislation requires the appointment of lawyers. The Home Office provides two or three weekend courses a year which many coroners attend from time to time though they are not obliged to.

Apart from the basic qualifications, there is no training requirement or provision for coroners on first appointment, though the Home Office provides some induction courses.

66. Coroners appoint their own deputies and assistant deputies, with the approval of their own appointing authorities except in Northern Ireland where deputies are appointed by the Lord Chancellor. There are around 133 deputy coroners and 122 assistant deputy coroners in England and Wales. Many coroners start as assistants, often to deputy coroners who are solicitors in the same practice. On a strict interpretation of the law, deputy and assistant coroners should not undertake coronial duties except when the coroner is absent from the jurisdiction.

67. Coroners are supported in England and Wales by coroners' officers whose roles and responsibilities can vary widely between locations, but who commonly do much of the detailed investigation and preparatory work and are the normal liaison channel with bereaved families. In most places these officers are employed and paid by the local police force, though in some the local authority has this role. In Northern Ireland there are no coroners' officers and any investigative and preparatory work for the coroner is provided by the police. Whilst some educational conferences for coroners' officers have been arranged by the Coroners' Officers' Association very few coroners' officers have received, or have access to, formal training specific to the work they do.

Special Features of the Coroners Court

68. In comparison with other judicial services, the coroners' court is an isolated local jurisdiction with no national court structure, and no structure of appropriately resourced dedicated superior courts to act in the most difficult and contentious cases, or to serve as an avenue of appeal. People dissatisfied by proceedings in the coroner's court can seek judicial review in the Administrative Court, at High Court level. The Attorney General has an overlapping jurisdiction to consent to an application being made to the High Court for an inquest to be held into a death or for a new inquest to be held and the original inquest's verdict to be quashed.

This jurisdiction applies in limited circumstances such as where an applicant can establish fraud or insufficiency of inquiry at the original inquest or sometimes where new evidence has come to light since that inquest. In Northern Ireland applications to the High Court do not need the consent of the Attorney General and the Attorney General can of his own volition direct any coroner to conduct an inquest.

69. The coroner's inquest also contrasts with other judicial services in that the proceedings are "inquisitorial" rather than "adversarial". The purpose is to find out what happened, and not to adjudicate between contending parties (prosecution and defence in the criminal courts, plaintiffs and defendants in civil proceedings). This means that it is the duty of the coroner to choose what evidence to bring into the court, to introduce it himself, to decide how much if any of it should be disclosed in advance to participants, to conduct most of the witness examinations, and to guide the jury on a suitable range of outcomes, or in the absence of a jury, to adjudicate on the outcome himself. Legal attribution of blame to any named party is not allowed. In England and Wales no-one is allowed to "address the coroner on the facts" - i.e. sum up in favour of a particular interpretation of what happened - though families and other participants or their representatives may ask questions of witnesses to the extent that the coroner considers relevant. In Northern Ireland the coroner has discretion to allow closing addresses on behalf of participants.

70. The scope of the inquest to examine causes of the death has traditionally been narrow, concentrating on immediate rather than underlying cause. In recent years the higher courts have tended to widen somewhat the scope of the examination, and there are unresolved issues about how far the inquest procedure in its present form may in some types of case comply with the obligation on the State to investigate deaths implied in Article 2 of the European Convention on Human Rights, though the coroner's inquest is not necessarily the only process through which this obligation can be met.

71. The outcome of an inquest is the "inquisition" which centres on the facts found, and may in England and Wales though not in Northern Ireland include a short-form verdict such as natural causes, industrial disease, dependence on drugs/non-dependent abuse of drugs, suicide, accident/misadventure, lawful killing, unlawful killing, or an "open verdict". There is also scope to add a "self-neglect or neglect" qualification to the outcome.

72. Of the 25,000 inquests in England and Wales in 2000 representing about one in every 20-25 deaths, 42% returned verdicts of accident/misadventure, 16% of suicide, 16% natural causes, 11% industrial disease. 11% had open verdicts, and 3% were drug-related. 178 cases had verdicts of unlawful killing and 4 of lawful killing. 33 (0.2%) included the "lack of care" qualification. 3% were held with juries, which are by law required in all deaths in custody or in the course of police activity as well as those fatalities, including railway fatalities, where legislation requires an investigation or inquiry, or where it is apparent that the death raises issues concerning the avoidance of future similar fatalities.

