Young, Christine

From: Carson, Ian
Sent: 04 November 2004 11:21
To: Gowdy, Clive
Cc: Neagle, Heather
Subject: FW: News on human rights report on hospital deaths

Clive,
Heather Neagle's first draft below. I have also attached the Home Office position paper on Reforming the Coroner and Death Certification Service. As you are aware we are taking this forward from a N.Ireland perspective jointly with the NI Court Service (David Lavery and I co-chair a Working Group), and in liaison with colleagues in England & Wales.
Yours, Ian.

12.03.04 Position Paper TSO Cm...

-----Original Message-----
Fr Neagle, Heather
t: 22 October 2004 17:09
Carson, Ian
Cc: Browne, Andrew
Subject: RE: News on human rights report on hospital deaths

Ian
Happy to do that. I have spoken to Percy Johnston who is willing to look at any legal points. I have asked DH London if they have had any input from Human Rights, and what they know about what other EU countries do as far as routine investigation of all deaths. I will circulate the MDs next week. I have looked at the report and made some 1st commnets, chapter by chapter, but probably a final response will nedd to be less datailed and look at the big issues ie
Does Article 2 actually require investigation of all deaths in a healthcare setting, or only those likely to be due to healthcare intervention?
Audit, internal investigations etc have a role which is valid but different from Article 2 investigations
Does responsibility lie with DHSSPS or legal system to investigate (or both)
I have attached the wordy and very rough first thoughts, with nothing about conclusions or recommendeations of the report

human rights report HN10-2-04....

ve a good weekend
ather

-----Original Message-----
From: Carson, Ian
Sent: 22 October 2004 16:56
To: Neagle, Heather
Subject: RE: News on human rights report on hospital deaths

Heather,
I would be grateful if you would co-ordinate this - gather what you can from the MDs, get any input from Secondary Care etc. You may have seen Tony McGleenan on the Insight programme. Secretary and Andrew Hamilton are both keen that we respond.
Yours, Ian.

-----Original Message-----
From: Neagle, Heather
Sent: 19 October 2004 14:02
To: Willis, Claire; Carson, Ian
Subject: RE: News on human rights report on hospital deaths

DHSSPS-C Gowdy 001-125-375

This report seems to be getting a fair bit of coverage, and I know we also distributed it to the Medical Directors at their meeting with CMO. Perhaps we need to make a formal response to NIHRC. I am happpy to go through it in detail and make a first cut of the key points we need to address (I'll probably get that done on Thursday morning) do we need to meet with secondary care to agree a response?
Heather

-----Original Message-----
From: Willis, Claire
Sent: 19 October 2004 13:49
To: Neagle, Heather; Carson, Ian
Subject: FW: News

Ian/heather

How does this fit with your group/work on deaths in hospital?
Any views on Maureen's question below - there would clearly be overlap with the the work of the confidenitial enquiries

Thanks
Claire

-----Original Message-----
From: Murnin, Christine
Sent: 19 October 2004 12:30
To: Carol Beattie (E-mail); Willis, Claire
Subject: News

Carol/Claire

What is the next step to a report like this? Who is expected to respond? Where will it be considered further?

NB See P3 Para (iv).

Christine Murnin PS/Dr Maureen Scott

<< File: copy_.rtf >>

DRAFT 1 – 22.10.04

DRAFT RESPONSE TO
NORTHERN IRELAND HUMAN RIGHTS COMMISSION'S REPORT
"INVESTIGATING DEATHS IN HOSPITAL IN NORTHERN IRELAND"

We welcome this thought provoking report and agree that in light of the investigation into Dr Harold Shipman and other reviews of law concerning the coroner's system the time is right to consider what, if any, measures need to be taken to ensure that deaths in hospital are properly reviewed. We note that this report is also one method by which the Commission is attempting to redress individual concerns concerning alleged medical negligence in hospitals and that the report is part of a larger body of work which the Commission is undertaking in the area of death investigation.

1. INTRODUCTION

Paragraph 1.1 refers to sudden and unexpected death arising from surgical or medical intervention and the need to understand the systemic or individual causes of such a fatality.

Paragraph 1.3 talks about healthcare fatalities. The remainder of the study seems to consider healthcare fatalities as any death within a hospital setting.

Just over half of all the people who died in Northern Ireland died in hospital. Many of these deaths are neither sudden nor expected, and do not arise from surgical or medical intervention but to disease processes. In many cases neither of the professionals involved nor the family need further investigation to determine the cause of death or the circumstances surrounding that death.

2. ARTICLE 2 OBLIGATIONS: THE LEGAL BACKGROUND

Paragraph 2.1 indicates that the Article 2 obligation may be breached where the State does not have in place an adequate means of ensuring that life is not lost. Hospitals in Northern Ireland have a duty of care and a duty of quality which is part of the obligation to protect life

under Article 2 of the Convention (eur.comm..hr,no.20948/92,dec.22.5.95,d.r.81,p.40) as quoted in *Erikson v Italy.*

Paragraph 2.2 notes the procedural obligation to initiate public investigation in circumstances which it appears …that agents of the State are or may be in some way implicated.

By their very nature, healthcare providers will often be involved around the time of someone's death and in fact symptom relief and palliative care are an important part of healthcare provision. The provision of that care may not be implicated in the circumstances of the death.

Paragraph 2.3 notes that in the case of *Jordan v United Kingdom* (2001) at paragraph 105 it is noted that the State cannot leave it to the initiative of next of kin either to lodge a formal complaint or to tale responsibility for the conduct of any investigative procedures and that they must act of their own motion.

This case involves the shooting of a person by an RUC officer. Paragraph 105 refers to "there should be some form of effective official investigation when individuals have been killed as a result of the use of force".

Paragraph 2.4(v) again notes that authorities must act of their own motion. However this is again in the context of part i and part ii when individuals have been killed as the result of a use of force.

3. IS ARTICLE 2 ENGATED IN HOSPITAL FATALITIES?

Paragraph 3.2 in *Erikson v Italy* the European Court of Human Rights noted that obligation included a requirement for hospitals to have regulations for the protection of their patients' lives and to establish an effective judicial system for establishing the cause of a death which occurs in hospital and any liability on the part of the medical practitioners concerned. The application under Article 2 was rejected because once the applicants had filed a complaint the judicial authorities carried out a thorough investigation this is despite the fact that the applicant's mother had died within a few hours of discharge from hospital and that no enquiry was made into the events and no explanation sought from the doctors who had visited

her the day before her death. The Court also stressed that it was open to the applicant to bring an action for negligence against the hospital and that the State had provided a mechanism whereby those with criminal or civil responsibility may be held answerable.

Paragraph 3.3 comments on the case of *Powell v United Kingdom*. This was a case of a child with Addison's disease who developed vomiting and was seen by several doctors before admission to hospital where he died. No inquest was held on the basis that Addison's disease was the natural cause of death. The report comments that "The Powell judgment appears to suggest that Article 2 is engaged in case of healthcare related fatality". The Court commented that where a contracting State has made adequate provision for securing high professional standards among health professionals and the protection of the lives of patients it cannot accept that matters such as error of judgment on the part of healthcare professionals are sufficient of themselves to call a contracting State to account from the standpoint of its positive obligations under Article 2. The Court also noted that the family had the opportunity to take disciplinary action (through the Medical Services Committee) and that they withdrew their appeal and that they were able to take civil action which they chose to settle with the responsible health authority. There was no allegation by the family that the doctors had intentionally killed their son and no criminal case was taken.

Paragraph 3.4 looks at the case of *Sieminska v Poland*. This case was declared inadmissible on the basis that there was a criminal investigation and that it was open to the applicant to bring a civil action in court and to institute proceedings in order to establish disciplinary responsibilities through the chamber of physicians. The Court found that there was no failure to provide a mechanism whereby criminal disciplinary or civil responsibility of persons who may be held answerable could be established.

Paragraph 3.5 *Calvelli v Italy* was about the death of a baby aged 2 days following a high risk birth where the doctor had not remained present for the delivery.

The Court noted that "if the infringement to the right of life … is not caused intentionally, the positive obligation imposed by Article 2 … does not necessarily require the provision of criminal law remedy in every case. In the specific sphere of medical negligence the obligation may, for instance, also be satisfied if the legal system affords victims a remedy in the civil courts... disciplinary measures may also be envisaged."

These cases and their findings would seem to indicate that provided the State has made regulations for hospitals to protect their patients' lives and has an effective judicial system either criminal or civil to establish the cause of death and liability on the part of medical practitioners concerned that these fulfil the requirements of Article 2.

4. CURRENT PROVISION FOR INVESTIGATION OF HEALTHCARE FATALITIES

Paragraph 4.2 notes that no scheme has yet been implemented in Northern Ireland for a mandatory reporting of adverse healthcare incidents and specified near-misses under confidential process to facilitate healthcare professionals in making such reports.

Interim advice on the reporting of adverse incidents has been issued **(NEED TO GET REFERENCE OF THIS ADVICE)**

Paragraph 4.3 notes medical articles including those by De Leval and Poloniecki et al about investigation of surgical death. However, he refers to this as a body of opinion within the medical profession which contends that there are sound clinical reasons for ensuring that a coherent investigative process is instituted in response to every healthcare fatality. This is taking comments made about specific operative deaths and extending them across all deaths within the healthcare setting.

