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CHAPTER 2

THE PRESENT-DAY OFFICE OF CORONER

APPOINTMENT AND QUALIFICATIONS

2-01 Prior to 1959 coroners in Northern Ireland were appointed by local authorities,[1] and this is still the position in England and Wales and the Republic of Ireland.[2] In accordance with the recommendation made by the Nugent Committee in 1957,[3] however, the 1959 Act transferred the power of appointing coroners in Northern Ireland to the Minister of Home Affairs. On the prorogation of the Parliament of Northern Ireland in March 1972, the responsibility became that of the Secretary of State for Northern Ireland;[4] but with the abolition of that Parliament in 1973 the power of appointment from 1 January 1974 was transferred to the Lord Chancellor.[5] This arrangement was confirmed and continued by the Judicature (Northern Ireland) Act 1978,[6] with the result that section 2(1) of the 1959 Act (as amended by the 1978 Act) now provides:

> "The Lord Chancellor may appoint one, or more than one, coroner and deputy coroner for such district or districts and on such conditions as to numbers, remuneration, superannuation or otherwise as the Lord Chancellor, after consultation with the Treasury may determine ..."

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[1] Local Government (Ir) Act 1898, s 14(1) - see above Chapter 1, para 1-18.

[2] Coroners Act 1988, s 1 [E and W]; Coroners Act 1962, s 8(2) [Ir].

[3] *Report of the Committee on the Finances of Local Authorities* (Cmd 369, 1957), para 222. In the debates on the 1959 Bill, the Minister of Home Affairs explained that "The local authorities have no objection to this proposal, which is in their interests, and it seems only logical that following the acceptance of responsibility by my Department for county courts and petty sessions courts it should now accept responsibility for the coroners' courts": HC Debs (NI), vol 44, cols 1412-1413 (14 May 1959)(Mr WWB Topping). This centralisation of the power of appointment anticipated the recommendation of the Brodrick Committee that the power of appointing full-time coroners in England and Wales should also be transferred to the Lord Chancellor in the interest of the consistent application of uniform standards of selection: *Brodrick Report*, paras 20.30 and 20.31. This recommendation has not been implemented; however, the Coroners' Society of England and Wales has made available its expertise to local authorities faced with filling a vacancy, on the grounds that "We can offer information and assistance to the appointment committee and avoid unnecessary difficulties for them and the person appointed": *Annual Report 1992*, p 10.

[4] Northern Ireland (Temporary Provisions) Act 1972, s 1.

[5] Northern Ireland Constitution Act 1973, s 2(2), Sch 2(9); Northern Ireland (Modification of Enactments - No 1) Order 1973, art 3 and Sch 2. By art 2(1) of and Sch 1 to the 1973 Order, other matters pertaining to coroners remained the responsibility of the Secretary of State until they, too, were transferred to the Lord Chancellor by the 1978 Act.

[6] Section 122(1) and Sch 5, Pt II. Accordingly, s 1 of the 1959 Act now reads: "The Lord Chancellor shall be responsible for the administration of all matters relating to coroners".

2-02 Since only barristers or solicitors qualified to practise in Northern Ireland are eligible for appointment,[7] details of a vacancy in the office of coroner are not advertised in the national or provincial press, but are published in local legal publications and circulated to all members of both branches of the legal profession. Selection is by competitive interview.

2-03 In Northern Ireland there are currently seven coroner's districts,[8] with each district having a coroner and a deputy coroner.[9] Prior to 1959, each local authority appointed a coroner for its district and the areas covered by the present-day districts are still influenced by that practice, although each coroner's district now comprises more than one local authority district. The trend, both in Northern Ireland and in England and Wales, is to increase the size of coroners' districts and thereby reduce the number of coroners. Districts with larger caseloads are more economical to administer; but perhaps more importantly, the policy of encouraging amalgamation facilitates the acquisition of greater experience and expertise and the appointment of more full-time coroners. To date the creation of larger districts has been achieved over time through the amalgamation of districts as vacancies occur;[10] if change in the much shorter term was required, a more radical strategy would have to be implemented by the Lord Chancellor.

2-04 The coroner for Greater Belfast, in whose district live approximately one-half of the province's total population, is the only full-time appointment. This district represents the amalgamation over a period of years of the old City of Belfast district with other neighbouring districts, as vacancies occurred, with the aim of achieving a caseload that would justify the appointment of a full-time coroner.

2-05 Section 2(3) of the 1959 Act (as amended[11]) provides:

> "No person, other than a person who is a coroner in Northern Ireland immediately before the coming into force of this Act, shall be appointed a coroner unless he has practised for not less than five years either as a member of the Bar of Northern Ireland or as a solicitor of the Supreme Court."[12]

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[7] 1959 Act, s 2(3), discussed below para 2-05.

[8] Greater Belfast, South Down, Armagh, Fermanagh and Omagh, East Tyrone and Magherafelt, Londonderry and North Antrim.

[9] There is no equivalent in Northern Ireland of the office of assistant deputy coroner found in England and Wales (1988 Act, s 6(1)(*b*)). In practice, no Northern Ireland coroner's district has more than one deputy; although s 2(1) of the 1959 Act does provide for this possibility. Rule 39 of the 1963 Rules provides that where a deputy coroner acting for, or as, the coroner signs any document, "he sign it in his own name as deputy coroner".

[10] Pursuant to the provisions of s 3 of the 1959 Act. The possibility of Northern Ireland being served "by several full-time coroners" was alluded to by the Minister of Home Affairs, when he moved the second reading of the 1959 Bill: HC Debs (NI), vol 44, col 1414 (14 May 1959)(Mr WWB Topping).

[11] By the Judicature (NI) Act 1978, s 122(1) and Sch 5, Pt II.

[12] The Minister of Home Affairs stated that he was implementing the recommendation (No 26) made in the *Report of the Departmental Committee on Coroners* (the "Wright Committee Report")(Cmd 5070, 1936): HC Debs (NI), vol 44, col 1412 (14 May 1959).

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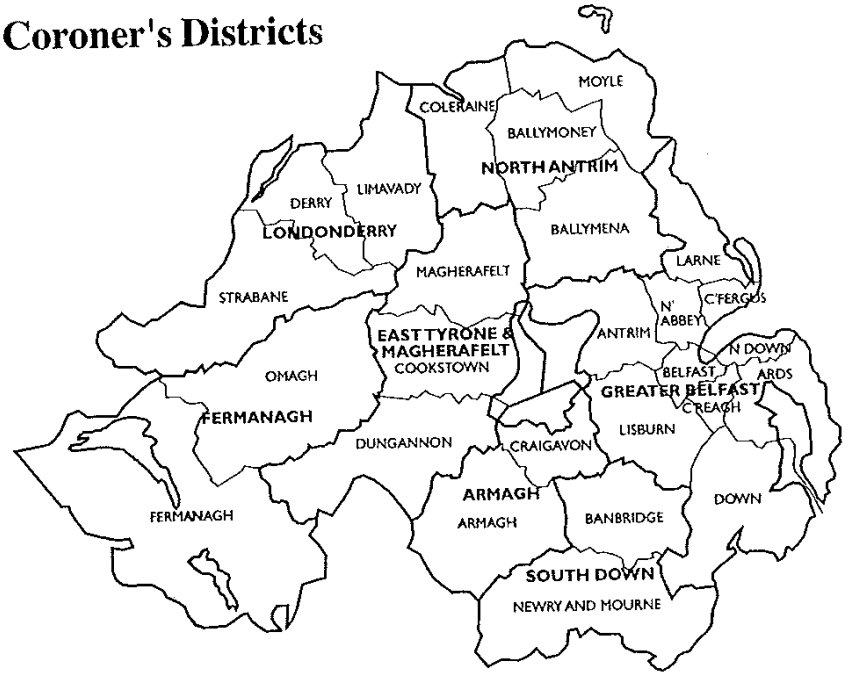
Coroner's Districts



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This provision, which provoked considerable controversy during the debates on the 1959 Bill,[13] may be contrasted with the position both in England and Wales and in the Republic of Ireland, where a medical qualification is also acceptable.[14] Some coroners in those two jurisdictions have a dual qualification in law and medicine; in Northern Ireland, however, all the coroners appointed since 1959 have been solicitors.