Focus of Review

73. We have received a great deal of comment from families, voluntary groups, coroners themselves, doctors and police and solicitors and barristers, about the quality, character, and especially the lack of predictability in coroners courts, compared to the mainstream civil and criminal justice systems. It will be important to retain simplicity and adaptability of court process, but we are generally disposed in favour of aligning the structures for the judicial investigation of death much more closely with those of other justice services. This would probably mean:-

1 Continuing to appoint coroners for each region or locality, in the context of modern national death investigation jurisdictions for England, Wales and Northern Ireland.

2 Jurisdiction to preside over inquests to include the coroner, possibly suitably qualified District or Circuit Judges as well, and extended to High Court Judges for a very small number of particularly contentious or complex cases including some involving multiple deaths after disasters, with some suitable support to the inquest-presider for such cases in the preparation and presentation of issues.

3 A mechanism of review or appeal on major points of procedure and law but not findings of fact to a dedicated higher level tribunal, including applications to hold inquests where the coroner at first instance has declined to do so, or to hold second inquests where there are represented to be grounds for setting aside one already held. We question whether the role of the Attorney General needs be retained in such cases, although the work of assisting the applicant in preparing the papers to a formal standard, and which is currently carried out by his office, along with the provision of help and advice to potential appellants, would need to be available from other sources. In Northern Ireland the Attorney General's power to direct a coroner to hold an inquest has been rarely used.

4 Clear, consistent and predictable rules of procedure, including those on disclosure, established through Rules Committees respectively for England and Wales and Northern Ireland, that might include representatives of family and support groups as well as professional interests. The presumption should be in favour of disclosure of all witness material, and a right on the coroner's part to receive relevant material from all parties for the duration of the inquest.

5 Appointment at all levels to be on merit by the Lord Chancellor, after consultation with local interests, the criteria to include suitability to work with bereaved families. In Northern Ireland the responsibility for appointment should fall to the Executive once the justice system itself is devolved.

6 Conduct and discipline responsibilities to be with the Lord Chancellor.

7 The appointment procedures should involve public advertisement and nationally agreed job descriptions to be agreed with the relevant interested parties including the Northern Ireland Executive and the Wales Assembly and those with experience of bereavement issues.

8 A balance between whole-time and part-time coroners characteristic of mainstream judicial services, with most local jurisdictions having a full-time coroner, supplemented by part-time coroners as local circumstances and case-loads require.

9 Mandatory training on first appointment, and continuing professional education, under the oversight of the Judicial Studies Board, though the training would need to include bereavement issues and the administrative aspects of coronial work such as contingency planning for disasters.

10 As with other judges, assessment of the salaries by the Review Body on Senior Salaries.

74. We are also disposed in favour of giving the inquest court greater latitude to decide in each case the proper bounds of inquiry, so that the court within the inquest jurisdiction could respond appropriately, in suitable cases, to the evolving requirements of Article 2 of the European Convention on Human Rights and meet major public interest concerns without resort to *ad hoc* public inquiries requiring a specific authority from government.

75. *We would welcome comments on the following broad proposals:*

1 Coroners courts should each work to a consistent set of procedures laid down by a Rules Committee.

2 *There should be an avenue of appeal to a specified higher court on points of procedure and law, including against the decision not to hold an inquest.*

3 *In a complex or especially contentious case it should be possible for a suitably qualified District or Circuit Judge, or a High Court Judge, to be appointed to preside over the inquest. The court should have some latitude to decide the scope of the inquest.*

4 *The appointment of coroners should involve an assessment of their suitability to work with bereaved families and individuals.*

5 *Appointments at all judicial levels to the inquest jurisdiction should be made by the Lord Chancellor who should also be responsible for standards of coronial conduct and discipline.*

6 *There should be mandatory specific training for coroners on appointment, and continuing in the role should be linked to updating the professional training received. The training should include awareness of bereavement issues and training in the administrative work of the coroner.*

7 *There should be full-time coroners in each region or locality supplemented by part-time appointments as necessary.*

8 *There should be a national jurisdiction, so that although coroners work in a local area they are appointed as coroners in England, or Wales, or Northern Ireland.*

9 *Pay and terms under the new arrangements should be considered by the Senior Salaries Review Body.*

CHAPTER 5 - THE PUBLIC INQUEST

76. In the nineteenth century and earlier, the coroner's inquest was a key justice procedure for deciding which deaths were natural and which involved foul play.