Paragraph 4.5 notes that clinical audit is essentially a quality assurance tool and lacks the transparency required for Article 2 compliance. We would agree with this. However some of the criticisms of clinical audit appear to be based on papers now more that 10 years out of date. **(DO WE HAVE MORE POSITIVE UP-TO-DATE PAPERS)**

Paragraph 4.7 refers to the National Confidential Enquiry into Peri-Operative Death (NCEPOD). This routine collection of data on all hospital deaths within 30 days of a surgical procedure has now been discontinued. NCEPOD is now the national confidential enquiry into patient outcome and death and looks at patient outcomes in both surgical and medical care.

Paragraph 4.8 discusses hospital post mortem. The report quotes from the Shipman Inquiry that junior members of the clinical team may feel an expectation to certify the cause of death rather than reporting to the Coroner. This does not relate specifically to cases which have had a hospital post mortem.

Paragraph 4.9 refers to Coroner's post mortem. It notes that the coroner's post mortems are held in a lower percentage of cases in Northern Ireland than in England and Wales. Coroner's rules are different in Northern Ireland in that in Northern Ireland a doctor can complete can complete an MCCD if they have seen and treated the patient within the last 28 days. In England and Wales the doctor must have seen and treated the patient within the last 14 days.

Paragraph 4.10 notes that hospital notes may provide significant insight into the circumstances surrounding the care provided to the deceased whereas post mortem is likely to disclose the actual cause of death. We would agree with the report that any system of securing and scrutinising notes and records of all patients prior to release of the body for burial or cremation would raise practical concerns both about resources and delays.

Paragraphs 4.11– 4.18 refer to the coronial system.

Paragraph 4.19 notes that the GMC's role is to look at the actions of individual doctors and therefore does not scrutinise systemic failures.

Paragraph 4.20 notes the option of civil litigation. There are some difficulties with this area including the possible costs involved in bringing a case, that cases may be taken against either a Trust or an individual clinician, that settlement in negotiation before court prevents effective investigation into the circumstances surrounding death. It is commented that in *Jordan and in Wright* the fact that an individual is entitled to pursue a remedy for damages through the civil courts does not of itself discharge the State's procedural obligations under Article 2.

Paragraph 4.21 notes that the Ombudsman can investigate both administrative actions and clinical judgment in healthcare. Because the system is complaint- driven the report feels it does not necessarily meet the requirements of Article 2.

Home Office

BUILDING A SAFE, JUST AND TOLERANT SOCIETY

Reforming the Coroner and Death Certification Service

A Position Paper

Cm 6159

Reforming the Coroner and Death Certification Service

A Position Paper

Presented to Parliament
by the Secretary of State for the Home Department
by Command of Her Majesty

March 2004

Cm 6159

£7.50

DHSSPS-C Gowdy

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Home Office

Reforming the coroner and death certification service

A position paper

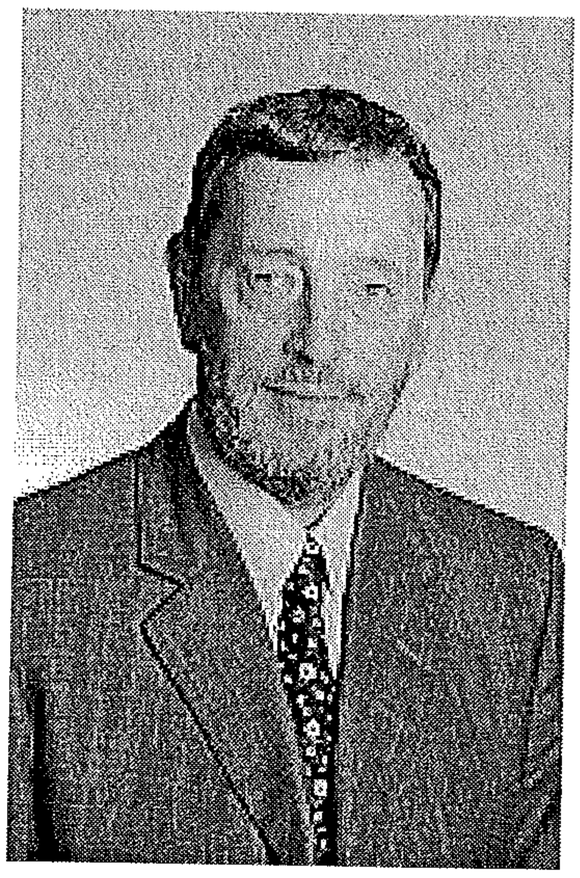
Both the Fundamental Review of Death Certification and Coroner Services, and the Shipman Inquiry, consulted widely on their recommendations for death investigation. This paper constitutes the Government's response to that work and contains our outline proposals for reform. It sets out what changes we are introducing now, and what we aim to accomplish over the next few years.

We do not intend to conduct a further period of public consultation, which could lead to unnecessary delay to this process of reform. However, as the proposals are developed over the coming months we will discuss the detail, practicalities and the costs with relevant professionals and those who have experience of the existing arrangements to ensure that what is proposed is effective, feasible and affordable.

The Northern Ireland Court Service has carried out wide-ranging consultation with key stakeholders on the application of the recommendations made for Northern Ireland by the Fundamental Review. It is publishing proposals for the administrative redesign of the coroner service in Northern Ireland that do not require primary legislation.

Contents

Foreword from the Home Secretary



DAVID BLUNKETT

An effective death certification and investigation system is a vital component of a civil society. It is essential for a modern system of public health monitoring as well as for the detection of suspicious circumstances, medical errors or other shortcomings. I believe the best way forward is to continue to have a single, seamless, system that meets both requirements, including a more detailed investigation into every individual death where there is a cause for concern. I am committed to providing a world class system.

The existing coroner and death certification arrangements have a long history. In general, the system has served us well over the years and is widely respected. That is a tribute to the hard work of many dedicated individuals within the existing system, who have kept it functioning as well as it has. But the law and practice no longer reflect our expectations for a modern public service. There is an irrefutable case for reform. Indeed, many coroners and others working in the system have expressed their desire for change and their willingness to move forwards in advance of the new legislative framework which I believe we now need to give proper effect to our proposals.

Change is necessary because many of the practices underpinning the coroner system are outdated (for example, coroners do not have access to a uniform information technology system; are not required to attend training or be subject to appraisal; and the funding arrangements for the service are archaic). Moreover, the practices do not allow effective performance management or promote consistently high quality; nor do they deliver a cost-effective service across the country (for instance, a bereaved family's experience can vary widely according to where the coroner's investigation takes place).

Secondly, public inquiries into Bristol Royal Infirmary and Alder Hey hospitals, as well as the Marchioness disaster and the murders perpetrated by Harold Shipman, have shown shortcomings throughout the system. In particular, Shipman's activities, which went undetected for years, highlighted the weaknesses in the death certification system. We must build a better system of death investigation so that such tragedies can never happen again. We are committed to the creation of a system in which the public will have confidence.

This document sets out the Government's proposals on the way forward. It draws on the work of, and the recommendations from, the Government-commissioned independent Fundamental Review of coroner and death certification systems, chaired by Tom Luce CB, former Head of Social Care Policy at the Department of Health, and the third report of the Shipman Inquiry chaired by Dame Janet Smith, an Appeal Court judge.

I am grateful to both the Inquiry and the Review for the enormous care and effort that went into their reports. We must respond fully to their well-argued conclusions. Although both identified similar shortcomings and the thrust of many of their proposals are broadly comparable, their recommendations differed in detail. This is largely due to the separate contexts in which the reports were generated. The Inquiry's remit was to investigate the criminal activities of an individual within the medical profession and how those crimes remained undetected for so long. When the Inquiry's report was published, I expressed my commitment to learning lessons from these tragic events, as did my colleague Dr John Reid, Secretary of State for Health. By comparison, the Review Group was tasked with evaluating the entire death certification and coroner systems in England, Wales and Northern Ireland, including the handling of deaths not requiring further investigation. I have considered both sets of recommendations very carefully with my Ministerial colleagues before reaching conclusions about the structure of a reformed system.

Although the criminal activities of Harold Shipman taught us a lot about the shortcomings in the existing systems, most deaths do not require detailed scrutiny or judicial investigation. I therefore propose to introduce a new system that will combine an independent check on all deaths and a professional oversight of death patterns, with, for the majority of cases, the minimum of bureaucracy. This will, we believe, enable us to avoid unacceptable delays to burial and cremation, putting the needs of the bereaved at the centre of the new system. We will also aim to ensure that the system will not impose unnecessary burdens for relevant professionals, for the voluntary sector, or for the public. However, I am confident that the approach now proposed should have the necessary capability to identify the limited number of cases where additional investigation will be needed. I am also committed to developing proposals to ensure that the system that is ultimately put in place represents good value for money: we need a system that is both effective and affordable.

The new coronial system we propose must be:

- **Independent** – free to judge the circumstances of a death without outside influence;

- **Professional** – its staff will be better regulated than at present and will benefit from continuous professional development, including training to high standards;

- **Medically-skilled** – staffed with qualified medical practitioners, and with ready access to high level medical and public health advice;

- **Modern** – providing a high quality service to the public at large and particularly to the bereaved, recognising their special needs and the input they can make to the death investigation process;

- **Consistent** – a uniform service across England and Wales, and Northern Ireland, with unified high standards of performance;

- **Robust** – better able to prevent or detect foul play on the one hand and, on the other, itself subject to rigorous inspection and performance monitoring; and

- **Transparent** – the public will understand the way it operates.