TERMS AND CONDITIONS OF APPOINTMENT

Disqualifications

2-06 In Northern Ireland there are no statutory disqualifications to being appointed as coroner.[15] However, the terms of appointment of the coroner for Greater Belfast provide two *extra*-statutory disqualifications. First, a coroner must on appointment relinquish all commercial directorships and cease any kind of political activity or any other activity which could be the subject of political controversy or which would make undue demands on his time. Secondly, a full-time coroner may not engage in practice either directly or indirectly as a barrister or solicitor or as an agent for a barrister or solicitor.

This recommendation, that "in future, only solicitors or barristers should be appointed as coroners, but, whenever possible they should have had experience as deputy coroners and should have a knowledge of forensic medicine," was made on the basis that the coroner acts in a judicial capacity and therefore a legal training is more important than a medical one. A similar recommendation was made in the Brodrick Report (see below note 14).

13 See especially HC Debs (NI), vol 44, cols 1429-1432 (14 May 1959)(Professor Lloyd-Dodd). Under the pre-1959 law, both doctors and justices of the peace of five years' standing could also be appointed coroners - see above, Chapter 1, para 1-16. The Government's justification for changing the law in the face of representations by the British Medical Association was that: "In these modern days all the medical aspects of the case can be fully presented by expert medical witnesses, and the sifting of the evidence thus presented is for a legal and not a medical mind": *ibid*, col 1413.

14 Coroners Act 1988, s 2(1)(*b*) [E and W]; Coroners Act 1962, s 14(1) [Ir]. The Brodrick Committee favoured a legal qualification: *Brodrick Report*, para 20.41. This issue was also considered, *inter alia*, in two subsequent non-government reports both published in 1986: *Coroners Courts in England and Wales* (A Report by *Justice*) and *Deaths in the Community* (A Report of the British Medical Association). The report by *Justice*, whilst recognising that a dual qualification in law and medicine was "highly desirable", recommended no change in the existing qualifying requirements. The report by the British Medical Association recommended regionally-based offices under a coroner who held a dual qualification in law and medicine, though it expressed a preference for a medical qualification.

15 This contrasts with the position in England and Wales - see 1988 Act, s 2(2)-(4)(disqualification of certain local authority councillors and aldermen) and in the Republic of Ireland - see 1962 Act, s 8(3)-(5)(qualifications as to age, health and character for appointment may be declared by Minister for Justice after consultation with the Local Appointments Commissioners).

Declaration of office

2-07 Provision is made in the making by the coron appointment and before hold

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Although it is "customary" declaration,[18] no coroner o Ireland has been asked by t declaration does not appear indeed be some uncertainty making power conferred b extends to rules which "regu with inquests...".[20]

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16 Coroners Rules 1963, Sch 3,

17 The declaration of office for Sch 4, Form 1 in virtually id

18 *Jervis*, para 2-21.

19 Rule 41 provides merely tha the purposes for which they

20 It should be noted, however, by the 1988 Act, s 32(1) is s

21 See below Chapter 5, paras

22 Local Government Act 1972 *Brodrick Report*, para 20.43.

23 *Cf* Coroners Act 1962, s 1 residence in his district". B

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ales - see 1988 Act, s 2(2)- d aldermen) and in the Republic o age, health and character for ter consultation with the Local

Declaration of office

2-07 Provision is made in Northern Ireland,[16] as in England and Wales,[17] for the making by the coroner of a "Declaration of Office" following his appointment and before holding his first inquest:

> "I, solemnly, sincerely, and truly declare and affirm that I will well and truly serve our sovereign Lady the Queen and Her Liege people in the office of coroner for the district of and that I will diligently and truly do everything appertaining to my office to the best of my power for the doing of right, and for the good of the inhabitants within the said district."

Although it is "customary" for coroners in England and Wales to make such a declaration,[18] no coroner or deputy coroner presently in office in Northern Ireland has been asked by the Lord Chancellor to do so. The making of the declaration does not appear to be required by the 1963 Rules,[19] and there may indeed be some uncertainty as to whether the declaration is intra vires the rule-making power conferred by section 36(1)(b) of the 1959 Act, which only extends to rules which "regulate the practice and procedure at or in connection with inquests...".[20]

Availability

2-08 With the exception of periods of illness or holiday leave, coroners or their deputies must always be available to fulfil the duties of their office. Rule 2 of the 1963 Rules provides:

> "A coroner shall at all times hold himself ready to undertake, either by himself or his deputy, any duties in connection with deaths reported to him, inquests and post-mortem examinations."

Therefore, either the coroner or deputy must be contactable on a 24-hour basis every day of the year. This is particularly important when the coroner's consent to organ retrieval for transplantation purposes is required.[21] Accordingly, most coroners carry mobile telephones, and this practice has eased to some extent what is otherwise a very onerous burden.

Residence

2-09 As in England and Wales,[22] there is no longer any requirement that the coroner or deputy coroner reside in the district to which he is appointed.[23]

[16] Coroners Rules 1963, Sch 3, Form 1.

[17] The declaration of office for coroners in England and Wales is set out in the 1984 Rules, Sch 4, Form 1 in virtually identical terms.

[18] *Jervis*, para 2-21.

[19] Rule 41 provides merely that "The forms set out in the Third Schedule ... *may* be used for the purposes for which they are expressed to be applicable" (emphasis added).

[20] It should be noted, however, that the rule-making power conferred in England and Wales by the 1988 Act, s 32(1) is stated in identical terms.

[21] See below Chapter 5, paras 5-38 to 5-44.

[22] Local Government Act 1972, s 272(1) and Sch 30, implementing a recommendation in the *Brodrick Report*, para 20.43.

[23] *Cf* Coroners Act 1962, s 12(1) provides that an Irish coroner "shall have his ordinary residence in his district". But s 12(2) provides that he may live outside the district with the

Salary

2-10 Section 36(2) of the 1959 Act provides that the Lord Chancellor, with the consent of the Treasury, may determine "the salaries or fees and superannuation" to be paid to coroners. The remuneration of part-time coroners is calculated on the basis of their annual caseload and therefore it will fluctuate from year to year. Built into this calculation is a factor to cover expenses. The full-time coroner for Greater Belfast receives an annual salary (with superannuation benefits), calculated by reference to a scale agreed by the Joint Negotiating Committee for Coroners which represents the coroners of England and Wales.

ACTS INCONSISTENT WITH THE OFFICE OF CORONER

2-11 A coroner (or his deputy) is subject to the rule against bias.[24] Accordingly, he must not act in any inquiry into a death where he may be biased or prejudiced in a way which precludes a fair and genuine consideration being given to the issues arising in the course of that inquiry. Nor should he so act where, however disinterested he may be in fact, the circumstances are such that they give rise to the risk or appearance of bias or prejudice on his part.