77. During the twentieth century, the relative roles of the coroner's inquest and other processes of investigation changed:-

- With the development of police investigation, and prosecution services, the coroner's role in the identification of criminal deaths was much reduced.

- There grew up alongside the coroner's inquest a variety of other processes through which deaths could be investigated. These include civil court actions for negligence, statutory public service complaints, investigation and disciplinary procedures (in prisons, the health service, the police for example), and specific statutory processes for the investigation of aircraft, railway and maritime deaths, deaths in the workplace and from industrial disease. Public judicial inquiries into catastrophes involving multiple deaths have also been held when the Government considers this justified.

78. There has been some adaptation of the coronial inquest system as a result of these developments. Inquests are adjourned if serious criminal charges are in preparation and not usually resumed where there are convictions. Inquests can also be adjourned by direction of the Lord Chancellor if the death is being investigated by a judicial inquiry. But the changes have generally been in the direction of containing the scope and outcomes and of reducing or deferring the coroner's involvement in criminal deaths. There has been little change of structure to address the modern public's expectations of the investigation of other deaths, though many individual coroners have adapted and modernised their practices within the limits of the resources and systems available to them.

79. It is clear that the independent judicial investigation of deaths is an essential public safeguard, and an important opportunity for families and sometimes local communities when they would not otherwise be able to find out how a death has occurred. The importance of the inquest has been increased by the case law that is evolving under the European Convention on Human Rights and domestic Human Rights legislation.

80. We are looking particularly at the use made of the public inquest, the range and type of outcomes available in inquests, and the help given to bereaved families at and in preparation for inquests.

Use of the Public Inquest

81. We are considering whether it is necessary to hold public inquests on the scale that now occurs, or whether it is necessary routinely to hold public inquests into all the categories of death which in England and Wales are usually inquested.

82. We consider that there should be a strong presumption in favour of public inquests into all deaths of prisoners, people compulsorily detained under Mental Health Act powers, and at the hands of the law and order services. It is not so clear that deaths in some other categories should automatically be investigated in formal public inquests.

83. We particularly have in mind cases in which people take their own lives, deaths on the road, deaths from occupational disease and accidents at work. These are all categories of deaths which some coroners have themselves mentioned when asked if there were some inquests which they think less useful than others, or less suitable for automatic formal judicial investigation in public.

84. A public inquest into deaths by own hand is not routine in Northern Ireland but at the discretion of the coroner. They are not automatically investigated in public in any other jurisdiction we have so far heard of. There can undoubtedly be cases in which there is a public interest to ascertain the circumstances in public, or a very strongly grounded family interest for doing so. In such cases it would be right to hold public inquests.

In others, the circumstances of death could be settled administratively in private, without publicity and with respect for family privacy, but with the discretion to move to a public inquest, or apply to do so, if circumstances as they emerged appeared to warrant a change of approach.

85. It is important to families, and a matter of wider public interest, that occupational disease deaths should be fairly and properly identified. It has been put to us that this can be done satisfactorily without a public judicial investigation but with full participation rights for the family and others with an interest, and the safeguard of moving to public process if warranted.

86. Traffic deaths are invariably investigated by the police and may be considered also by the police and the Crown Prosecution Service for criminal proceedings. Accidents at work are investigated by the Health and Safety Executive and in some cases considered for prosecution by them or the police. There may also be civil proceedings for damages.

87. The issue is not whether deaths in these categories should always or never be the subject of a public inquest. It is whether there should be the discretion to weigh issues of need and benefit along with the wishes of the family, and then decide how full an investigation should be and whether it should be in public.

88. Some possible criteria might be;-

1 Significant uncertainty about the circumstances or cause of the death.

2 Sufficient uncertainty or conflict of evidence to justify the use of public judicial process.

3 The apparent degree of public interest, from the perspective of uncovering systems defects or general dangers not already known about; or in the particular circumstances of the case.

4 The wishes of the family, whether for privacy or public investigation, and of other relevant interests.

5 The availability or otherwise of other investigative process, the degree of openness and independence of such processes, and their accessibility to the family; and the overall suitability of the alternative process as a means of investigating sufficiently the cause and circumstances of a particular death.

89. An approach on these lines might have an evolving effect over time on the character of, and public confidence in, some of the processes used in public services to investigate complaints or alleged incompetence.