Within this framework, I look forward to using these outline proposals as a basis for developing a reformed system. More details will be published as work progresses. In the meantime, I have asked my officials to work closely with all those affected to take forward interim improvements as quickly as possible.

David Blunkett

The Home Secretary, the Right Hon David Blunkett MP

The current system

1. This outline briefly explains the existing arrangements for death registration, certification, coroners and coroner investigations in England and Wales, and Northern Ireland.

Death registration and certification

(see Figure 1 overleaf)

2. All deaths must be **registered** by taking the **medical certificate of cause of death** to the local registrar of births and deaths and providing further details about the deceased. Where the death is referred to the coroner and there is a need to hold an inquest, registration takes place following receipt of a coroner's certificate of cause of death after inquest.

3. The doctor who treated the deceased during the fatal illness can normally issue t**he medical certificate of cause of death**. However, if no doctor is able to do this with certainty or if the cause of death is unnatural, the case is referred to the coroner. There is no statutory obligation to **verify the fact of death**.

4. Following these steps, **burial** or **cremation** can be authorised. The registrar provides authority for burial when the death is registered. Where the body is to be cremated, there is an extra tier of certification required unrelated to registration. This involves:

   - Completion of an application form by the executor or relative arranging cremation.

   - The issue of a more detailed certificate, usually by the same doctor who issues the medical certificate of the cause of death.

   - The issue of a certificate by a second, independent doctor, who has checked the information provided by the first doctor.

   - Approval by a third doctor, the medical referee appointed for the crematorium where the cremation is to take place.

5. The doctors who issue the cremation certificates normally charge a fee. A fee is also payable to the medical referee.

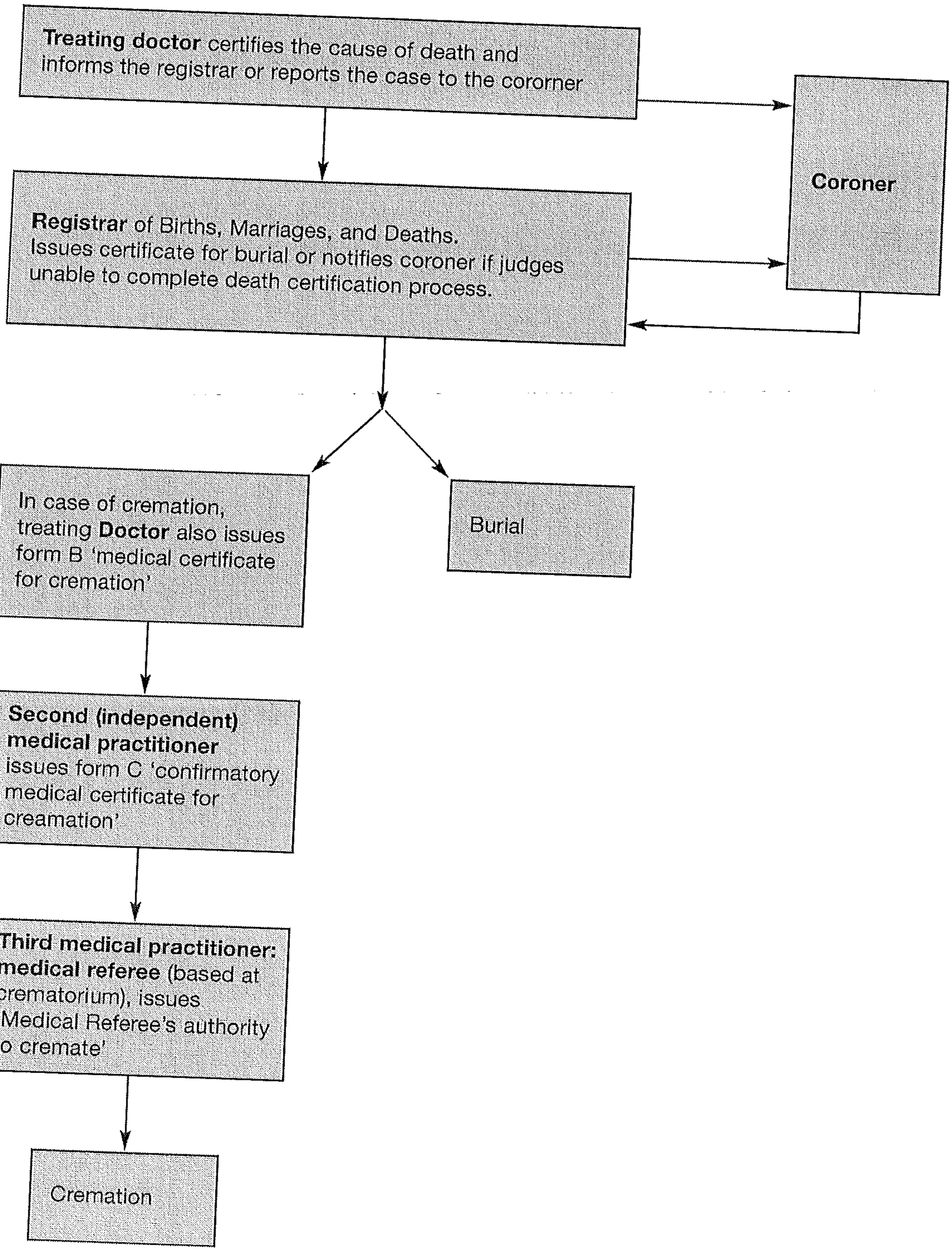
6. Where the death has been referred to the coroner, he or she may issue a certificate for cremation to replace those of the doctors in steps 2 and 3 above. If there is to be an inquest, the coroner will issue a burial order or a cremation certificate as required once no further examination is needed.

Figure 1. Current Certification Process

Indicative figures for England and Wales:

550,000 deaths per year: 70% resulting in cremation; 30% resulting in burial

200,000 deaths reported to coroners per year: 120,000 requiring in post mortems and 20,000 requiring inquests



Coroners

7. The certification arrangements rest largely on general practitioners and hospital doctors, who carry out these duties in the margins of their responsibilities for the living. The 200 or so cremation medical referees authorise cremations on a part-time basis.

8. If further investigation of a death is required, England, Wales and Northern Ireland have recourse to a specialist medico-legal investigator, the coroner, who operates within territorially defined areas. Although not widely replicated elsewhere in the world, the coroner system is well established here.[1]

9. There are 127 coroner jurisdictions in England and Wales, mostly based on administrative counties. Some coroners have responsibility for more than one area. A few work full-time but the majority work part-time depending on the volume of work within their jurisdictions. Coroners have a deputy and an assistant deputy to replace them when they are absent or engaged in other coronial work. There are seven coroners' districts in Northern Ireland.

10. The coroner can be legally or medically qualified (in Northern Ireland legally qualified only). Part-time coroners normally continue to work as solicitors or as doctors in private practice. The Home Office works with the Coroners' Society to provide training for coroners, which is attended on a voluntary basis.[2]

11. The coroner service is essentially a local service with a variety of local support arrangements. The coroner is appointed and funded by the local authority (by the Lord Chancellor in Northern Ireland) but holds office under the Crown.

Coroners' investigations

12. Each coroner operates independently to **scrutinise deaths reported to him or her**. Coroners have no powers in relation to a death not reported to them.

13. If a reported death appears to be violent or unnatural an **inquest** must be held. If the death was sudden and unexpected, but the coroner is satisfied as a result of his or her enquiries that the death was due to natural causes, no inquest is required. If an inquest is held, the coroner, or his or her jury in certain cases, is responsible for ascertaining who has died, when, where and how.

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[1] Similar systems exist in the Republic of Ireland and other countries with historic links to England and Wales, such as Australia and New Zealand, as well as some states in the USA and some provinces of Canada. The system is not used in Scotland or elsewhere in Europe.

[2] The Coroners' Society for England and Wales represents the professional interests of its members.

14. When a case is reported to the coroner, he or she may decide that a **post mortem** is required to help to establish the cause of death. Where the post mortem reveals that the death is of a natural cause, the coroner will not need to conduct an inquest. In other cases, it may be appropriate to hold an inquest but not to order a post mortem. A qualified medical practitioner carries out a post mortem examination on behalf of the coroner. The purpose of the examination is strictly to ascertain the cause of death. The coroner has the power to order a post mortem without the consent of the next of kin, as well as to remove and retain, for as long as necessary, any tissue or organs which may help to ascertain the cause of death.[3]

15. Coroner caseloads vary from 100 to 6,500 reported deaths a year.[4] The average caseload is around 1,560.[5] In 2002, some 200,000 deaths were reported to coroners in England and Wales; that is about 38 per cent of registered deaths. Of these deaths, 58 per cent were subject to a post mortem examination (but no inquest), and 13 per cent resulted in an inquest (mostly with a post mortem examination). In Northern Ireland, 14,586 deaths were registered in 2002[6], of which 3,563[7] (24 per cent) were reported to coroners, giving an average caseload of 509. Of these, 36 per cent were subject to post mortems without inquests and 6 per cent resulted in inquests (with post mortems).