Actual bias or prejudice

2-12 It is well established that actual bias or prejudice on the part of a decision-maker invalidates his decision: "if actual bias is proved, that is an end of the case".[25] The most obvious example of such bias is a direct pecuniary or proprietary interest in the outcome of the proceedings.[26]

Apparent bias or prejudice

2-13 Prior to 1993, various tests were applied to determine whether the possibility of bias was of such a degree that a decision should be invalidated on the ground of *apparent* bias.[27] However, in *R* v *Gough*,[28] where bias on the part of a juror in a criminal trial was alleged, the House of Lords held that the test to be applied is whether, in all the circumstances of the case, the court considers that there appeared to be a "real danger" of bias; if so, the decision cannot be allowed to stand. In the words of Lord Goff of Chieveley:

> "... I prefer to state the test in terms of real danger rather than real likelihood, to ensure that the court is thinking in terms of possibility rather than

permission of the Minister for Justice - a concession to "modern methods of transport": Seanad Éireann Debs, vol 55, col 126 (21 March 1962)(Minister for Justice) - and such permission is usually given.

[24] See especially de Smith, Woolf and Jowell, *Judicial Review of Administrative Action* (5th ed, 1995), Chap 12.

[25] *R* v *Gough* [1993] 2 All ER 724, 737, *per* Lord Goff of Chieveley. See eg *Dimes* v *Grand Junction Canal Co Proprietors* (1852) 3 HLC 759.

[26] In *R* v *Camborne Justices, ex parte Pearce* [1954] 2 All ER 850, 853, Slade J stated: "... any direct pecuniary or proprietary interest in the subject-matter of a proceeding, however small, operates as an automatic disqualification."

[27] See eg de Smith, Woolf and Jowell, *op cit* note 24 at pp 526-527.

[28] [1993] 2 All ER 724. See also *R* v *Secretary of State for the Environment, ex parte Kirkstall Valley Campaign Ltd* [1996] 3 All ER 304.

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> probability of bias. Accordingly, having ascertained the relevant circumstances, the court should ask itself whether, having regard to those circumstances, there was a real danger of bias on the part of the relevant member of the tribunal in question, in the sense that he might unfairly regard (or have unfairly regarded) with favour, or disfavour, the case of a party to the issue under consideration by him...."[29]

His Lordship stated further that "the same test should be applicable in all cases of apparent bias, whether concerned with justices or members of other inferior tribunals ...". In *R* v *Inner West London Coroner, ex parte Dallaglio and Another*[30] the Court of Appeal confirmed that the "real danger" test applies to coroners.

2-14 The law having been settled by the House of Lords, the problem now is to determine whether, in all the circumstances of a particular case, the "real danger" test is satisfied. The cases involving coroners may be considered under four broad headings, as follows.

Professional relationship

2-15 The 1959 Act makes express provision for two particular situations where a risk of bias or prejudice may arise:

(1) "A coroner shall not act as solicitor or barrister in proceedings arising out of any matter which may have come before him as coroner ...";[31] and

(2) "A solicitor or barrister appointed as coroner or deputy coroner under this Act shall not conduct any inquest upon the body of, or hold any inquiry into the death of, any person, if he has drawn up, or assisted in the drawing up

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[29] [1993] 2 All ER 724, 737-738. Lord Goff further held that the "real danger" test should be applied from the point of view of the reviewing court and not from that of the reasonable man. He added, however, that "Since ... knowledge of such circumstances as are found by the court must be imputed to the reasonable man ... it is difficult to see what difference there is between the impression derived by a reasonable man to whom such knowledge has been imputed, and the impression derived by the court, here personifying the reasonable man". His Lordship appears to agree with the statement of Webster J in *R* v *West Yorkshire Coroner, ex parte Smith, The Times*, 6 November 1982 that an allegation of possible bias is judged by the supervisory court at the time it reviews the matter and the facts to which it has regard are *all* the matters in evidence at the time of hearing the application.

[30] [1994] 4 All ER 139 - see especially pp 151-152 (*per* Simon Brown LJ) and 162 (*per* Sir Thomas Bingham MR).

[31] 1959 Act, s 2(5). The restriction to "proceedings" was designed to prevent this provision from being "unduly oppressive" and will, for example, allow a solicitor who is a part-time coroner to take out probate to an estate even though he has held the inquest into the testator's death: see HC Debs (NI), vol 44, col 1655 (3 June 1959)(Minister of Home Affairs). *Cf* the equivalent restriction in the Republic of Ireland is limited to *criminal* proceedings: 1962 Act, s 53.

of, *and* is a beneficiary under, any testamentary disposition made by such person."[32]

It is suggested that these particular provisions do not operate to exclude the operation of the general rule against bias, and that there may well be other situations in which a coroner should withdraw from an inquiry on "professional" grounds.

2-16 The only occasion on which an apparent conflict of professional interest involving a coroner in England and Wales appears to have been considered arose in the course of proceedings before the Solicitors' Disciplinary Tribunal of the Law Society of England and Wales.[33] A part-time coroner had opened an inquest into the death of a man who had died following an abseiling accident. Following the receipt of formal evidence of identity the inquest was adjourned. The coroner, a solicitor, then learned that the deceased was the employee of a corporate client which ran "outward-bound"-type courses and he correctly transferred the inquest to another coroner. For unconnected reasons the resultant inquest was quashed. The original coroner then agreed to appear for his client at the second inquest: "He was reluctant to act but after consulting *Jervis on Coroners* he formed the view that, as the first inquest had in fact been erased, the new inquest was a *venire de novo* and he might properly represent his client at it". In finding substantiated an allegation of conduct unbefitting a solicitor, the Tribunal stated:

> "In consulting only *Jervis* and by not considering his position as a solicitor the respondent's reasoning had been at fault. His knowledge of the matter had not been expunged by the order quashing the first inquest and he had acted in the same matter as both coroner and advocate for an interested party. Such behaviour was reprehensible. The conflict of interests was clear."[34]

The lesson from this case must be that if there is any doubt as to the propriety of acting as coroner or legal representative in cases not expressly covered by the 1959 Act, the coroner should err on the side of caution and take no part in the proceedings in either capacity. As *Jervis* advises:

> "... wherever there is a real danger of bias on the coroner's part, for example arising out of his personal or professional connection with the deceased or the deceased's family, he should make arrangements for another person to act in his place as coroner, even if he himself believes that he is capable of acting impartially.... [I]t would be unwise for a coroner ... to act professionally in connection with any legal proceedings resulting from the death of a person into whose death he has held or may be about to hold an inquest or post-mortem examination, and, indeed, the Coroners' Society recommends that a coroner should not so act.

[32] 1959 Act, s 2(6) (emphasis added). In the Republic the 1962 Act, s 35(2)(*a*) is in similar terms.

[33] *Re Peter Lothian Brunton* (1995) 92(17) *Law Soc Gaz* 42. The proceedings concerned Mr Brunton's conduct as a solicitor rather than as a coroner.

[34] *Ibid.* The Tribunal took certain mitigating circumstances into account and formally reprimanded Mr Brunton.

> Further, it is undesirable independent judicial office an inquest before another of his judicial status."[35]

Personal hostility

2-17 In *R* v *Inner West L* the coroner had decided proceedings. Prior to mak journalists, described the m displayed an attitude of h application being made to hi and the case was taken on ju *Gough* quoted above (parag:

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[35] Paras 2-27 and 2-28. See *Solicitors* (7th ed, 1996), pa

[36] [1994] 4 All ER 139. Fo *Dallaglio*" [1996] *Jud Rev* 1

[37] [1994] 4 All ER 139, 160.

[38] (1994) 158 JP 357. The cas

[39] *Ibid*, pp 374-377.