90. It would be important in revised statutory provision for the investigation of deaths to provide explicitly for the proper handling of death investigation administratively, as well as by public inquest. The present law contains little or no explicit provision for how coroners should handle cases where there are no inquests. A new statute should define the processes by which cases would be chosen and dealt with administratively, the rights of the family and others with an interest to propose, or oppose, an administrative investigation; the rights of attendance and/or representation; and the rights to propose or oppose proceeding to a public hearing.

91. Another category of inquest we are considering concerns those which can occur after deaths abroad. Present practice is for the coroner into whose jurisdiction the body is repatriated to hold an inquest if he would have done so had the death occurred at home. Opinions differ about the value of such inquests. The evidence available from abroad may be poor and there is no power to compel extra-territorial evidence or witnesses. The findings have no legal force or standing in the overseas country. Other countries have their own investigative processes including European countries which like the United Kingdom have ratified the European Human Rights Convention and are therefore also covered by Article 2. On the other hand, there can be circumstances - e.g. group holidays for children or other potentially vulnerable groups, where the holiday planning and precautions by the domestic organisers might reasonably be the subject of inquiry; an inquest at home can sometimes more easily access other UK witnesses - for example holiday companions, and there undoubtedly have been some cases where families have appreciated the coroner's work on their behalf.

Inquest Outcomes

92. We are considering whether there should be:-

- More "considered" outcomes to inquests, with a strongly narrative content.

- Short-form verdicts broadly as now (in England and Wales) but with some changes to those available.

- A combination of these two.

93. Advocates of "considered" narrative outcomes argue that the inquest ought to be a dispassionate inquiry into the circumstances of a death which provides the family with a full and authoritative account of what happened and meets the public interest by identifying general risk factors which can in the future be contained or eliminated. They see the focus on short-form verdicts as a distraction, and as a temptation to participants to turn the inquest into an adversarial process which undermines its unique nature and capacity for benefit, and leads it into overlap with the civil and criminal courts whose purposes include the finding of fault and whose processes are properly adapted for those purposes.

94. Advocates of the short-form verdict say that without them the inquest process would be deprived of an important meaning which it now has and that this is so particularly in relation to "unlawful killing" and, in cases where there are other outcomes, the "neglect" qualification is available. Even when the argument is, there is no prosecution, or no successful prosecution, in cases with such outcomes, families do at least have a summary statement from a judicial process of what has happened to their relative or relatives.

There is a long history of controversy around the appropriateness of such outcomes to the inquest. The Brodrick Committee, for instance, recommended the abolition of the traditional requirement for "short-form verdicts". In Northern Ireland the current legal position is that there is no provision to return a verdict in an inquest. A recent judicial review in Northern Ireland upheld this point although there is an appeal against this last decision still to be heard.

95. A related issue is the role of juries. At the moment juries countersign the factual findings of the inquest inquisition though these are usually fairly brief. It is not clear that the use of a jury would be natural in inquests with primarily considered narrative outcomes and a focus on systems investigation, since the outcomes would tend to be written up at greater length than it may be sensible to expect from a collective process. On the other hand, the role of the jury is understandably seen as important in cases where the state or its agents, or a private company, may perhaps have been involved in causing a wrongful or avoidable death to a member of the public; and there are those who see those cases in which the coroner's court may have come closest to infringing its own constraints on implied incrimination - such as the "unlawful killing" verdicts from juries in the Marchioness disaster inquest and the Stephen Lawrence inquest- as justifications of the coronial process.

Customary Verdicts

96. We are, however, clear that in some respects the customary verdict structure for England and Wales needs amendment, if any verdict structure is retained. Many families have said to us that some "verdicts" of "natural death," "accidental death," or "misadventure" - not a word with much natural meaning to the general public - are in some circumstances meaningless and can be offensive. If an inquest is held into the complex circumstances of a hospital death - a category of death that has in recent years increasingly occupied coroner's attention- and there are serious issues about the suitability of the treatment given, it is inadequate to summarise the outcome as an accidental or a natural death; and the use of this bland vocabulary is also offensive to many families after deaths on the road.

97. The apparent over-use of the broad categories of "accidental death" and "natural causes" gives some families an impression that the inquest system lacks teeth, and is apt blandly to classify deaths which could (in many road deaths for example) have been avoided or which might have been avoided as, in effect, "just one of those things". If short-form verdicts are retained, it would in our view, be desirable to restrict use of "accidental death" and "natural causes" to circumstances where the public consider them to have a fair and natural meaning; and to introduce other categorisations (such as "traffic death"; and "death in the course of treatment for serious natural disease") which at least convey the circumstances of the death even if they do not imply liability for its cause.

