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CHAPTER 3

THE REPORTING OF DEATHS TO THE CORONER

UNDER THE CORONERS ACT (NORTHERN IRELAND) 1959

3-01 The principal circumstances in which deaths are reportable to the coroner are set out in sections 7 and 8 of the 1959 Act, which "are framed so as to secure, as far as humanly possible, that all questionable deaths are brought to [the coroner's] notice".[1]

The duty of medical practitioners and others to report a death (section 7)

3-02 Section 7 of the 1959 Act provides:

> "Every medical practitioner, registrar of deaths or funeral undertaker and every occupier of a house or mobile dwelling and every person in charge of any institution or premises in which a deceased person was residing, who has reason to believe that the person died, either directly or indirectly, as a result of violence or misadventure or by unfair means, or as a result of negligence or misconduct or malpractice on the part of others, or from any cause other than natural illness or disease for which he had been seen and treated by a registered medical practitioner within twenty-eight days prior to his death, or in such circumstances as may require investigation (including death as the result of the administration of an anaesthetic), shall immediately notify the coroner within whose district the body of such deceased person is of the facts and circumstances relating to the death."[2]

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[1] HC Debs (NI), vol 44, col 1414 (14 May 1959) (Minister of Home Affairs). Other circumstances in which a death must be reported to the coroner are set out in paras 3-13 *et seq*.

[2] There is no *statutory* equivalent of this provision in England and Wales; at common law, however, any person "about the deceased" is under an obligation to give immediate notice to the coroner (or to the police) of circumstances requiring the holding of an inquest: *R* v *Clerk* (1702) 1 Salk 377, 91 ER 328. Various persons are also under a statutory duty to report a death to a registrar of deaths, who must, in turn, report certain deaths to the coroner - see Births and Deaths Registration Act 1953, ss 15-17 and Registration of Births and Deaths Regs 1987, reg 41(1), discussed in *Jervis*, paras 5-16 to 5-45. In practice, however, it seems that medical practitioners do often report deaths directly to the coroner; nevertheless, the Brodrick Committee considered that they should be under a statutory duty to do so in a number of instances: *Brodrick Report*, para 12.03. *Cf* in the Republic of Ireland, there is a statutory duty to report a death to the coroner in much the same terms as s 7 of the 1959 Act, but that duty may be discharged by immediately notifying a member of the Garda Síochána not below the rank of sergeant - who will in turn notify the coroner: 1962 Act, s 18(3)-(5).

The report is normally in the form of a telephone call to the coroner's office or to the coroner in person.[3] Failure to make such a report is a summary offence punishable on conviction with a fine not exceeding level 2 on the standard scale (currently £500).[4] Where there is reason to believe that the death is covered by section 7, it is also a summary offence, punishable on conviction with a fine not exceeding level 3 on the standard scale (currently £1,000) to cremate or bury the body, to apply any chemical to it externally or internally, or to make any alteration "of any kind" thereto without the authority of the coroner.[5]

3-03 The five categories of "reportable" death listed in section 7 overlap to some extent - and, indeed, all appear to be subsumed in the general requirement that a death must be reported if it resulted, directly or indirectly, from "any" cause other than natural illness or disease for which the deceased had recently been seen and treated by a registered medical practitioner. Even in such a case, the death is reportable if there is reason to believe that it occurred "in such circumstances as may require investigation".[6] The very wide ambit of the section may be emphasised by listing the various categories of death to which it refers; the coroner must be informed of any death where any one of the persons referred to in the section "has reason to believe" that the deceased died "either directly or indirectly" -

(1) As a result of violence or misadventure or by unfair means;
(2) As a result of negligence, misconduct or malpractice on the part of others;
(3) From any cause other than natural illness or disease;
(4) From natural illness or disease for which he had not been seen and treated by a registered medical practitioner within 28 days prior to his death; or
(5) In such circumstances as may require investigation.