Support for coroners

16. The 127 coroner jurisdictions in England and Wales are supported by 430 coroner's officers, of which 394 are full time.[8] Coroners' officers bring a variety of experience of working in other sectors, including the emergency services. Police authorities fund most coroner's officers, either as serving police officers or more commonly as police civilians (often retired police officers). Many coroners also have secretarial and administrative staff. For the most part, local authorities pay for these, although support is often also received through coroners' legal firms or medical practices by the sharing of clerical assistance and office accommodation.[9] In a small number of cases, there are staff employed directly by the coroner. In Northern Ireland, coroners are supported in their investigations by the police service, while financial and logistical support is provided directly by the Northern Ireland Court Service.

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[3] This contrasts with other post mortem examinations, frequently referred to as 'hospital post mortems', which are for medical research and public health protection purposes. The consent of the next of kin is required for these examinations.

[4] Not including the Scilly Islands or the Coroner of the Queen's Household.

[5] Source: *Home Office Statistical Bulletin: Deaths Reported to Coroners, England and Wales 2002*, 06/03 (HOSB 06/03).

[6] Annual Report of the Registrar-General for Northern Ireland

[7] Source: Northern Ireland Statistics and Research Agency

[8] Figures according to a recent survey conducted by the Home Office; see *Work underway*, below.

[9] Results of a recent survey conducted by the Home Office.

Government responsibilities

17. The work that coroners do relates to the responsibilities of a number of Government Departments and other organisations.

- The **Home Office** has policy responsibility for death certification and the coroner service, including the relevant legislation.

- **Local authorities** recruit, appoint and fund coroners, using resources provided by the **Office of the Deputy Prime Minister**.

- **The Lord Chancellor** has the power to discipline coroners; makes the Rules of Court; and supervises the Northern Ireland Court Service. The **Northern Ireland Court Service** is responsible for the coroner service in Northern Ireland. The **Department for Constitutional Affairs** has responsibility for policy on public funding for legal representation and, through the **Court Service** and **the Magistrates' Courts Service**, for the court estate which coroners widely use.

- The **Office for National Statistics** has responsibility for the registration of deaths and the production of mortality statistics.

- In England, the **Department of Health** and the **NHS** have responsibility for medical aspects of death certification and employ many of the pathologists who carry out coroner's post mortems. The **Department of Health** also oversees public health and uses mortality data from the **Office for National Statistics** in the development of preventative measures.

- In England, the **Department for Education and Skills** has lead responsibility for safeguarding and promoting the welfare of children. Local Area Child Protection Committees have responsibility for carrying out a case review when a child dies and abuse or neglect are known or suspected to be a factor in the death. The **Department for Education and Skills** commissions biennial overview reports drawing out the key findings of these case reviews and their implications for policy and practice.

- In Wales the **National Assembly for Wales** is responsible for health. In Northern Ireland, that responsibility rests with **Department of Health, Social Services and Public Safety**.

- There are also links to the **Foreign and Commonwealth Office**, where a death occurs abroad; **the Department for Work and Pensions** in relation to benefits for the bereaved and pensions; the **Department of Trade and Industry** for accidental deaths in the home, and the **Health and Safety Executive**.

18. The **Attorney General's** consent must be obtained before an application to the High Court for a new inquest can be made, or he may apply himself. In exercising this function, he acts quasi-judicially as guardian of the public interest, and not in his role as a member of the Government.

19. In addition as a legacy of the mediaeval origins of coroners, inquiries into local treasure finds (formerly treasure trove) are also undertaken by coroners. This provides a link to the **Department for Culture, Media and Sport**, which is responsible for the law relating to portable antiquities and for museums.

Summary of key proposals for change

The Government wishes to retain the coroner system but is committed to its reform, as well as to a complete overhaul of the death certification system.

The Government believes that effective and affordable death certification and investigation could be achieved by reorganising and re-focusing the existing arrangements. A reformed coroner service would:

- meet the needs of the bereaved and the public at large
- deal quickly with the majority of deaths
- identify more effectively those cases requiring investigation and target resources accordingly
- operate consistently across England and Wales, and Northern Ireland
- have regional oversight of death trends through Regional Directors of Public Health (Directors of Public Health in Northern Ireland and Wales)
- be a better managed and more professional national service under a chief coroner, with around 40-60 coroners, and dedicated trained medical support
- be judicially independent
- have an advisory Coronial Council
- have direct links to public health
- incorporate a greater degree of medical expertise in scrutiny, training, and accountability
- ensure there is a system of inspection and monitoring to attain high standards
- work within a new legislative framework for death investigation, with close links to other relevant professionals, for example registrars

Our proposals provide for verification of the fact of all deaths; for certification of the cause of death by the doctor, as now; for scrutiny of all certificates by a medical examiner in the coroner's office; and for referral to the coroner of all deaths which cannot be certified or which are unnatural.

Such a system would be more robust without causing unacceptable delay. As now, the great majority of deaths would not require an inquest. However, those deaths that required further investigation would be subject to public judicial proceedings. The product of the inquest would be more clearly focused on the need to learn lessons and to avoid preventable deaths. There would need to be a clearly defined relationship between the death investigation and public health systems.

This model is set out in Annex 1. A new system must be affordable and over the coming months, we will ascertain how existing resources can be re-allocated to enable us to develop the reformed system.

Comments on the outline proposals contained in this document should be sent to Amaryllis Elphick, Coroners Unit, The Home Office, Allington Towers, 19 Allington Street, London SW1E 5EB. Amaryllis.Elphick[redacted]

The Government's approach

20. The Government has considered very carefully the recommendations of both the Fundamental Review of Death Certification and Coroner Services, and the Shipman Inquiry. It has noted that both identified similar shortcomings in the existing arrangements and that there was considerable agreement between the two as to what changes should be made to achieve a death investigation system that was appropriate to the particular circumstances of England and Wales, and Northern Ireland. In particular, strong support was articulated for maintaining a coroner system. No recommendations were made to adopt either the arrangements in Scotland (where the procurator fiscal has overall responsibility for the investigation of criminal, sudden and unnatural deaths), nor any of the non-coroner systems elsewhere in the world.[10]

21. The Government has accordingly decided to continue to rely on specialist coroners to provide an effective, coherent, and publicly accountable death investigation system. This system is widely accepted within the British Isles as the appropriate mechanism to oversee deaths. However, it must now be set within a new framework which will deliver real benefits to families and public health policy, help reduce avoidable deaths, and detect and deter medical malpractice and crime.

22. The Government's final decisions on the shape of the new arrangements must have regard for their affordability. By streamlining the current system and redeploying existing resources we intend to create a new system which, in total, costs no more than at present. However, the complexity of the current arrangements means that more work is required to assess exactly what funds go into the system. When this is complete, we will establish costings for the proposed system and finalise the feasibility of transferring the available funding. We therefore intend to work over the coming months with the professionals involved to draw out the financial detail in order to reach firm conclusions on the way forward, informed by responses to the proposals in this document and taking account of those options providing both an effective service and best value for money.

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[10] The Fundamental Review of Death Certification and Coroner Services looked at systems in other countries. The Review divided all forms of death investigation into three broad categories:

- generic criminal investigation and the judicial system;
- a medical examiner system; and
- the coronial system.

Germany and France rely on their normal criminal and judicial structures to investigate sudden or unnatural deaths. This means that the priority in these and many other European countries is to establish whether deaths that are suspicious are criminal, rather than to ascertain the facts of all sudden and unnatural deaths, which can inform public health policy.

Conversely, the medical examiner system found in the United States of America and in some provinces in Canada not only provides a forensic service in criminal cases but also investigates non-criminal deaths. Apart from its input to criminal cases, the procedures are usually administrative rather than judicial. Its results can feed into public health protection.

The reformed system

The bereaved

23. Central to the changes we are proposing is the need to make the system **sensitive to the needs of the bereaved** and to provide a high standard of service in what are inevitably difficult circumstances. We will balance the need to put families at the heart of the system with the requirement for the service, acting independently and scrupulously, to find the answers to questions concerning a death and to provide accurate information for public health purposes.

24. All those involved in the new system will be expected to approach families and friends sensitively in all cases. Both the Fundamental Review of Death Certification and Coroner Services, and the Shipman Inquiry recommended a more involved role for the family of the deceased. The Inquiry makes it clear that the bereaved can frequently provide relevant further information. We propose to make this an integral part of the new system so that it will be **easier to raise any concerns** families may have about a death in future.

25. We will set out in a **family charter** precisely what the deceased's family can expect from the service. This will be displayed in all coroners' offices and be provided for all those coming into contact with the service.[11] The role of others involved in the process, such as **witnesses**, will also be made clear in the reformed system, together with what they can expect from the coroner service.

26. The family charter will recognise the needs of **all communities**, including the particular sensitivities of some faiths and individual families. These needs will be respected as far as is consistent with the social obligation to undertake a thorough investigation of individual deaths in certain circumstances. Some faiths, for example, require prompt burial and our proposals must ensure this is achieved wherever possible.

27. In accordance with recommendations from the Fundamental Review and the Shipman Inquiry, we aim to raise the **public profile** of the service. We propose to do this by encouraging coroners to initiate or to continue programmes of public events, including visits and talks, in order that the public has a better understanding of their work.

Death verification and certification

28. Our outline proposals for death verification and certification recognise the need for better **medical scrutiny** in the system, as identified in the Shipman Inquiry's Third Report and by the Fundamental Review. The

[11] The family charter will be a logical follow-on from work already underway to improve the availability and consistency of information for the bereaved provided by all agencies, whether or not they come into contact with the coronial system. See *Work underway* below.

proposals also acknowledge the need for better **audit, checks, and safeguards**, similarly recommended by both the Inquiry and the Review.