98. We also question whether the verdict of "suicide" is apt or necessary. Along with the "unlawful killing" verdict it requires proof at the criminal standard "beyond reasonable doubt", while for all the other inquest outcomes the civil "balance of probability" test applies. A good deal of effort is spent in inquests into deaths by the action of the person who has died trying to find out whether the death was an intended consequence of the action taken (in which case, if proved, the verdict is "suicide"), or was more in the nature of a signal of acute distress and a need for help and support which accidentally went further than may have been intended, in which case the verdict is usually "accidental death". It may well often be impossible to know the answer, and the degree of distress for the family in trying to find out, particularly in public proceedings, may be out of proportion to any benefit. If a summary verdict is necessary in such cases, it might be more calculatedly neutral such as "death by own actions".

99. One possibility might be to retain short-form verdicts in some types of case, particularly for example those in which there is a finding that the death occurred at the hands of a state agent, but not for the generality of cases.

100. A further possibility for a general approach to inquest outcomes might be for the main emphasis to be on establishing the facts clearly and authoritatively, addressing issues of causation and possible systems defects, and then for the coroner to add a rider or general comment suggesting that the circumstances appear to justify, or as the case may be, not to justify, further attention in the relevant public service redress or disciplinary procedure, or the civil courts. Such a comment would have no decisive effect in such proceedings but might be a helpful signal to the family and a salutary though non-incriminating public comment.

101. Some advocate taking a further step by giving the inquest court a power to settle questions of civil liability including possibly damage awards as part of the investigation of deaths in which such liabilities arise. This would be a significant extension of the inquest court's jurisdiction but might from the family's perspective give the inquest a concrete outcome and purpose which some say within its existing limitations it does not have.

102. In effect there are several ways of responding to these issues about the outcomes and purpose of the inquest:

1 Increase the analytical and narrative content of inquest outcomes, and dispense with short- form verdicts, (except possibly in a small number of cases e.g. where the death is found to be at the hands of state agents).

2 Put the emphasis mainly on analytical and narrative outcomes, but give the coroner a discretion to add such further comment as the facts found justify and would be helpful in the public interest or to interested participants.

3 Go further and extend the inquest court's jurisdiction in suitable cases (and perhaps with the agreement of the family and other interested participants) to settling related civil liability questions.

4 Continue with broadly the present arrangements but with a modernised verdict structure.

Support for Bereaved People

103. We plan to recommend an agenda for putting the support of bereaved people at the centre of a reformed inquest process. We have in mind to propose a set of standards covering promptness of inquests following the death, clear and timely notification of all inquest arrangements to the family; a service which explains to people what an inquest is and what happens at it; decent premises, with disability access and provision for families to wait or consult advisers without being forced into the close company of other participants; proactive support in finding sources of bereavement counselling and other expert help for particular forms of loss. We shall be considering methods to monitor the delivery of such standards, over a period of years for premises improvement but more quickly in the other respects. We shall be considering whether an inspectorate might check the delivery of these administrative standards.

Legal Aid

104. The Legal Services Commission in England and Wales last autumn somewhat liberalised the availability of legal aid for families at certain categories of inquest. There is currently a similar extra-statutory, ex-gratia scheme in operation in Northern Ireland. We acknowledge the strength and logic of the argument that families, subject to means, should be represented at public expense where other participants are represented. We will be studying the implied effects of last autumn's changes in a wider context.

105. We have had a variety of comment from families about their experiences of representation by solicitors or barristers, and will be considering whether to recommend that publicly funded legal aid should be available only when representation is from panels of suitably experienced practitioners.

Public Safety Comments

106. The activity analysis we have commissioned from Peter Jordan will include some sampling of "Rule 43" comments. (Under Rule 43 - Rule 23 in Northern Ireland - of the Coroners Rules coroners may announce at the inquest that they are reporting to the relevant authorities in order to prevent similar fatalities). We shall be considering whether this process needs to be given more impact, and whether there should be more monitoring of follow-up by the public services at which they are directed, for example in the reports of their inspectorates.