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> Further, it is undesirable and inconsistent with the status of the coroner as an independent judicial officer for him to act as a professional or expert witness at an inquest before another coroner, the more so in front of a jury which is aware of his judicial status."[35]

Personal hostility

2-17 In *R* v *Inner West London Coroner, ex parte Dallaglio and Another*[36] the coroner had decided not to resume an inquest following criminal proceedings. Prior to making this decision, he had, during a meeting with journalists, described the mother of one of the deceased as "unhinged" and displayed an attitude of hostility towards her. This conduct led to an application being made to him to remove himself. He would not agree to do so, and the case was taken on judicial review. After referring to the passage from *Gough* quoted above (paragraph 2-13), Farquharson LJ stated:

> "Applying that test to the present case, the court must ask itself whether in all the relevant circumstances ... there was a real danger of bias on the part of the coroner. As already pointed out, there is no question of actual bias here. Neither is it necessary for the applicants to show that the coroner was aware that he was displaying bias. The question that has to be posed is: 'Does it appear that there was a real danger of bias on the part of the coroner affecting his decision not to proceed with the inquests?' ... The vital matter is the reference to the second applicant being 'unhinged'."[37]

The use of such language meant that there was a "real danger" of bias on the part of the coroner and he should therefore have removed himself. The court accordingly ordered that the question whether the inquests should be resumed be considered afresh by a different coroner.

2-18 *R* v *HM Coroner for Western District of East Sussex, ex parte Homberg, Roberts and Manners*[38] underlines the need to consider *all* the circumstances in cases of apparent bias. An application to quash an inquisition was based (*inter alia*) on the allegation that the coroner had made comments in his opening remarks to the jury which showed bias towards the legal representatives of the families of the deceased. Simon Brown LJ accepted that:

> "[The coroner's remarks] were to say the least unfortunate, most particularly in combination. Their cumulative effect must inevitably have been to make the jury doubt the good sense and legal competence, if not actually the integrity, of those representing the families. Certainly they had much better been left unsaid."[39]

But he added that such considerations as may tend to explain those remarks must also be taken into account, and he found that the families' lawyers were

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[35] Paras 2-27 and 2-28. See also the Law Society's *Guide to the Professional Conduct of Solicitors* (7th ed, 1996), para 15-06.

[36] [1994] 4 All ER 139. For further discussion of this case, see Rayment, "Bias after *Dallaglio*" [1996] *Jud Rev* 102.

[37] [1994] 4 All ER 139, 160.

[38] (1994) 158 JP 357. The case report refers to "Homber", but this is a misspelling.

[39] *Ibid*, pp 374-377.

"not entirely blameless" and had been "markedly too prone to try to impose their own ideas about how the inquest should be run". In such a context, the coroner's remarks and general conduct "are perhaps more readily understandable".[40] Taking all these considerations into account, Simon Brown LJ concluded, "not without hesitation", that the coroner's conduct was *not* such as could properly be said to have undermined public confidence in the proceedings.

> "It was ... regrettable that in the various remarks he made the coroner allowed himself to express a resentment which by then he had undoubtedly begun to feel against those representing the families ... [However] this can hardly have been the first time that a tribunal has been inappropriately caustic with regard to the lawyers' role. But only in the most extreme cases (not least in the context of inquisitorial proceedings) should challenges founded upon such remarks succeed on grounds of apparent unfairness."[41]

Personal friendship

2-19 In the New Zealand case of *In re Sutherland*[42] an inquest verdict was quashed and a new inquest ordered where the coroner, who knew the deceased both "as a personal friend and as a professional adviser", not only held the inquest into her death but also purported to give evidence of identity in the course of the hearing. The coroner was a legal practitioner and had concluded a matrimonial property settlement on behalf of the deceased some years previously. Subsequently, the deceased lived on property owned by the coroner. Barker ACJ stated:

> "... by the act of formally identifying the deceased's body, she gave evidence before herself, something no judicial officer should contemplate .... There must be a real danger that the knowledge of the deceased which the coroner must of necessity have acquired over the years of her acquaintance with the deceased could, even subconsciously, have affected her judgment; her pre-knowledge might have rendered her incapable of deciding on a proper verdict purely on the evidence presented before her."[43]

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[40] *Ibid*, p 376. Simon Brown LJ continued: "Where, as here, [an inquest] is presided over by a highly experienced coroner, a measure of tact, sensitivity and restraint is called for on the part of those representing interested parties. Their clients are not ... parties to adversarial litigation. Their only legitimate interest is one shared by the coroner - to investigate and discover the true circumstances of the death ...".

[41] *Ibid*, p 377. It would appear to follow that a coroner can adopt a more robust attitude towards legal representatives than towards unrepresented properly interested persons. That there may be different "thresholds" for apparent bias appears implicit in Lord Goff's reference in *R* v *Gough* [1993] 2 All ER 724, 737 to the preliminary need "to ascertain the *relevant* circumstances from the available evidence" (emphasis added).

[42] [1994] 2 NZLR 242, a case in which *Gough* was cited with approval.

[43] *Ibid*, p 249. See also *R* v *West Yorkshire Coroner, ex parte Smith*, *The Times*, 6 November 1982 where the applicant sought judicial review of a coroner's refusal to cause an inquest to be held by another coroner on the ground (*inter alia)* that the original coroner might appear to have links with a person or persons said to be present on the occasion of the deceased's death; the allegation of such a link was expressly withdrawn, however, and Webster J rejected the applicant's claim. He also rejected a further allegation that the coroner might

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2-20 In *R* v *West Yorkshire Coroner, ex parte Smith*[44] the applicant, who sought judicial review of the coroner's refusal to cause an inquest to be conducted by another coroner, alleged that the coroner appeared to have prejudged the verdict or an issue or issues that might arise at the inquest. Webster J disagreed; the evidence "put the question wholly beyond doubt" that he had done no such thing.[45]

2-21 In *Smith*, the applicant's concern arose from a statement made by the coroner in an attempt to indicate "clearly and without delay" what action he proposed to take in the case. Clearly the coroner needs to be very careful about such remarks, even if made in private; *a fortiori* if he decides to make any public comment about any current coronial matter. In the course of his judgment in *Dallaglio*, Farquharson LJ referred to the coroner's interview in that case with journalists and stated that "it is wrong or at least undesirable for anybody sitting in a judicial capacity to discuss the case he is trying or preparing to try with anybody else, or to make any public comment about it".[46]

RETIREMENT AND REMOVAL FROM OFFICE

2-22 As in England and Wales, there is no express statutory provision providing for the age at which a coroner must retire;[47] but section 2(1) of the 1959 Act permits the Lord Chancellor to appoint coroners and deputy coroners on such conditions as "the Lord Chancellor, after consultation with the Treasury, may determine". The terms of appointment of the full-time coroner for Greater Belfast, who was appointed in 1991, stipulate that he may continue to hold office until attaining the age of 70 years; thereafter the Lord Chancellor has a discretion to extend the appointment from year to year until the age of

appear to be associated with an alleged attempt to cover up the circumstances of the deceased's death. Although it is unlikely to have affected the outcome of either claim, it should be noted that the court relied on the "reasonable man" test since rejected by the House of Lords in *Gough* - see above, note 29.

44 *The Times*, 6 November 1982.

45 As already pointed out (above, note 43), Webster J applied the "reasonable man" test since rejected in *Gough*; but the outcome would clearly have been the same under the law as laid down in that case. It should also be noted that Webster J also rejected a claim that the coroner might appear to be biased in the conduct of the inquest because the applicant was entitled to apply for an order for costs against the coroner in respect of an earlier application.

46 [1994] 4 All ER 139, 161. In the section on "Medicine and the Media" in *The Oxford Medical Companion* (1994), reference is made to a warning given by the distinguished physician, Sir William Osler, to medical students: "In the life of every successful physician there comes the temptation to toy with the Delilah of the Press - daily and otherwise. There are times when she may be courted with satisfaction, but beware: sooner or later she is sure to play the harlot and has left many a man shorn of his strength, *viz* the confidence of his professional brethren". This advice is just as apt for coroners.