3-04 To illustrate the extent of these provisions we may take the facts of an English case, *R* v *Poplar Coroner, ex parte Thomas*.[7] The deceased, a 17-year-old girl, suffered a severe attack of asthma; despite repeated telephone calls, it was more than half an hour before she was taken to hospital by ambulance; by this time she had suffered a cardiac arrest and attempts to resuscitate her were abandoned shortly after her arrival at hospital. A post-mortem examination concluded that death was due to a prolonged asthmatic attack. But there was also medical evidence to the effect that there was a "good chance" that the deceased would not have died had she arrived earlier at the hospital. It was contended that the failure of the ambulance to arrive more promptly meant that there had died an "unnatural" inquest should be held.[8] was a natural cause of "unnatural" death by the ambulance.[9] In *Thomas*, been held; clearly, the co suggested that section 7 reported to a coroner in accepted in *Thomas*[10]) tha the ambulance was due t was surely reason in the deceased had died at least disease or that she h investigation".

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[3] Rule 2 of the 1963 Rules provides that "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". For this purpose most coroners have available a mobile telephone or pager for contact outside office hours. Nonetheless "immediate" contact is not always possible in practice.

[4] 1959 Act, s 10(1), as amended by the Fines and Penalties (NI) Order 1984, arts 5(2) and 6(5) and the Criminal Justice (NI) Order 1994, art 3(2).

[5] 1959 Act, ss 9 and 10(2), as amended by the Criminal Justice (NI) Order 1994, art 3(2).

[6] For example, where a person receiving medical treatment died as a result of typhoid or legionnaires' disease.

[7] [1993] 2 All ER 381.

[8] 1988 Act, s 8(1)(*a*).

[9] Dillon LJ (at p 386) sugge heavy traffic, roadworks, ambulance crew, but that n Brown LJ (at p 388) state late arrival of the ambular believe it did". *Cf Jervis, status asthmaticus*'. If the treatment given are serio untreated *status asthmatic* to be explained as a case i

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promptly meant that there was "reasonable cause to suspect" that the deceased had died an "unnatural" death for the purposes of determining whether an inquest should be held.[8] The Court of Appeal held that the asthmatic attack was a natural cause of death and that the death was not turned into an "unnatural" death by the unfortunate and unexplained delay in the arrival of the ambulance.[9] In *Thomas*, the issue was whether or not an inquest should have been held; clearly, the coroner had in some way learned of the death. But it is suggested that section 7 of the 1959 Act means that such a death *must* be reported to a coroner in Northern Ireland, even if (as appears to have been accepted in *Thomas*[10]) that there was no reason to believe that the late arrival of the ambulance was due to "negligence, misconduct or malpractice ...". There was surely reason in the circumstances of that case to believe either that the deceased had died at least "indirectly" from a cause other than natural illness or disease or that she had died "in such circumstances as may require investigation".

3-05 In practice, the duty imposed upon a medical practitioner, registrar of deaths, funeral undertaker, householder, etc to report a death to the coroner "immediately" may be reduced to four broad circumstances.

All deaths from unnatural causes

3-06 The underlying cause of the death, rather than the terminal event, is the test as to whether a death is from "unnatural causes" and therefore properly referable to the coroner.[11] Thus it would be wrong for a medical practitioner

[8] 1988 Act, s 8(1)(*a*).

[9] Dillon LJ (at p 386) suggested that the delay may have been due to the distances involved, heavy traffic, roadworks, computer malfunction, slack management or an inefficient ambulance crew, but that none of these possible scenarios made the death unnatural; Simon Brown LJ (at p 388) stated, however, that he would have held the death unnatural if "the late arrival of the ambulance had constituted a more extreme failure of the service than I believe it did". *Cf Jervis*, para 8-20: "[T]he cause of death would appear to be 'untreated *status asthmaticus*'. If the norms for the time taken to provide treatment and the type of treatment given are seriously departed from, it would seem sensible to conclude that untreated *status asthmaticus* is an unnatural cause of death." On this reasoning, *Thomas* is to be explained as a case in which there was no "serious" departure from the norm.