29. Under our proposals the fact of death would be **verified** as a separate step from certification of the cause of death. A doctor, paramedic, or senior nurse (a 'verifier') should be able to corroborate the fact of death and complete a verification form. This would start a comprehensive case record and the collection of medical and circumstantial documentation for all deaths, using relevant information technology. It would also enable the authorities to remove a body more promptly from the scene of the death, if that is required or requested. Although protocols exist allowing paramedics to do this work in some areas, present practice is generally for a doctor to attend the scene of all deaths before a body can be removed. This can lead to delays, which are distressing for families and friends. It also places an additional and unnecessary burden on doctors. The proposed procedure would provide more flexibility and release some doctor resources.

30. Once death is verified, a doctor who treated the deceased in the immediate past (referred to here as a 'first certifier') would, as under the current system, be required to complete a **certificate of the medical cause of death**. This is usually a hospital doctor or a general practitioner, and in the future could in some cases be the same person who verified the death. The new coroner service would need to provide training for doctors in first certification. First certifiers, who treated the deceased, would know that their certificate would be subject to close subsequent scrutiny by a medical professional. We think that first certifiers should also specify when they last saw the deceased and why they are satisfied they can certify the death accurately. A routine or random requirement to produce evidence to support this (for example, medical records, results of laboratory studies, or X-rays), coupled with a separate death verification procedure would deter careless or dishonest first certification.

31. We propose that all deaths would then have to be referred to a different medical practitioner (called the 'medical examiner' throughout this paper). The **medical examiner** would be a qualified doctor employed by the new coroner service. The examiner would be independent of the Health Service. This is a necessary safeguard in cases where there may be questions of hospital negligence or medical malpractice. He or she could be based in the coroner's office. The examiner would head a small **team of staff**, all with a clinical background, to screen all cases under the examiner's close supervision. Regular training and continuous professional development would be needed to support the examiner and the team. They would be able to access or seek relevant information about the deceased, including information from the deceased's family, so that the cause of death as given by the first certifier could be confirmed with confidence. The medical examiner and team could also provide regular feedback on their assessments to first certifiers (general practitioners and treating hospital doctors).

32. Once the medical cause of death has been confirmed, the medical examiner could **authorise burial or cremation** in cases not reported to the coroner. This would avoid unnecessary delay to the funeral and remove an existing responsibility from the registrar of births and deaths.

33. Such a system would enable the medical examiner to take over, in most cases, the current role of the coroner in authorising the **removal of bodies abroad**, where the next of kin requires someone who has died in England, Wales or Northern Ireland to be repatriated to another country.

34. Similarly, where bodies are **repatriated here** from other countries, the medical examiner would be well placed to authorise their burial or cremation. This would simplify the current arrangements whereby most applications for the cremation of bodies repatriated from abroad need to be made centrally to the Home Office.

35. The most effective arrangement would seem to be for the medical examiner to be appointed and managed from within the coroner service. He or she would continue to work closely with the registrar of births and deaths to provide a **seamless service** for the benefit of the public and for the collection of public health data.

36. We envisage that Regional Directors of Public Health should play a role in the examiners' appointment and the new service would have systematic links with **public health intelligence** arrangements. Both the Fundamental Review and the Shipman Inquiry recommended a more robust approach to death prevention and more effective use of the data the systems acquire. To this end, medical examiners could be responsible for keeping a database of deaths in their locality to help support public health initiatives as part of the need to strengthen our understanding of the pattern of deaths that occur. The Regional Directors of Public Health could be responsible for ensuring that data collected in this manner within their region was used appropriately to:

- identify regional trends in deaths;
- monitor the effectiveness of current public health initiatives; and
- inform future public health initiatives.

37. Similar arrangements could be made in support of the investigation of child deaths, liaising as appropriate with local authorities, Area Child Protection Committees and their successor bodies (Local Safeguarding Children Boards) and the relevant Inspectorates.[12]

38. This robust approach to the certification of all deaths would remove the need for additional certification in cases where the deceased is to be

[12] These would help give effect to the Government's proposals for safeguarding children, as set out in *Every Child Matters* Cmnd 5860.

cremated. As recommended by the Fundamental Review and the Shipman Inquiry, our proposal is that the **same system of certification would apply to all deaths**. It would be performed by a service where doctors would be better trained and more closely scrutinised.[13] The Shipman Inquiry recommends that more information about the circumstances of the death needs to be gathered than is currently collected. We will consult with organisations representing bereaved families on how best the medical examiner, and the coroner's investigating staff, can cross check the information from the first certifier. We will bear in mind the need for rigour and independence as well as sensitivity to the family and friends of the deceased. The proposed new system of certification, combined with plans for electronic record keeping by the NHS and developments in electronic registration, would mean that all relevant information could be captured and fed into the death investigation system.

39. Where a death occurs that is not due to a naturally occurring disease or degenerative process, or where the medical cause of death is unknown, we believe that there is real value in holding a judicial inquest. This allows the death to be publicly investigated by a local coroner in a court setting. Two types of death might be **referred to the coroner**: those from a list of reportable cases (for example, deaths in custody or deaths following occupational health treatment; see sample list at Annex 2) and, as at present, cases where the treating doctor is unable to certify the cause of death.

40. In cases referred to them, we propose that coroners should continue to be responsible for **ascertaining who has died; and when, where and how the person died**. They would also need to operate **independently** - of the Government, relatives of the deceased, and any other person or organisation which might have an interest in the death. This would be in line with the suggestions of the Fundamental Review and the Shipman Inquiry. We do not believe that the remit of the coroner should be extended to encompass civil liability or criminal responsibility on the part of a named person. When a case is reported to the coroner, he or she would continue to decide whether:

    a) the medical cause could be certified on the basis of information already available (with the advice of the medical examiner);

[13] Annual appraisal, linked to five-yearly renewal of the GMC licence to practise, has been introduced for doctors working in the NHS. This requires the doctor to bring to the process evidence about their whole practice, including that undertaken outside the NHS. One outcome of the process will be an agreed Personal Development Plan which will identify areas for development, including new or revised professional or clinical competences, and how to achieve them. Anonymised aggregated data from appraisals will be used to inform business planning and educational needs. In order to renew their licence to practise, all doctors (including those working wholly outside the NHS) will need to show the GMC that they have kept up-to-date and are fit to practise medicine in their particular field.

b) any medical tests were required (with the advice of the medical examiner), including whether or not to conduct a complete or partial post mortem examination; and

c) the case required an inquest.

41. When first certifiers identify cases that, in their view, should be reported to the coroner, we think that these should still be referred initially to the medical examiner and his or her team. This would provide consistency in auditing the work of first certifiers and filter out reports that did not, in the end, need to be referred to the coroner. This process would enable the medical examiner to provide an informed **medical account of the case**, which could then be submitted to the coroner if the case is reported to him or her. In this way, the system could gather the valuable information that the Shipman Inquiry identified as required for a comprehensive death investigation system.

42. The medical examiner could also provide any **supplementary advice on medical matters** that the coroner required, making all coroners' decisions much more medically sound. It would seem sensible for coroners, rather than the medical examiners, to be responsible for authorising burial or cremation in all cases that were reported to them. Within the proposed new system, it would be desirable if all decisions could be reported back to the first certifier and to the family.

43. Coroners could provide an additional safeguard by having a power to conduct **targeted further investigations**, as suggested by the Fundamental Review and the Shipman Inquiry. The medical examiner would advise the coroner in such cases, as well as help to identify potential targets for further investigation. This might arise, for example, with deaths in a particular hospital or care home. It would be important to ensure that coroners exercised any such powers with minimal disruption to the bereaved. Effectiveness would be enhanced if lines of responsibility were strengthened between the coroner and other investigating agencies, such as the Health and Safety Executive; the Commission for Social Care Inspection and the Commission for Health Audit and Inspection.[14]

44. A death certification process with better training, dedicated staff, and more robust checking of cases not referred to the coroner, would mean that the new procedures would be more effective and provide a **better safeguard for the public**. Such an approach would rid the system of the loopholes that enabled Harold Shipman to conceal his activities for so long.

[14] The Commission for Social Care Inspection will take on the National Care Standards Commission's (NCSC) role of regulating social care providers. The regulation of private and voluntary healthcare providers will move from the NCSC to the Commission for Healthcare Audit and Inspection. Both commence in April 2004.

Structure and personnel

45. We need to establish whether the Home Office would continue to be the most appropriate **parent Government Department** for the coroner and death certification services. We must ensure that we have in place a structure that best supports any new system.

46. We propose the creation of one **national jurisdiction** for England and Wales. This might then be divided administratively into local coroner areas, serving a population of a suitable size (one million may be a reasonable benchmark but the precise definition of local areas must take into account local conditions and the boundaries of the agencies with which the coroner service will be working). National jurisdictions should give greater consistency as well as increased flexibility in the deployment of resources. Arrangements for ready local access to the system would be vital. We would want inquests still to be held locally wherever possible.

47. Each **local coroner area** would have a full-time coroner assigned to it, supported by deputy coroners to cover absences, and a sufficient number of coroner's officers having regard to caseload.[15] Each coroner's office would also need to house at least one medical examiner and his or her team. Each area might therefore have a staff of about ten people. Against this background, the case for a separate coroner of the Queen's Household seems anomalous. We anticipate that this post would be abolished.