47 *Cf* Coroners Act [Ir] 1962, s 11(1): "Every coroner ... shall ... hold office until he reaches the age of seventy years".

75.[48] That apart, the absence of a statutory retirement age obviously facilitates the development of policy at a time when there would appear to be an impetus towards a general lowering of the retirement age for the holders of judicial offices.

2-23 The removal from office of any judicial officer including a coroner is a very rare occurrence.[49] Section 2(2) of the 1959 Act, by applying section 18(2) of the Interpretation Act (Northern Ireland) 1954, empowers the Lord Chancellor to "remove or suspend" a coroner;[50] but section 2(2) of the 1959 Act goes on to provide that the Lord Chancellor may remove a coroner only after "consultation" with the Lord Chief Justice.[51]

2-24 The 1959 Act does not specify the grounds upon which a coroner may be removed from office.[52] But the terms of appointment of the coroner for Greater Belfast suggest that the position in Northern Ireland is much the same as provided for by statute in England and Wales:

> "The Lord Chancellor may remove a coroner from office on account of misbehaviour or inability to perform the duties of the office."[53]

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[48] *Cf* the Brodrick Committee had recommended that a coroner should normally retire at the age of 65, but that the Lord Chancellor should have power to extend his tenure of office annually up to the age of 72: *Brodrick Report*, para 20.45.

[49] See *Jervis*, paras 3-14 to 3-19. During the debates on the 1959 Bill it was stated that "no coroners ... have been removed in Northern Ireland": HC Debs (NI), vol 44, col 1632 (3 June 1959)(Mr Bleakley).

[50] Section 18(2) of the 1954 Act further provides (in effect) that the Lord Chancellor may "in the like manner and subject to the like consent and conditions ... applicable on his appointment" (i) reappoint or reinstate a coroner, (ii) appoint another person in his stead, (iii) vary or withhold his remuneration during any period of suspension from office, and (iv) terminate his remuneration on his removal from office.

[51] The wording of s 2 means that the Lord Chancellor *must* consult the Lord Chief Justice, but he is not obliged to accept his opinion or advice. At the time of enactment the power of removal now vested in the Lord Chancellor was vested in the Minister of Home Affairs, and the requirement to consult was seen as an additional safeguard: "'prior consultation' would invariably mean the prior approval of the Lord Chief Justice ...": Sen Debs (NI), vol 43, cols 569-570 (20 October 1959)(Minister of Home Affairs). A proposal that coroners should only be removable by resolution of both Houses of Parliament was rejected in committee.

[52] *Cf* Local Government (Ir) Act 1898, s 14(3) had provided that the Lord Chancellor could remove any coroner "for inability or misbehaviour in the discharge of his duty" - see above, Chapter 1, para 1-18. This provision was repealed by the 1959 Act.

[53] *Cf* Coroners Act 1988, s 3(4): "The Lord Chancellor may, if he thinks fit, remove any coroner from office for inability or misbehaviour in the discharge of his duty". Section 3(5) further provides that a court which finds a coroner guilty of corruption, wilful neglect of his duty or misbehaviour in the discharge of his duty may order that he be removed from office. In the Republic of Ireland, the 1962 Act, s 15(1) provides that a coroner may be removed from office by the Minister for Justice if he "is of opinion that [the] coroner ... has been guilty of misconduct or neglect of duty or is unfit for office or incapable of the due discharge of his duties by reason of physical or mental infirmity ..."; s 15(2) provides that the Minister must specify the reason for the removal.

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The terms of appointment go on to provide some additional guidance as to the circumstances which might be viewed as justifying removal:

> "The Lord Chancellor regards the conviction of a serving member of the judiciary (including a coroner) for an offence of dishonesty, of moral turpitude or of an otherwise serious nature (including drink driving) as constituting misbehaviour, and it may cause him to consider whether he should exercise his powers of removal from office. If a coroner is charged with any criminal offence he should immediately report the details thereof to the Lord Chancellor."

2-25 Where a coroner is removed from office, dies or vacates his office for any reason "all documents, exhibits, registers and other things in [his] custody ... in connection with inquests or post-mortem examinations shall be transferred to the coroner next appointed to that office".[54]

ROBES

2-26 Whether a robe is worn during an inquest is a matter for the individual coroner. In England and Wales most coroners do not wear a robe; those who do, do not wear a wig.[55] In Northern Ireland the coroners for the City of Belfast formerly wore both gown and wig; but in the early 1980s this practice was discontinued. The present practice is for those coroners with gowns to wear them only on ceremonial occasions.

SUPPORT SERVICES[56]

Clerical staff

2-27 The full-time coroner for Greater Belfast is provided with clerical staff who are employees of the Northern Ireland Court Service. No clerical staff are provided for part-time coroners, who must therefore make their own arrangements. Since most of the present part-time coroners are solicitors in private practice, they invariably rely on the services of the staff of their practice for assistance with coronial work.

Office accommodation

2-28 Only the coroner for Greater Belfast is provided with office accommodation. Part-time coroners must make their own accommodation arrangements, which once again will usually be the offices of their practice. It is, however, permissible for a coroner who is not provided with office accommodation to work from home.

Coroner's officers

2-29 Although section 2(1) of the 1959 Act provides that the Lord Chancellor may, under the power conferred by section 69 of the Judicature

[54] 1963 Rules, r 40.

[55] *Jervis*, para 3-57 describes the wig and gown as "traditionally distinct from those worn by barristers and judges: the wig is like a judge's but without the back curl, and the robe is dark blue with black velvet yoke, black lace strips on the facings, and sleeves with four pleats".

[56] See generally *Brodrick Report*, Chap 21.

(Northern Ireland) Act 1978, appoint "coroner's officers and other officers to assist ... coroners", no such officer has been appointed in recent years. This contrasts with the position in England and Wales where, in spite of the fact that the post has *no* statutory recognition, there is at least one officer for each coroner's district.[57] Most of the coroner's officers are specially trained police officers on permanent secondment from the local police force, which remains responsible for their remuneration and conditions of service; but civilian coroner's officers may be employed by either the local authority or the coroner personally.[58] There is a trend towards civilianisation,[59] although the value of previous service as a police officer, with the experience and training that entails, is recognised.[60] There is no standard "job description" for coroner's officers; but so far as England and Wales is concerned, the following would be generally accepted as constituting their main functions: the establishment and maintenance of a proper liaison between the police service and the coroner in connection with the investigation of violent, unnatural or sudden deaths and the proper investigation and reporting of all such matters to the coroner; receiving, evaluating and investigating any report of a death and drawing it to the attention of the coroner, and collating and interpreting facts and circumstances to enable a proper course of investigation (medical or criminal or both) to be pursued. The performance of these functions may involve any one or more of the following:

(1) Receiving reports of deaths and, where appropriate, attending the scene and examining the body.
(2) Enquiring if there are any suspicious circumstances surrounding the death, liaising with the police and briefing the coroner of the progress in the enquiries.
(3) Liaising with the family and taking statements.
(4) Providing continuity of identification of the body throughout the investigation.
(5) Arranging removal of the body, the safe custody of any personal belongings of the deceased, arranging the post-mortem examination and any specialist examinations such as toxicology, liaising with the pathologist and ensuring proper control of specimens and exhibits.
(6) Where the death occurred in suspicious circumstances, consulting with the police over the choice of pathologist.
(7) Receiving the post-mortem findings and advising the coroner of these.

[57] See *Jervis*, paras 3-58 to 3-62, and *Thurston*, Chap 7. The size and population of the coroner's district determine the number of officers appointed. It is understood that coroners' officers are also appointed in the Republic of Ireland, at least in Dublin.