[10] Simon Brown LJ (at p 388) intimated that he would have regarded the death as "unnatural" if the late arrival of the ambulance had been due to "culpable human failure on the part of those responsible for providing a reasonably efficient emergency service".

[11] There is no statutory definition of the terms "natural" or "unnatural". In *Thomas*, however, it was held that "unnatural", as used in s 8(1)(*a*) of the 1988 Act, is to be given its ordinary meaning, and that whether a death is "natural" or "unnatural" depends on the cause of death. Dillon LJ stated that the cause of death was essentially "a practical question of fact" to be decided on the basis of "ordinary common sense"; but Simon Brown LJ, while agreeing that the issue should be decided on a commonsense basis, suggested that the question whether a particular death is properly to be regarded as unnatural is not "a pure question of fact", but one on which "some guidance at least can and should be given as a matter of law ...": [1993] 2 All ER 381, 386 and 388. In *R* v *HM Coroner of South District of Greater London, ex parte Weeks*, unreported, QBD, 6 December 1996 [transcript on LEXIS] Scott Baker J apparently agreed with Simon Brown LJ. But it is suggested with respect that the approach adopted by Dillon LJ is to be preferred in the context of section 7

not to inform the coroner but to issue instead a death certificate completed, for example, as follows: "bronchopneumonia due to immobilisation due to fractured neck of right femur".[12] The fractured neck of femur was an "unnatural" event and the underlying cause of the death, since the fracture caused the immobility which in turn led to the onset of the terminal event, namely, the bronchopneumonia. Of course, bronchopneumonia often occurs "naturally" and is the cause of death of many elderly, infirm, frail and debilitated persons. In a great many instances it is therefore entirely appropriate for the medical practitioner to issue a death certificate himself, without referring the death to the coroner, *provided there is no unnatural underlying cause or other circumstance "as may require investigation"*.[13] Immobilisation is a predisposing factor to the onset of bronchopneumonia and, if the immobility resulted from trauma (such as the fractured femur in the above example), the death should be reported to the coroner. It may be stating the obvious, but the onset of bronchopneumonia due to immobility may result from many other, and much more sinister, underlying causes that would merit a full-scale criminal investigation - for example, the effects of a gunshot wound, a drug overdose or the effects of injuries sustained in a road traffic accident.

3-07 The terminal event may be relatively innocuous and this in itself underlines the importance of close scrutiny of the causal chain. All coroners are able to cite examples of instances where the improper issuing by a doctor of a death certificate coupled with the initial failure to report has caused unnecessary upset and distress to a family, often because funeral plans have had to be rearranged to permit a post-mortem examination on behalf of the coroner. Where a medical practitioner believes a death is reportable to the coroner, a death certificate should *not* be issued unless, having reported the death and discussed the circumstances, the coroner directs that a death certificate may be issued.

All deaths from natural illness and disease for which the deceased person had not been seen and treated by a medical practitioner within 28 days of death

3-08 Section 7 requires that the deceased was both *seen* and *treated* within the 28-day period.[14] This appears to be a higher standard than that required by

of the 1959 Act. *Cf* for an interesting perspective on the decision by the coroner for Exeter that deaths due to HIV-related illness, when the HIV was contracted through anal sex or by needle-sharing, are "unnatural", see Brahms, "Unnatural death, AIDS and coroners" (1996) 347 *The Lancet* 777.

[12] For the purposes of this example, it is assumed that the fracture was the result of trauma rather than being pathological in origin, eg due to a tumour or osteoporosis; in the latter type of case, the death is from natural causes and need not be reported to the coroner.