Summary

107. *We invite comments on:*

1 *Whether the issues we are studying cover the necessary ground.*

2 *What is raised in paragraphs 81-91 about the use of public inquests, and the possibility of dealing with some cases administratively and in private.*

3 *The different types of inquest outcomes summarised in paragraphs 93-102, including whether there is any justification for any differences of approach in Northern Ireland.*

4 *What is said in paragraph 103 about support for bereaved people.*

5 *What is said in paragraphs 104-105 about legal aid.*

6 *What is said in paragraph 106 about public safety comments.*

CHAPTER 6 - SOME ISSUES OF STRUCTURE AND REPORTING

108. In our report we shall be recommending structures at local and national levels for the delivery of the services we recommend. These will recognise and support the professional independence of doctors and others in the death certification process, and the judicial independence of those conducting inquests. They will also address the problems of fragmentation seen by nearly all commentators in the present certification and investigation services, and the lack of predictability and uniform standards of procedure remarked on by nearly all commentators on inquests.

109. We shall be considering some particular issues of structure, as follows:-

- What is the right unit of geographical administration for these services in England and Wales. Should there, for example, be a 'regional coroner', supported as necessary by part-time coroners? Or should the unit remain as now smaller perhaps more locally identifiable areas- cities and counties or groupings of contiguous unitary local authorities? What weight should be put on the concept of 'the local coroner'?

- The relationship between a 'Medical Audit Service' as outlined in Chapter 2, and the judicial inquest services covered in Chapters 4 and 5. Should they be separate services with statutory links between them? Should the local medical auditor be self-standing or an advisor to (perhaps even on the staff of) the local or regional coroner? Should there be a special agency combining the medical audit and judicial inquest functions? Or should existing public service structures be, so far as possible, used instead?

- A structured inquest jurisdiction with dedicated higher courts as outlined in Chapter 4 implies at its higher levels support from the national courts service though continued support through local government at the first instance level may well be an option.

- What should be the relationship with the Registration Service, which is to remain delivered primarily through local authorities?

110. We shall be covering infrastructure and information technology support and will give special attention to the position of coroners' officers. The Police Service do not generally consider that their role in providing coroners' officers should continue. We are unlikely to recommend that it should do so in the reformed service, and our final report will contain full recommendations on the most appropriate structures, skills and management arrangements for the crucial people who will continue to be needed to support both the medical and judicial sides of the work. In the meantime, it is important that the coroners' officer service is maintained in a stable and effective way.

111. We shall also be looking carefully at the administrative work done by coroners. This includes, for example, participation in contingency planning for disasters, giving authority for the removal of bodies for burial abroad, as well as reaching decisions on the large number of deaths referred to them on which they decide not to hold public inquests. The work being done for us by Peter Jordan should throw some light on the scale of this work, in terms of time. We shall be considering what might be more suitable to a Medical Audit Service in the first instance, and what should remain with the judicial investigation function.

112. At national level, we shall be concerned to recommend an allocation of responsibilities most likely to facilitate the modernisation of the judicial inquest jurisdiction so that it is closer in standards, training and appointment practice to other judicial services, and continued adaptation to Human Rights law; and the introduction and maintenance of stronger certification practices by doctors and other health care personnel, as well as stronger links between certification data and national and local public health objectives.

113. We shall aim to reflect suitably the spirit of the new constitutional arrangements for the government of Wales and of Northern Ireland, including any devolution to Northern Ireland institutions of responsibility for justice administration.

114. We think it likely that because of the fragmentation of the existing systems and their slender resource base the public does not get maximum value from the information gathered on the causes of accidents and other risks to life. We shall be considering recommendations to improve analytical and reporting mechanisms so that the preventative potential of the system is properly realised, and its process and activities (including post- mortems) are suitably assessed for effectiveness.

115. We shall be costing our recommendations. They will include a recommendation for monitoring the general effectiveness of the services in future which would also be used to monitor the path towards initial reform.

116. We shall be looking at arrangements for transition from the present to the new structure so that essential and valued skills remain available for the future. We shall be considering the coroners' role in the administration of the "Treasure" law. We have had helpful material from the British Museum and from some coroners, but would welcome comment from others.

117. We have received a considerable number of comments on wider issues, and in particular the need for a fuller understanding amongst the general public of issues about death and what families may need to do after a death occurs.

118. *We welcome views on these structural issues.*

Responding to this Consultation

Thank you for studying this document. The death certification system and the death investigation system are very important services and the current review is an opportunity to develop these services in a way that is in keeping with the 21st century.