[58] In the latter situation, which is uncommon, the coroner seeks reimbursement of the relevant salary and related expenses from the local authority.

[59] As recommended by the *Brodrick Report*, para 21.11 and in line with the current view of the Home Office - see Organisation and Methods Branch of the Home Office, *Review of the Work and Methods of Coroner's Officers* (March 1983) and *Home Office Circular No 93* (1985).

[60] Many "civilian" coroner's officers are in fact former police officers.

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(8) Co-ordinating the arrangements leading to the release of the body and any personal belongings that had been held.
(9) Liaising with all "properly interested persons".
(10) Attending the inquest to give evidence concerning police enquiries into the death.
(11) Where necessary, acting as a jury keeper or court clerk.
(12) General administrative work on behalf of the coroner.
(13) Participating in a rota to provide 24-hour cover.

2-30 It is unfortunately the case that the non-appointment of coroner's officers in Northern Ireland may disadvantage coroners in the performance of the duties of their office, as compared with their counterparts in England and Wales. However, many of the functions listed above are in practice carried out by police officers in Northern Ireland.

The role of the police

2-31 In Northern Ireland only police officers are empowered to investigate deaths reported to coroners, and this is the position even when no criminal offence is suspected. The particular officer assigned to the investigation acts, in effect, as a coroner's officer for the particular case. Section 11(1) of the 1959 Act provides:

> "Where a coroner is informed that there is within his district the body of a deceased person and that there is reason to believe that the deceased person died in any of the circumstances mentioned in section seven or section eight he shall instruct *a constable* to take possession of the body and shall make such investigation as may be required to enable him to determine whether or not an inquest is necessary."[61]

The "constable" may be "any officer or member of the Royal Ulster Constabulary".[62] Once the coroner has advised the police for the area in which the death occurred of the death, a "police" decision will be made as to whether the investigation should be the responsibility of the uniform or criminal investigation branch, and the rank of officer to be appointed. It would appear sensible that such matters are left to the discretion of the police authorities. There is, of course, nothing to prevent a coroner raising particular concerns about any police decision in this regard with which he is unhappy. There exist both formal and informal channels for this to be done, for example, by writing to the sub-divisional commander for the district in which the death occurred or by simply telephoning the duty inspector at the police station concerned. In a

[61] Emphasis added. This provision has no counterpart in England and Wales, where the preliminary inquiry is made by the coroner's officer. For a helpful discussion, see *Jervis*, paras 5-48 *et seq.*

[62] 1959 Act, s 40. See also Interpretation Act (NI) 1954, s 43(2), which defines "constable" as "any member of the Royal Ulster Constabulary, any reserve constable, any member of any Harbour, Transport or Railway Police or of the Naval, Military or Royal Air Force and any other person having for the time being the powers of a constable". Thus, deaths occurring in or bodies recovered from Belfast Harbour are investigated by Belfast Harbour Police, rather than the Royal Ulster Constabulary.

particularly serious matter or where an important policy issue is concerned the coroner may write directly to the Chief Constable.

2-32 Since *any* police officer may be appointed to assist the coroner, the opportunity for an individual officer to develop specialised skills and expertise and, most importantly, sensitivity in coroners' work is very limited indeed. Some families have voiced concerns that the involvement of the police "criminalises" the death and the attendance of police officers at the home often causes embarrassment. There have been instances where the death was, for example, the result of direct intervention by the security forces and the family consequently refused to co-operate with the police and declined to make any form of statement. Yet they were prepared to co-operate with the coroner. Where the death occurs in such circumstances it is often impossible for the police to act in their normal policing role as well as in the capacity of coroner's officer. It is arguably unfair to put them in such an invidious position. Properly trained and appointed coroner's officers, similar to those in England and Wales, are likely to be much more acceptable. Even though they may be police officers on secondment their actual role as members of the coroner's staff would be inclined to distance them from the "policing" side of the investigation. Considerable tact and diplomacy is required in all coronial matters and the perception of the public and particularly the next of kin should never be discounted.

Force instructions to police officers[63]

2.33 The duties of a police officer acting on behalf of a coroner are as follows:

"Police investigations

In almost all cases of violent, unexplained or unexpected deaths or deaths in suspicious circumstances, coroners order post-mortem examinations which are carried out by pathologists. In order that the cause of death can be satisfactorily established the police must assist by providing the pathologist with information concerning the circumstances leading up to and surrounding the death. In order to ensure that these circumstances are promptly and efficiently investigated the following instructions will be complied with.

The member of the Force at the scene must remember that his duty is that of investigator. He should proceed as follows -

(1) On arrival at the scene, ascertain if life has been pronounced extinct by a doctor. Normally the deceased's own doctor should be called. In cases where the deceased is not known to be registered with a GP, a local doctor should be called. Should a local doctor not be available the forensic medical officer for that area should be called. If the death has taken place under suspicious circumstances the services of a forensic medical officer should be obtained in the first instance.

[63] These extracts from police instructions are reproduced by kind permission of the Chief Constable of the Royal Ulster Constabulary.

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d. If the death has taken place
s of a forensic medical officer

ed by kind permission of the Chief

(2) Obtain the formal details for Form 19.[64] Whilst gleaning this information he can establish an amicable liaison with those about him.

(3) Compile a detailed story of what happened from those who can give material assistance regarding the events before, during and after death. Accurate notes must be made at the time in the official notebook and statements taken whenever possible.

(4) Have the body identified to him by a responsible person who knew the deceased. Where the death has occurred in hospital and such identification is to be made in the hospital mortuary, identification may be made by medical staff in appropriate circumstances.

(5) Make a visual examination of the body. If there is anything unusual consider whether to request the attendance of a forensic medical officer.

(6) Make a visual examination of the scene. If the body has already been removed an examination is still important. Make accurate notes. A drawing might be useful. If there is anything unusual at the scene, consider whether to call in a scenes of crime officer.

(7) Obtain the deceased's medical history from those at the scene who knew him well. These people know best how the deceased has felt within days or weeks of his death. Ask whether he was taking pills and medicines and collect any that may be relevant.

(8) Complete Form P1[65] required by the Pathologist. By leaving this to the end the investigating officer will be reminded of things about which he has forgotten to inquire.

(9) Contact the family doctor, and say that he is acting on behalf of the coroner. Ask about any symptoms the deceased might have complained of and any treatment given.

The proper investigation of such deaths involves much more than a formal collection of names, addresses, ages and asking someone to explain briefly what happened. Key witnesses must be interviewed as early as possible in order to obtain the maximum information. At times this can, no doubt, be distressing to relatives or perhaps distasteful to members of the Force; but by using tact, thought and common sense, a practical police officer can obtain the necessary information with the minimum of distress or distaste. It is not a valid excuse to say that a key witness was too upset to be interviewed.

General

When it comes to the knowledge of a member of the Force that a dead body has been found in suspicious circumstances, that member will inform his immediate superior or, if more practicable, the duty officer. From then until it is decided foul play can be ruled out, the matter will be treated as murder.

When the investigation at the scene has been adequately carried out the body will be removed to the mortuary, authority having first been obtained, if possible, from the coroner. A local undertaker should be employed for this

[64] This form is reproduced at the end of this chapter.
[65] This form is also reproduced at the end of this chapter.

purpose. A member of the Force, if considered necessary, should accompany the body. In exceptional cases where the body has not been examined at the scene by a doctor, every effort must be made to have this done at the mortuary. Even when it seems apparent that a person is dead, a doctor is the only person qualified to pronounce life extinct.

The following points must receive particular attention:

(1) Deceased's name and marital status. Full names must be accurately recorded, ie, full forenames and surnames properly spelt. Initials shall not be used, nor names by which deceased was known locally. Date and place of birth, occupation, or former occupation if retired, must be accurately stated, eg, builder's labourer, retired civil servant. It is not sufficient to say, unemployed, retired, etc. The marital status of the deceased must always be obtained.