48. In order to provide professional guidance and leadership to the service, we believe there is a case for the appointment of a **Chief Coroner**. The Chief Coroner would be responsible for the deployment of coroners; oversee professional standards; and might undertake the most complex inquests where it seemed appropriate. He or she could also represent the coroner service in its dealings with other organisations and agencies. The Chief Coroner would not be subject to Ministerial direction.

49. Having regard to the importance of medical expertise, we believe there is a need for a **Medical Advisor to the Chief Coroner** to maintain professional medical standards and provide high-level medical oversight and advice to the service.

50. In order to provide accountability for the service to Ministers and Parliament but without jeopardising the judicial independence of the chief coroner it would be appropriate for responsibility for the administration and performance of the service to lie with a **Chief Officer**.

51. These arrangements should in themselves suffice to ensure the effective performance of the service, alongside its judicial independence. We will introduce a system of **inspection**, as recommended by the Fundamental

[15] Part-time and job share arrangements could be used to cover full-time posts.

Review. This would involve consideration and advice on standards across the national jurisdiction. It would not look at coroners' judicial decisions, however, which clearly need to remain independent and subject to the oversight of the higher courts. Shortcomings could be reported to the Chief Coroner, the Medical Advisor, or the Chief Officer (as appropriate) for action.

52. We believe that a new system must be open to advice from those with whom it deals. We would therefore propose to create an advisory **Coronial Council**, initially administratively, but in due course on a statutory basis, whose members could be drawn from the various professional stakeholders as well as lay organisations. A Council could be an effective way to harness relevant experience and expertise to assist any new arrangements to deliver a responsive and informed service for all those affected by, or with a professional interest in, deaths.

53. Both the Shipman Inquiry and the Fundamental Review consider **a right of appeal** to be a requirement of a new system. Currently the bereaved have very limited rights of appeal in respect of judicial decisions taken by the coroner. There is provision for a fresh inquest to be ordered by the High Court, on an application made by, or with the authority of, the Attorney General. There is also provision for the High Court to oversee the coroners' decision-making process by means of judicial review. We anticipate that an improved coroner service with more consistent decisions would mean that few people would have cause to appeal. However, we wish to consider a simpler, more effective, and accessible appeal process should the enhanced system require it.

54. We will consider the costs and benefits of an **improved and uniform IT system** that captures mortality data; is open to audit; and can be interrogated for relevant statistics. Such a system should also enable coroners to communicate effectively with each other, including sharing best practice. Many coroners' information technology packages currently allow officers and support staff to monitor the status of any case. A uniform system would enable them all to do this in a consistent way, and may link to new electronic registration data and to plans for electronic health records. Better IT would lead to improved case management and, ultimately, fewer delays.

55. We need to consider how to provide better and more accessible **offices and courts** for coroners and their staff. Few coroners have dedicated courts, or even office accommodation. Facilities for families and witnesses can be limited. We will consider co-location of coroners' officers with other relevant services, such as registrars in suitable areas; a number of coroner's offices already benefit from this, for example, Teesside, Liverpool, and Sandwell and Dudley. This not only reinforces professional links but is also more convenient for the bereaved. We will also consider how the existing court and tribunal estate across all jurisdictions could be used more effectively to provide good-quality locations for inquests.

56. Coroners and their deputies should in future always be appointed through fair and open competition. Their **terms of service** should be much more clearly defined and consistent than they are now. We would expect all coroners to be **legally qualified** and to work to a nationally applied job description. Those with only a medical qualification would not be eligible to become coroners.[16]

57. We envisage **a highly skilled and respected profession**, as independent as the judiciary and as diverse as the society it serves. Local knowledge and sensitivity to the needs of the community would remain important.

58. We aim to provide a programme of **mandatory professional development** for coroners, centred on compulsory and continuous training. We will consider the introduction of a vocational qualification linked to their training programme.

59. We understand how important it is for the work of the coroner to be supported by a team of **coroner's officers and administrative staff.**[17] We think that, in future, coroners' officers and administrative staff should be employed directly within the new service.

60. We see the coroner's officer as having a more clearly defined and consistent **investigative role** than is often the case at present: going out to take statements from the next of kin or to visit scenes of death, where relevant. In this way, they could take over from the police many responsibilities in relation to non-suspicious deaths. Coroners' officers would need to continue to maintain close links with bereaved families throughout the death investigation process.

61. As now, it would be for coroners' officers to obtain relevant **information** regarding the circumstances of reported deaths **from the bereaved**. As the Shipman Inquiry recommends, it is important that the bereaved have an opportunity to raise any concerns that they have with the coroner's officer and to supply any information they consider relevant. Any new system will need to facilitate this.

62. Currently there is no universal **coroner's officer training**. In due course, we would want all officers to receive mandatory training as soon after appointment as practical. **Support and administrative staff** should also have access to relevant training opportunities.

<u>Coroner's investigations</u>

63. The coroner currently has no statutory **power to enter premises or to seize documents** in order to investigate the circumstances of a death. However, in some cases the only way to establish the identity of a next of kin is to enter the deceased's home. New legislation would be needed

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[16] However, we would expect to allow existing medically-qualified coroners to be eligible to apply for coroner appointments in any new system.

[17] There is no post of coroner's officer in Northern Ireland, where the police carry out the duties of coroner's officer.

to give the coroner, or those acting on his or her behalf, increased powers to enter premises and to seize documents relevant to the investigation; although there would be safeguards to ensure that such powers were only exercised when justified.

64. There is currently a marked inconsistency across the country **in the proportion and scope of post mortem examinations** that coroners request.[18] This cannot readily be justified and we welcome the efforts currently being made by coroners, the Royal College of Pathologists and individual pathologists to ensure that discrepancies in approach are addressed.[19] Establishing the medical cause of death and associated circumstances is the aim of the coroner's post mortem and the work must be carried out to agreed professional standards, and open to audit. There must not be an automatic recourse to such examinations, which we know can cause distress to the bereaved.

65. We set out above how we would wish to improve medical oversight in the system, which should enhance the current contribution by the pathologist working for the coroner. Having an increased medical input into the system would also facilitate **better use of post mortem medical examinations**, as the Fundamental Review and the Shipman Inquiry Third Report have recommended, because coroners will have access to proper medical advice when taking a decision on whether to order such examinations.

66. Where such examinations are necessary, coroners would be able to take advice from their medical examiner to ascertain and prescribe the **minimum level of invasiveness** to establish the cause of death. To minimise invasiveness, pathologists must have as much background information as possible to inform their work, including details of any medical procedures and examinations that took place before death. Nevertheless, they must also have the option to extend the scope of their examination if that is what it takes to ascertain the cause of death.

67. Coroners must continue to have the option to **retain any tissue or organs necessary to ascertain the cause of death** but in all cases the next of kin must be told that they have done so and for how long the tissue will need to be retained. The Coroners Rules governing this procedure need to be clarified to remove current uncertainties. As now, consent from the bereaved would not be required where the coroner retains organs and tissue for the purposes of death investigation. However, retention should only take place where absolutely necessary and the coroner and his or her other staff should take account of the needs of families and friends carefully throughout the process. Relatives must have the option to discuss and decide on the options for the disposal of retained tissues and organs, when they are no longer required for the investigation of the death.

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[18] HOSB 06/03 (See footnote 5)

[19] Annual appraisal, linked to five-yearly renewal of the GMC licence to practise, introduced for doctors working in the NHS is outlined in footnote 15 above. This will include pathologists.

68. In order further to facilitate **close working relationships** between coroners and pathologists, we will seek to build on examples of good practice already underway. For example, the medico-legal centre in Sheffield accommodates both the coroner and pathologists on one site (this includes the Forensic Pathology Department of Sheffield University, which has expanded to include the former department at Leeds University). Similar arrangements exist in Birmingham and Westminster. Such solutions may not be feasible everywhere but we will look at ways to enable all coroners to benefit at a regional level from the types of facilities that are currently only available in a limited number of locations.

69. We believe that the inquest should remain a **public hearing** into the circumstances of unnatural deaths, providing an essential safeguard and public scrutiny. We have carefully considered whether certain inquests should be conducted in private but this is difficult to reconcile with the principles of open justice. However, we would particularly welcome further views on what remains a finely balanced issue. It is not practical for inquests to be subject to inflexible time limits but we would expect most, as now, to be completed within six months.

70. We consider that there should continue to be **certain cases where inquests will be mandatory**. These must include deaths in custody; multiple deaths after a disaster; workplace deaths; and those cases where the death is alleged to have been caused by state agents.

71. Special arrangements will be needed where **other investigations** about the death or circumstances of the death are also underway (for example, criminal proceedings). In general, the coroner's work would, as now, wait upon their outcome. We do not think that a coroner should be obliged to investigate a death, when he or she is satisfied that it has already been adequately investigated by other means.

72. **Pre-inquest hearings** to establish the scope of the inquest in complex cases may benefit from being put on a statutory footing. Where inquests are likely to be especially lengthy or complex, provision may also be needed for coroners to have the assistance of **Counsel**, should that seem appropriate. We need to consider further, however, whether the cost of these arrangements would be offset from savings in the length of and improved effectiveness of the inquest.