We value everyone's comments so please send them to Sophy Osborn, either at:

sophyosborn@coronersreview.org.uk

or at:

The Review of Coroner Services
100 Pall Mall
St James's
London SW1Y 5HP

In some cases we may wish to show comments to others besides the Review Group. Please say if you would like your comments to be treated as confidential and we will not do this.

The closing date for this consultation is 22 November 2002.

Please try and get your comments to us by that date.

Further copies of this document may be obtained from Sophy Osborn at the above address. It may also be viewed and downloaded from our website at www.coronersreview.org.uk

MEMBERS OF THE REFERENCE GROUP FOR ENGLAND AND WALES

Mr Tom Beldon

John O'Hare - Chairman
PITY II Bereaved
Parents Support Group
Executive Committee

Eileen Dallaglio
Marchioness Contact Group

Margaret Lockwood-Croft
Marchioness Action Group
& Victims Voice

Rose Dixon
SAMM (National)

Joyce Epstein
The Foundation for the
Study of Infant Deaths

Pip Finucane
Victims Voice Trustee
& Member of RoadPeace

Billy Gorman
Marchioness Contact Group

Christabel Hilliard - Welfare Advisor
CRUSE Bereavement Care

John Mellor - Councillor
Wolverhampton City Council

Erin Pizzey

John Sandwell - Chairman
SAMM Liverpool

Mr Tony & Mrs Yvonne Brown

David Frei
London Beth Din
and Office of the Chief Rabbi

Eleanor Platt QC
The Board of Deputies of British Jews

Barbara Davis
Marchioness Contact Group

Graeme Skidmore
Funeral Standards Council

Pauline Fielding
RoadPeace North West

John Flanagan
Training & Information Officer
Merseyside Asbestos Victims Support

Lorraine Gwinnutt
Association of Personal Injury Lawyers

Ebrahim Ahmed Jasat - Secretary
Muslim Burial Council of Leicestershire

Graeme Peart
The Compassionate Friends

Dr Gordon Pledger
Medical Referee

Helen Shaw & Deborah Coles
INQUEST

Zoe Stowe - Chair
RoadPeace

Michael Summers - Trustee
The Patients Association

Mary Teesdale
National Schizophrenia Fellowship

Lucy Thorpe - Policy Advisor
NSPCC

The Cremation Society of Great Britain

Michaela Willis
NACOR

Lynne Lovelock
SAMM South Wales

Mr Phil Hammond
Hillsborough Families Support Group

Vanessa Eden-Evans
The Samaritans (General Office)
(will also contribute for The Samaritans to the Northern Ireland Reference Group)

MEMBERS OF THE REFERENCE GROUP FOR NORTHERN IRELAND

Paul O'Connor
The Pat Finucane Centre

Michael Gallagher
The Omagh Support and Self-Help Group

Sandra Peake - Director
The WAVE Trauma Centre

Paul Mageean - Legal Officer
Committee on the Administration of Justice

Dr David Stevens - General Secretary
Irish Council of Churches

Ian Elliott - Divisional Director
NSPCC Northern Ireland

William Frazer - Outreach and Development Worker
Families Acting for Innocent Relatives (FAIR)

Vanessa Eden-Evans
The Samaritans

Alan Wardle
Shankhill Stress Centre

TEXT OF OUR RESPONSE TO THE RETAINED ORGANS COMMISSION'S CONSULTATION

The Review of Coroner Services

100 Pall Mall

London SW1Y 5HP

020 7664 8895

tomluce@coronersreview.org.uk

Professor Margaret Brazier
Chair, The Retained Organs Commission

Dear Professor Brazier

February 2002 Consultation Document

1. The Retained Organs Commission's Consultation Document mentions in paragraph 13 of its Introduction that since the Commission was established the Home Office has set up a full-scale review of the Coroner Service.

2. I am writing as chair of the Fundamental Review of death certification and the coroner services in England, Wales and Northern Ireland to let you have such comment as we are at present able to make on the issues raised in the Commission's document. We were appointed last summer and are to report to our appointing Minister in the Home Office early next year. We are about half way through our review. Our comments at this stage must therefore be provisional.