(2) Deceased's address. Correct addresses must be quoted. In cities or towns the streets and house number must be given. In rural areas the townland and post town must be accurately stated. It is not sufficient to quote a local name for an area which embraces a number of townlands. Where there is a district number or postal code this should also be given.

(3) Request for post-mortem examination. On the police being directed by a coroner that a post-mortem examination is necessary, the member in charge of, or supervising the investigation, will collect as much preliminary information about the case as he can and notify the State Pathologist's Department in accordance with the instructions contained in Appendix 49A to this Manual. On no account should arrangements be made in the first instance with local pathologists. The member concerned must be in a position to supply relevant preliminary information concerning the death and in particular the name and age of the deceased, where the body lies and a brief account of the death. Care must be exercised to ensure that telephoned information is clear and precise.

(4) Previous medical history. The name and address of the deceased's doctor and any previous medical history which he can give should be available for the pathologist.
Should the doctor not wish to disclose details of deceased's medical history, he should be asked to furnish same in a sealed envelope for the information of the pathologist. The investigating officer should also enquire from the family and neighbours of the deceased as to his health prior to death, anything unusual being noted - dizzy spells, black-outs, severe headaches, depression, etc.

(5) Identification of the deceased. The member of the Force who carried out the investigation should be in a position to identify the body to the pathologist at the post-mortem examination and supply him with all the information acquired. In his unavoidable absence, another member of the Force must be detailed to do this. In homicide cases, and in fatal road traffic accidents, continuity of evidence is essential to prove that a body

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found in situ was that of a certain individual and that the individual met his death by a particular cause. To do so evidence is necessary from:

(a) the person who witnessed the death (if such be available);
(b) the person who discovered the body;
(c) the pathologist who conducted the autopsy; and
(d) the relative or other person who identified the body;

together with evidence that proves conclusively that all are speaking of the same person and body.

(6) Attendance at post-mortem examination. The investigating member is required to attend the post-mortem examination for two main purposes:

(a) To identify the body to the pathologist. It follows that the investigating officer must first have had the body identified to him.

(b) To furnish the pathologist with details of the deceased, the circumstances of the death and the results of the member's own investigations. Where investigation has disclosed matters such as suicide notes, defective gas or oil heaters, faulty electrical appliances, natural hazards etc, these must be fully described to the pathologist. For this purpose Form P1 must be accurately completed. The pathologist cannot commence the autopsy until the policeman has put him in the picture in this way.

The member concerned must be at the mortuary on time. The pathologist cannot start without the above information and lack of punctuality can upset busy schedules.

It should be rare for the investigating member not to be able to attend the autopsy. He should not start an investigation if it is apparent he will not be able to see it through. However, should untoward circumstances arise, it is the investigating police officer's duty to see that a deputy can attend. He must, of course, ensure that the deputy can identify the body and is fully conversant with the information gleaned at the scene. Members of the Force will not be required to act as note-takers to the pathologist during post-mortem examinations. They will remain until the examination is finished or until the pathologist states that their presence is no longer necessary. At the termination of the autopsy the pathologist will hand the investigating member two forms:

(a) A form giving the preliminary results of the autopsy. This information must be transmitted to the coroner at once by hand or by telephone. If there is any delay the information loses its value.

(b) A form authorising a payment to be made to the mortuary attendant. This form must be handed to the

member in charge of the station for transmission to the divisional commander's clerk.

(7) Supervisory ranks will ensure that those who are required to attend post-mortem examinations have the necessary knowledge.

(8) Further information for the pathologist. After the autopsy the pathologist may require further information on some fact. The investigating member must obtain this promptly and telephone it to the pathologist at the earliest opportunity. Should further police enquiries bring more light to the circumstances of the death, the investigating member is responsible for seeing that the pathologist is told. It might alter the pathologist's interpretation of his findings."

DETAIL
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To be complete

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When the Coroner has asked the p
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of Forensic Medicine, Grosvenor Rc

REPORTING DEA

DURING OFFICE HOURS

Monday-Friday 9

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AFTER OFFICE HOURS

Telephone the State Patho

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ATTENDANCE AT POSTMORTEM

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DETAILS REQUIRED FOR CORONERS' POSTMORTEM EXAMINATIONS

To be completed by the police officer attending the autopsy

REQUEST FOR POSTMORTEM EXAMINATION

When the Coroner has asked the police to arrange a postmortem examination of the body, the police officer concerned should telephone preliminary information about the death to the State Pathologists Department, Institute of Forensic Medicine, Grosvenor Road, Belfast BT12 6BS.

REPORTING DEATHS TO STATE PATHOLOGISTS DEPARTMENT

DURING OFFICE HOURS

Monday-Friday	9 a.m.-5.15 p.m.	Telephone State Pathologist's Department: BELFAST (01232) 894648 (Direct Line) or (01232) 240503 Ext. 2748/2698/2520/2559

Report cases as soon as possible. Those notified after 10 a.m. might not be dealth with that day.

AFTER OFFICE HOURS

Telephone the State Pathologist's Department at 9 a.m. *the following morning.*

AT WEEKENDS OR IF SERIOUS CRIME IS SUSPECTED AND A PATHOLOGIST IS REQUESTED TO ATTEND THE SCENE

Telephone the *Duty Inspector,* F.C.I.C., at R.U.C. Headquarters (Belfast 650222) for the pathologist on duty. He knows where the pathologist can be contacted.

ATTENDANCE AT POSTMORTEM EXAMINATION

The investigating member is required to attend the postmortem examination for two main purposes:

1. To identify the body to the pathologist;
2. To furnish the pathologist with details of the deceased, the circumstances of the death and the results of the member's own investigations. THIS QUESTIONNAIRE is designed to help the member to collect this information. Further information concerning the police investigation will be found in the RUC Manual, chapter 49, para 21. Attention is drawn to the need to:

   (i) make a careful investigation in the true sense of the word. This involves more than a formal collection of names, addresses, ages and asking someone to explain briefly what happened. The police officer must go to the scene; getting information over the telephone is not adequate. Key witnesses must be interviewed as early as possible to obtain the maximum information. When relatives are distressed this is not easy but by using tact a practical police officer can obtain the necessary information.

   (ii) make accurate notes in the official notebook and take statements whenever practicable.

FURTHER INFORMATION FOR THE PATHOLOGIST

If the pathologist requires further information, the investigating member must obtain this promptly and telephone it to the pathologist at the earliest opportunity. Should further police enquiries being more light to the circumstances of the death, the investigating member is responsible for seeing that the pathologist is told.

AFTER THE POSTMORTEM EXAMINATION

The pathologist will hand the investigating officer a form giving the preliminary results of the autopsy. This information ***must be transmitted to the coroner at once, by hand or by telephone.*** If there is any delay, the information loses its value.

P.1

1

Please answer ALL questions whenever applicable

1. Police officer attending the autopsy:

   Rank: _____ Surname: _____ Forename Initials: _____

   Station: _____ Tel. No. incl STD code: _____ Ext. _____

2. Were you the police officer who carried out the enquiries into the death? YES/NO

3. If not, who carried out the enquiries?

   Rank: _____ Surname: _____ Forename Initials: _____

   Station: _____ Tel. No. _____

   Has the police officer given you full information about the death? YES/NO

4. Which coroner requested the autopsy? _____

5. Who identified the body to you? _____

   You must have the body identified to you in person so that you can identify to the pathologist the body on which the Coroner has ordered an autopsy.

6. What is the *full* name of the deceased?

   Surname: _____ Forenames: _____

   The name must be accurate. Have you the correct spelling?