73. **Juries** (which consist of between 7 and 11 jurors in inquests) are currently mandatory in certain cases. We believe the existing basis for using juries should continue. Broadly-speaking, juries are required where a death raises issues of broad public interest or confidence, for example a prison death, or where key facts are disputed. The size of coroners' juries needs to be rationalised so that they are both effective and practical. We do not consider that they need to be as large as a criminal jury: the jury in an inquest case has an entirely different function. A maximum of nine jurors would, we think, be an appropriate number (and could allow for majority verdicts) but an inquest might continue provided there were no fewer than seven jurors.

74. The most effective outcome for inquests would, in our view, be a **narrative verdict**, as current short-form verdicts do not always give an adequate explanation and are used inconsistently.[20] Narrative verdicts can be more helpful and informative than simple verdicts such as 'accident' or 'misadventure'. The latter can be used inconsistently and are sometimes without any clear distinction. They can also imply that no-one was responsible for a death rather than that the death was not intended. Narrative verdicts provide a fuller explanation of the circumstances of a death and better inform mortality data for the prevention of similar occurrences.[21] As the Fundamental Review makes clear, consideration would need to be given to how narrative verdicts can be recorded in a meaningful way to help inform mortality statistics, death prevention strategies and public health policy.

75. The provision of **public funding for legal representation at inquests** is at present limited. The Fundamental Review recommended that such funding should be extended to families in all cases where a public authority was legally represented. We do not propose curtailing the present criteria for public funding. However, finding an equitable and affordable formula that will provide relatives and others affected by an inquest with the level of legal support they need raises complex issues that require further consideration as our proposals develop. Legal representation needs to assist the court to make swift, accurate and complete findings, rather than become a source of additional delay.

76. Coroners may currently **report the circumstances of a death to an appropriate authority to try to prevent similar deaths in the future**. However, the authority is under no obligation to respond or take action. Nor is the existence of coroners' reports widely known. There is no mechanism for monitoring reports from different coroners in relation to similar problems or shortcomings. It is vital for better use to be made of the lessons that can emerge from a coroner's investigation. We think it might be helpful if **coroners' reports** were sent to the Health and Safety Executive and to any relevant inspectorate or Directors of Public Health, as well as to the individual or organisation directly responsible for the circumstances. This process could be assisted by production of an **annual report** to be presented to Parliament by the Chief Coroner. This could recount reports made, responses received and action taken.

77. Responsibility for the investigation of **treasure** finds sits uneasily with a coroner system designed primarily for the investigation of deaths. We are considering with the Department for Culture, Media and Sport, and the British Museum how to ensure historic finds can be adequately

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[20] Narrative verdicts consist of a short descriptive and non-judgmental account of the facts leading to the death.

[21] The use of narrative verdicts in inquests has been considered by the House of Lords in the case of *Middleton v HM Coroner* for the *Western District of Somerset and the Secretary of State for the Home Department* and the outcome will be taken into account before reaching final decisions on this issue.

investigated without a disproportionate diversion of coroner resources away from death investigation. Options include: a small number of coroners specialising in such cases; another judicial officer or organisation to undertake the function; or a single judicial officer (a coroner or other) to conduct all treasure inquests across the national jurisdiction.

How will we get there?

78. We have set out our vision for a reformed system in the preceding pages. In what follows, we outline the steps we are taking to work towards this.

Timing

79. An indicative timetable is attached at Annex 3. Broadly, reform is planned to be a four-stage process:

1. Interim improvements which are already underway (see pages 27-29 below for further details)

2. Resolving the detail and costs of the new proposals (see below).

3. The creation of a representative Coronial Council in England and Wales, with members from Northern Ireland, to help us to take forward improvements that can be made without new legislation. A separate council in Northern Ireland might prove appropriate in the future.

4. The introduction of new legislation and complementary Rules of Court and procedural guidance to complete the reform process as soon as the Parliamentary timetable allows.

80. This four-stage approach will help us to create a system that can adapt to changing requirements. The coronial council would be an independent advisory body, which would work administratively until it had the appropriate statutory basis. It would help the service to maintain the highest standards of performance and consistency across England and Wales, and Northern Ireland.

81. Each stage of work, including the new legislation necessary for reform, would need to be integrated with a number of other related initiatives. These include:

- modernisation of the registration service being undertaken by the Office for National Statistics;[22]

- the ongoing review of the forensic pathology service within the Home Office;

- work on public inquiries and judicial appointments; and the creation of a Unified Courts Administration and Tribunals Service being carried out by Department for Constitutional Affairs; and

[22] The Office for National Statistics issued a consultation document on reform of registration in July 2003. The closing date for comments was 24 October 2003. Responses are now being analysed and Ministers will take decisions on the future of registration based on these responses. Reform of coroners' work will link into any changes to the registration system.

- the Human Tissue Bill and other work on the taking and use of organs and tissues, including the proposed Human Tissue Authority, being led by the Department of Health. This builds on the advice issued by the Chief Medical Officer in response to the reports on Bristol and Alder Hey: *The Removal, Retention and Use of Human Organs and Tissue from Post Mortem Examinations*.

82. We will also need to ensure that reform is in line with the current review of burial law. We published a consultation paper on this subject on 15 January 2004.

Funding

83. Funding for death certification and the coroner service currently comes from a number of sources: local government (in England and Wales), the police (provision of most coroners' officers), the public (cremation certification) and central government (mainly in Northern Ireland). Coroners' solicitor's offices or GP surgeries provide additional support, where the coroner combines coronial work with private practice. Because of these complexities, further work will be needed to determine the precise level of total resources deployed within existing system.

84. We intend our reforms to be affordable within existing resources. To achieve this, we will need not only to make an accurate assessment of the existing resources and likely expenditure, but also ensure that existing resources can be captured and re-directed towards the new system. We will also need to plan a timed development and phasing as necessary for resourcing.

85. One of the principle purposes in publishing these proposals is to provide a basis for further discussions and development. There remain a number of variable factors, including the workload and staffing levels for any new service, which cannot be estimated with precision in advance of discussion of the overall model with practitioners and relevant professionals. For this reason we are not yet in a position to give firm and final costings for the new coroner system outlined in this paper.

86. Our proposals have however, been devised on the basis that a reformed system will be funded from within the existing resources in the coroner and death certification services. We will have to revisit the proposals if the funds are not realisable or if the plans prove too costly. Our final decisions will have regard to both affordability and value for money.

87. We will approach this work over the coming months by continuing to refine our knowledge of what resources are where in the current system, building on the most detailed and up-to-date figures that are available and using the information gathered by the Fundamental Review. In advance of a draft bill, we will work with stakeholders to cost and refine all the processes that will be required to run a new system, as they are determined in greater detail. These will then be subject to formal consultation as part of a draft bill.

Work underway

88. Work is already in hand to improve the current system. So far as England and Wales are concerned:

- In April 2003, the General Register Office circulated additional guidance to registrars on the procedures to be followed when deaths are reported to coroners, but where further inquiries need to be made of the doctor certifying the death. The Home Office issued comparable guidance to coroners.

- The Home Office has tightened up existing cremation arrangements. In November 2003 advice was issued to cremation authorities on the appointment of medical referees and detailed guidance was issued to medical referees on cremation procedures. Similar advice was drawn to the attention of all doctors in England early this year. The advice is also being promulgated to doctors in Wales.

- The Home Office is also working with the Department of Health to provide better information and support for families when a post mortem takes place. This builds on the extensive guidance issued by the Department of Health in April 2003, to inform and support families at the time of post mortem.

89. In England and Wales, we are also working towards other goals.

Providing higher quality and more consistent information for families
Both the Fundamental Review and the Shipman Inquiry made recommendations relating to the needs of bereaved families including improvements in the provision of information. With the help of key stakeholders, including hospital bereavement trusts and support groups, we have identified the information that is currently available. We are discussing with coroners' representatives how best to maintain a stock of core information, including details of local support groups, which can be drawn to the attention of the bereaved. We are considering the feasibility of a short leaflet, produced locally, which could include details of the coroner, registrars, bereavement services and support groups. Guidance has also been produced on the information that families are likely to need, based on most frequently asked questions.
This work will ensure that in future the service provided is much more family friendly. *A project group has been set up to look at what information coroners should routinely make available. Officials will work with organisations dedicated to looking after the needs of the bereaved, such as Cruse Bereavement Trust, and with other stakeholders in the bereavement process to promote a more joined-up approach.* *Officials are also working closely with the Westminster Coroner's Court Support Service, a voluntary group which provides practical support to all victims and witnesses who attend this court. The aim is to pilot an extension of this model in other London jurisdictions.*

Supporting coroners in order to achieve greater consistency in decisions which relate to the use of post mortem examinations
Both the Shipman Inquiry and the Fundamental Review of Death Certification and Coroner Services call for a more targeted use of the post mortem examination. We are working to find ways to achieve greater consistency in the decisions coroners take on the need for medical and laboratory investigations. In some areas coroners carry out post mortems in almost all cases that are referred to them. Elsewhere they request very few post mortems. We aim to ensure that the decision to conduct a post mortem is only taken after careful consideration of all the available facts. We want to raise standards of post mortem practice and to ensure that, where an autopsy is required, it will be conducted to the minimum level of invasiveness consistent with the need to ascertain the medical cause of death or other relevant information. Appropriate use will be made of toxicology, microbiology, and histology, as well as full use of the information from any medical consultations or examinations that took place before death.
We expect this change to take root over time as protocols are established locally between coroners and pathologists that reflect national standards. Future reform, outlined elsewhere in this paper, will be designed to reinforce this move towards consistency.