3. They are directed to the issues raised in Section II of your document. This reminds all readers of the set of ethical principles for organ and tissue retention proposed by the Chief Medical Officer for England in his advice to the Government, viz:

- *Respect:* treating the person who has died and their families with dignity and respect
- *Understanding:* realising that to many parents and families their love and feelings of responsibility for the person who has died are as strong as they were in life

- *Informed Consent:* ensuring that permission is sought and given on the basis that a person is exercising fully informed choice: consent is a process not a one-off event
- *Time and Space:* recognising that a family member may need time to consider whether to agree to a post mortem examination and to consider donation of tissue and organs and will not wish to feel under pressure to agree in the moments after death
- *Skill and Sensitivity:* staff must be sensitive to the needs of the relatives of someone who has died and sufficient staff skilled in bereavement counselling must be available
- *Information:* much better information is required, both generally by the public and specifically for relatives who are recently bereaved, about post mortems and the use of tissue after death. Relatives may also require information about the progress of research involving donated material
- *Cultural Competence:* attitudes to post mortems, burial and the use of organs and tissues after death differ greatly between different religions and cultural groups; health professionals need to be aware of these factors and respond to them with sensitivity.
- *A gift Relationship:* the emphasis in all present legislation and guidance is on "taking" and "retaining". The balance should be shifted to "donation" so that tissue or organs are given as a gift to help others and recognised as deserving of gratitude to those making donations

4. In paragraph 16 it is said that the Commission recognises that the need for consent, information and a gift relationship may apply only partially - if at all - in practice to Coroners' post mortems.

5. The Review Group has considered these and other related issues in the consultation document in the light of the work we have so far done on the death certification and coroner services issues within our remit. We offer the following comments though they are in some respects bound to be provisional and subject to our own further work in these areas and to the further thinking of the Retained Organs Commission following its own consultation.

6. Our comments are based on the assumptions that:-

- the state, under Article II of the ECHR and for other reasons of public policy concerned with the health and safety of the population will have a continuing need and obligation to investigate the causes of some individual deaths, and to monitor trends in the causes of death in the population as a whole,

- in some cases there will foreseeably be a need for such purposes to conduct autopsies to establish the cause of death; and that in some autopsies it will be necessary to (a)retain some organs or tissues for the purpose of the tests necessary to establish a cause of death and (b)in some cases where there are legal reasons connected with criminal justice processes or other essential public protection issues to retain some organs or tissues for longer.

7. On these assumptions our comments are that of the ethical principles suggested by the CMO:-

- Those concerned with respect, understanding, skill and sensitivity, information, and cultural competence apply as much to all coroners' post mortems as to voluntary hospital post mortems
- The other principles should apply equally to coroners' post-mortems as to voluntary hospital post- mortems in respect of organs or tissues retained for any research or other purpose going beyond the purpose for which the coroner's post mortem is justified
- In cases where the state has need and obligation on grounds of public protection to arrange for post mortems to establish the cause of death the principles of informed consent may not be applicable, and that of "time and space" may not be fully applicable in respect of organs or tissues retained in accordance with (a) and (b) in paragraph 6 above though wherever possible the wishes of families should be ascertained and given consideration

8.We shall be working further on the definition of the circumstances in which family consent to an autopsy might legitimately be dispensed with. Later this summer we shall be consulting publicly on a range of issues within our terms of reference. In this consultation we shall, without prejudice, be inviting views on whether consent should always be dispensed with when the issue to be settled is not whether a death had any untoward or suspect causes but which natural disease caused it.

9. We shall continue to keep the Retained Organs Commission in touch with our progress and thinking, and will have a keen interest in the outcome of its consultations.

10. We would generally favour an approach to these issues in which the rights of individuals and families and the responsibilities of those who administer the system for investigating deaths should be clearly set out in statute law with appropriate regulations, together with mechanisms for monitoring and enforcing compliance. In principle, if timing and other practical considerations allow, we would favour a single statutory framework suitably covering both consented and un-consented post mortems, providing for both a common framework of principles and, where necessary, allowing for differences of approach between the two. This framework should be considerably more detailed and specific than the present Coroners' Rules. It should include accountability arrangements for all the key participants, including pathologists doing post-mortem examinations.

11. We agree with the Commission that "presumed consent" or approaches relying mainly on professional self-regulation would be inadequate.

12. I am sending copies of this letter to Liam Donaldson and Nick Dean of the Department of Health; and to the Chief Medical Officers of Wales and Northern Ireland. We have recently seen the June 2002 report of the Northern Ireland Human Organs Inquiry, and will be considering whether there are issues in it on which we wish to comment.

Tom Luce