7. What is the address of the deceased?

   .....

   .....

   ..... Tel. No. (if any) .....

8. What is the deceased's age? _____ Date of Birth: _____

9. Was the deceased single of married, widower or widow? _____

10. Any children? _____ boys _____ girls

    How many living at home? _____ boys _____ girls

11. Was the deceased at school/working/unemployed/retired/housekeeping?
    Ring appropriately.

12. What is, or was, the deceased's work? _____
    Be as specific as possible. (e.g. NOT civil servant)

13. Who did the deceased live with? _____
    Just state relationship or landlady or male/female friend.

14. What kind of accommodation?
    Ring appropriately.

    (i) Private/Housing Executive/Corporation
    (ii) House/Bungalow/Cottage/Flat/Farmhouse
    (iii) Single Storey/Two Storey
    (iv) Detached/Semi-detached/Terrace
    (v) Other _____

15. Ask the person the deceased w
    List here:

    Complaint

16. What medicine was the decea

17. Have you visited the deceaser

18. Who is the deceased's doctor

    Surname: _____

    Address: _____

    _____

    _____

    This must be accurate becau

19. Enquire from the doctor:

    (i) if the deceased has hac

    (ii) what drugs, if any, he v

If the doctor does not wish to give envelope for the pathologist.

applicable

____ Forename Initials:_____

e: _____ Ext. _____

th? YES/NO

____ Forename Initials:_____

_____ Tel. No. _____

ES/NO

_____

_____

lentify to the pathologist the body on

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ing?

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Housing Executive/Corporation
Bungalow/Cottage/Flat/Farmhouse
Storey/Two Storey
d/Semi-detached/Terrace

_____

15. Ask the person the deceased was living with or who knew him well about any illnesses or complaints. List here:

Complaint	How long ago? Did it persist until death?

16. What medicine was the deceased taking? Obtain sample if possible. Note here:

17. Have you visited the deceased's home? YES/NO

18. Who is the deceased's doctor?

Surname: _____ Forename Initials: _____

Address: _____

_____

_____ Tel. No. _____

This must be accurate because the pathologist has to write to him about the cause of death.

19. Enquire from the doctor:

(i) if the deceased has had any relevant illness or complaint. Note here:

(ii) what drugs, if any, he was being prescribed. Note here:

If the doctor does not wish to give you this information verbally, ask him if he will give you a note in a sealed envelope for the pathologist.

3

20. Who witnessed the death? _____

Date of Death: _____ Time of Death: _____

21. If not witnessed,
who discovered the dead body? _____

Date: _____ Time: _____

who last saw the deceased alive? _____

Date: _____ Time: _____

what was the deceased then doing? _____

22. Who pronounced life extinct? _____ At scene/hospital? Time: _____

23. Did you see the body at the scene? YES/NO

24. Are there any visible marks on the body? Note here:

25. Was resuscitation tried by pressing on the chest? YES/NO

26. Have you examined the scene? YES/NO

27. Were any photographs taken of the scene? YES/NO

28. From whom was information about the death obtained. Note names only here:

1. _____ 3. _____

2. _____ 4. _____

29. Who have you yet to interview? Note names only here:

1. 3.

2. 4.

30. Were there any special difficulties in collecting this information?

N.B. The information provided by the investigating RUC officer must be reliable and accurate. If further information becomes available or if the details supplied need to be amended you **must** inform the pathologist at the earliest opportunity.

Signature: _____

Date: _____

4

To H. M. Coroner .....

.....

.....

Surname: .....

Maiden Name: .....
(if appropriate)
Address: .....

.....

Occupation (or last occupation): .....
if retired, the word 'Retired' should be inserted before

Marital Status: Single ☐ Marri

If married or widowed, tick here ☐
the husband's name, address and occupa

If under 16 years, tick here ☐
the father's name, address and occupatior

If an illegitimate child, tick here ☐
the mother's name, address and occupatic

Local Sub Division where cause of death

Time and Date of death: .....
If deceased is a child who lived for less than 24 hours

Place of death: .....

Persons witnessing the death: .....

Deceased's Medical Practitioner: .....

Medical Practitioner who attended deceas

Medical Practitioner who pronounced life

Medical History: .....

.....

.....

Circumstances relating to death: .....

.....

Next of kin: .....

.....

Investigating Officer
Note The above information will also be recorde

.....

To .....

.....

Sudden death of, Name .....

Address .....

I consider no inquest is required on the ab

Time of Death: _____

Time: _____

Time: _____

e/hospital? Time: _____

s only here:

eliable and accurate. If further information you **must** inform the pathologist at the

Form 19

Royal Ulster Constabulary
Coroners Act (Northern Ireland) 1959
Police Report Concerning Death

To H. M. Coroner .....

Date Stamp

Surname: ..... Other Names: .....

Maiden Name: ..... Date of Birth: ..... Place of Birth: .....
(if appropriate)
Address: .....

Occupation (or last occupation): .....
If retired, the word 'Retired' should be inserted before the last occupation

Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐ (tick whichever applies)

If married or widowed, tick here ☐ and state the husband's name, address and occupation

If under 16 years, tick here ☐ and state the father's name, address and occupation

If an illegitimate child, tick here ☐ and state the mother's name, address and occupation

Name .....
Address .....
Occupation .....

Local Sub Division where cause of death occurred: .....

Time and Date of death: .....
If deceased is a child who lived for less than 24 hours the age in completed hours, or if less than one hour, in minutes, should be added e.g. Aged 4 hours

Place of death: .....

Persons witnessing the death: .....

Deceased's Medical Practitioner: .....

Medical Practitioner who attended deceased before death: .....

Medical Practitioner who pronounced life extinct: .....

Medical History: .....

Circumstances relating to death: .....

Next of kin: .....

Investigating Officer _____ Sergeant i/c of Station _____ Station _____

Note The above information will also be required in connection with still births

---------- please detach and return the bottom part to the above Station ----------

To .....

Date .....

Sudden death of, Name ..... on .....

Address .....

I consider no inquest is required on the above death _____
Coroner for

NOTIFICATION BY POLICE OF POST MORTEM

Deceased _____

Post Mortem Date _____

Scheduled Time _____

Place _____

The following persons should be notified of the date, time and place of the Post Mortem.

1. Any relative of the deceased who has notified the coroner of his desire to be represented at the post mortem.

   NO / YES (details) _____

   _____

2. Deceased Regular Medical Attendant

   NO / YES (details) _____

   _____

3. If died in hospital, inform hospital.

   NO / YES (details) _____

   _____

4. If deceased died of a notifiable accident or disease or any other matter requiring referral to a Government Inspector.

   NO / YES (details) _____

5. Any Government Department which has notified Coroner of its desire to be represented at the examination.

   NO / YES (details) _____

_____

NAME RANK NO

On completion detach this form and submit with inquest papers (if applicable).

THE REPORTIN

UNDER THE COR(

3-01 The principal ci coroner are set out in sect to secure, as far as huma to [the coroner's] notice".[1]

The duty of medical (section 7)

3-02 Section 7 of the 1

> "Every medical practiti occupier of a house c institution or premise reason to believe that of violence or misadve misconduct or malprac natural illness or dis registered medical pra in such circumstances result of the administ coroner within whose and circumstances rela

[1] HC Debs (NI), vol 44, co circumstances in which a de *seq.*

[2] There is no *statutory* equiv however, any person "about the coroner (or to the police (1702) 1 Salk 377, 91 ER 3 death to a registrar of death Births and Deaths Registrat Regs 1987, reg 41(1), discus that medical practitioners d Brodrick Committee consid number of instances: *Brodri* statutory duty to report a de Act, but that duty may be Síochána not below the ran 18(3)-(5).