Developing coroners' procedures in relation to post mortem examinations
Recent reports on the way in which organs and tissue have, without authority, been retained for other uses after coroners' post mortems have highlighted the need for better information for families, tighter supervision over processes, and clearer instructions for pathologists. There is also a need to ensure that coroners' procedures link seamlessly with the new provisions regulating examination practices contained within the current Human Tissue Bill.
Coroners have generally introduced new procedures to ensure that families are kept properly informed where material needs to be retained and that their wishes for the disposal of any such material are observed. More work is required to take account of the requirements of the Human Tissue Bill, and this will be progressed during 2004 with the passage of the Bill.

Identifying those resources currently in the system that might be used better or in different ways
Officials have undertaken a survey of all coroners' offices to establish what resources are currently in the system (including staffing, mortuary and court facilities, and information technology). This information will provide a firm basis from which to develop our proposals for change. We will consider, along with other organisations, the most effective ways to link up other electronic records, including medical records and registration, with those of the coroner.
A survey of coroners' resources has been completed.

Improving training for coroners, including work on communications and diversity; and working with the Coroners Officers Association to support its training programmes
In addition to maintaining its existing training programme for coroners, run in conjunction with the Coroners' Society[23], the Home Office is currently developing a communications course and a diversity course for coroners. The Home Office continues to liaise with the Coroners Officers Association on the training that it provides for its members.[24] The Department of Health has opened up NHS bereavement training to coroners' staff, while the Judicial Studies Board has agreed similar arrangements in relation to the training it provides for Tribunal chairmen and members. We will consider further training for coroners and their officers on awareness of bereavement issues during the year.
The first communications course for coroners is expected to be run in the first half of this year.

Collecting examples of good practice and considering how to encourage their wider dissemination
Officials have gained a picture of good practice already in place in parts of the system; for example, coroners who lecture on their work to GPs, hospitals, registrars, and others; coroners' offices with developed office manuals on procedures and quality standards; GPs seconded to coroners' offices to provide additional medical expertise; and coroners who build up links with local groups.
Officials have begun to work with representatives of the Coroners' Society to consider how best to disseminate good practice across the service.

[23] These courses include induction training and continuous professional development on coroner law and practice, and relevant medical practice and procedures.

[24] As reform takes shape, the Government will play a more active part in the provision of coroner's officer training.

Introducing appropriate performance management techniques for death certification and coroners, including peer review
Meetings are already underway between officials and coroners' representatives to establish the most effective way to develop performance management for this area of work.
We expect a system to be underway later this year.

Piloting possible changes and suggested improvements
Some of the changes that we propose may require piloting to ensure that they are an effective way to improve the coroner system within existing legislation.
We have already started to work with coroners to establish which of the present jurisdictions would be best suited to each pilot. This will enable us to get testing underway as soon as we can.

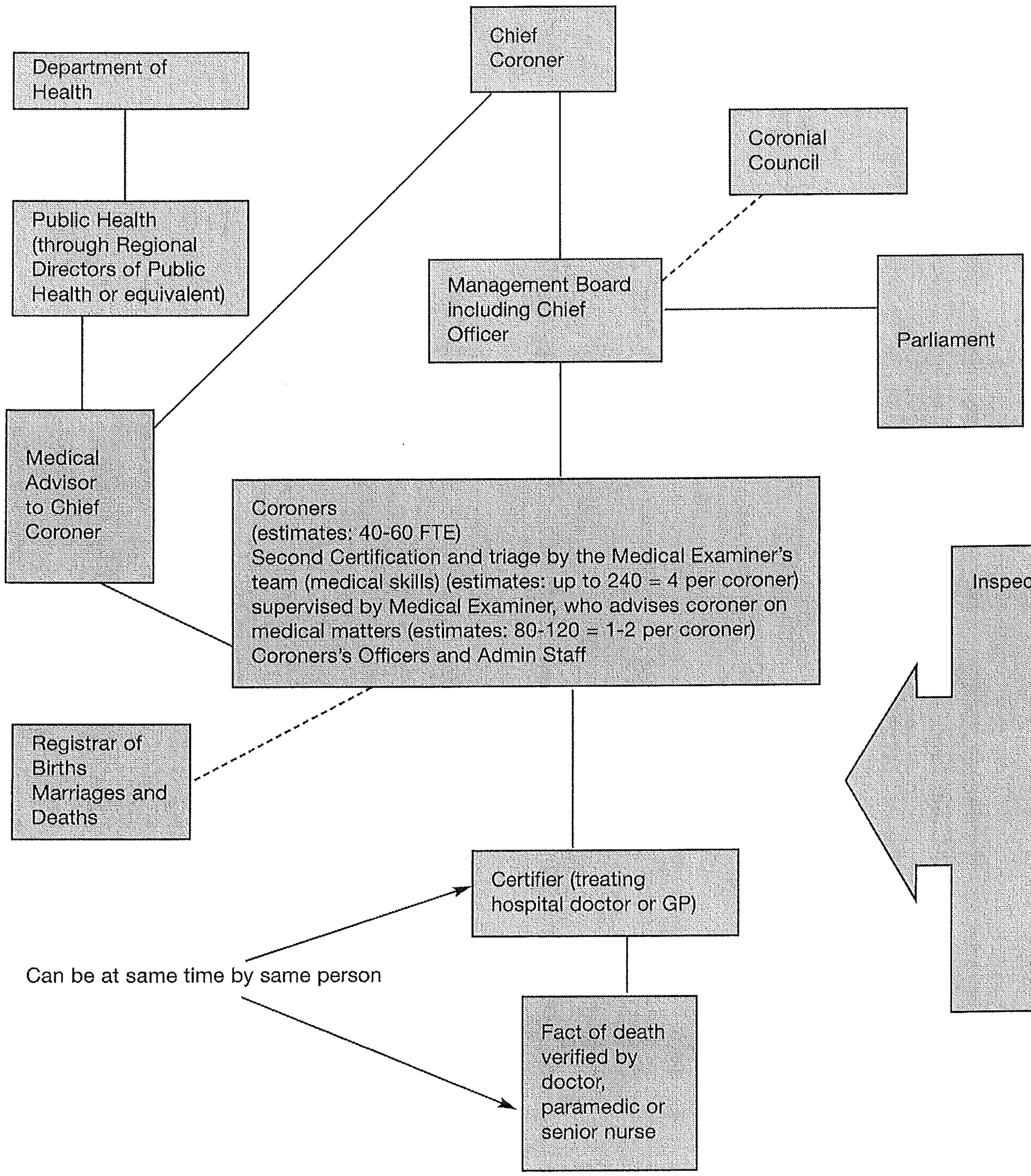
All these improvements will provide a strong platform on which to base further reform of the death certification and investigation system.

Annex 1 - Organisational Charts for the proposed system

Figure 2. Proposed Model in England and Wales

Indicative figures:

We estimate 70-80% of deaths will be registered without referral to coroner and 20-30% will go to the coroner.



Annex 2 - Provisional list of cases requiring investigation by the coroner[25]

- Any violent or traumatic death, including all traffic deaths, workplace deaths, deaths apparently from self-harm, from injury, poisoning, fire or drowning or other unnatural cause in the home or in any other place, or as a result of the operations of the law and order services.

- Any death of a person detained in a prison or in military detention, in police custody, in a special hospital or under statutory mental health powers, or of a person resident in a bail or asylum hostel.

- Any death in which occupational disease may have played a part.

- Any death in which lack of care, defective treatment, or adverse reaction to prescribed medicine may have played a part, or unexpected deaths during or after medical or surgical treatment.

- Any other death which a doctor may not certify as being from natural disease.

- Any death which is the subject of significant unresolved concern or suspicion as to its cause or circumstances on the part of any family member, or any member of the public, any health care, funeral services or other professional with knowledge of the death.

- Any death in respect of which the Registrar has significant continuing uncertainties.

[25] This is based on the list recommended in *Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review* (4 June 2003). We envisage that these cases will require an inquest hearing in public if the coroner cannot otherwise be satisfied that the death is due to natural causes.

Annex 3 - Timetable of work for England and Wales

Completed

- Survey of all coroner resources
- General Register Office circulated additional guidance to registrars on the procedures to be followed when deaths are reported to coroners which require further inquiries to be made of the doctor certifying the death
- Complementary Home Office guidance has been issued to coroners
- The Home Office has tightened up existing cremation arrangements by issuing advice to cremation authorities on the appointment of medical referees and detailed guidance to medical referees on cremation procedures.

Underway

- The Home Office is also working with the Department of Health to provide better information and support for families when a post mortem takes place; building on the extensive guidance issued by the Department of Health to inform and support families, pathologists and coroners at the time of post mortem.

Within one year

- Improved training for coroners
- Higher quality and more consistent information for bereaved families
- Working with the Coroners' Society towards dissemination of good practice
- System of performance management/peer review in place, through the Coroners' Society
- Start pilots of improvements
- Model whole system, including costs, for approval by Ministers.
- Draft Bill and White Paper.

Within three years

- Coronial Council set up and working administratively
- Move towards greater consistency in decisions to order post mortems
- Improved support for the Coroner's Officers Association training for coroner's officers
- Continuing pilots of improvements

Subject to Parliamentary time

New legislation

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