[13] See eg *R* v *HM Coroner for South District of Greater London, ex parte Weeks*, unreported, QBD, 6 December 1996 [transcript on LEXIS] (death of elderly lady in old peoples' home due to arteriosclerosis, congestive heart failure and diabetes; no reasonable grounds for believing that death was due to unnatural causes).

[14] In England and Wales, where the duty to report to the coroner lies with the registrar of deaths, the referral period is 14 days: Registration of Births and Deaths Regulations 1987, reg 41(1).

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article 25(2) of the Births and Deaths Registration (Northern Ireland) Order 1976, which sets out the circumstances in which a medical practitioner is under a duty to issue a death certificate:

> "Where any person dies as a result of any natural illness for which he has been *treated* by a registered medical practitioner within twenty-eight days prior to the date of his death, that practitioner shall sign and give forthwith to a qualified informant a certificate in the prescribed form stating to the best of his knowledge and belief the cause of death, together with such other particulars as may be prescribed."[15]

Although the article goes on to prohibit the giving of a certificate where the death has been, or will be, referred to the coroner,[16] the 1976 Order, rather surprisingly, imposes no express obligation on the medical practitioner to have "seen" the deceased within the 28-day period. It may be that this is to be inferred from the requirement of treatment; but it is suggested that this is not necessarily the case. Coronial practice is to require adherence to the apparently higher standard of section 7 of the 1959 Act, so that if the deceased has not been both "seen" and "treated" within the 28-day period, the death is reportable. For the purposes of the section it would be logical to assume that "seen" means "seen in person in connection with medical treatment".[17] Thus, a casual sighting in the street by a medical practitioner or the receipt by the deceased of a repeat prescription within the 28-day period will not prevent the death from being reportable to the coroner.[18]

All deaths from "occupational" diseases

3-09 Deaths from "occupational" diseases are "unnatural" deaths[19] and hence are reportable to the coroner under section 7, irrespective of whether they result from negligence, misconduct or malpractice on the part of others. Asbestosis and mesothelioma are two well-known examples, but there are many others.[20] Even where an "occupational" or "industrial" link is only suspected, the death

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[15] Emphasis added. It would appear that the 1976 Order does not impose any obligation on the medical practitioner to examine or even to see the body prior to issuing a death certificate. The Brodrick Committee recommended that this should be required in every case: *Brodrick Report*, para 5.22. Although this recommendation has not been formally implemented, most medical practitioners will view or examine the body as a matter of good practice.

[16] Art 25(3)(*a*). Art 25(3)(*b*) further prohibits the giving of a certificate where there is reason to believe that the death was due to an industrial disease of the lung.

[17] "[T]he introduction of the words 'seen and' will ensure that the doctor will have actually seen his patient within a short period prior to death and, therefore, be able to confirm, or alter, his diagnosis and the consequent treatment": HC Debs (NI), vol 44, col 1659 (3 June 1959)(Mr WWB Topping).

[18] This does not mean, however, that a post-mortem examination is inevitable: see further below, Chapter 5, paras 5-20 to 5-23.

[19] "[T]hough the illness took its course leading to death, the inception of the illness was from unnatural causes": *R* v *Poplar Coroner, ex parte Thomas* [1993] 2 All ER 381, 385, *per* Dillon LJ.

[20] The Registrar General maintains an extra-statutory list of causes of death that are referable to the coroner.

should be reported. Many years may have passed between the employment responsible for the deceased's condition and the death and the deceased may have been employed in a number of different occupations. Accordingly, it may be crucial for the medical practitioner to take a detailed employment history from a patient, particularly where he or she presents symptoms suggestive of a possible industrial link to the illness. It is, for example, not at all unusual for a death to be referred to a coroner where the deceased was a former shipyard worker who had worked in the shipyard only for a relatively short period, but whose exposure to asbestos during that period led to his death decades later.

All deaths during an operation or resulting from the effects of anaesthesia

3-10 In most instances where death occurs in the course of medical treatment or anaesthesia no question of negligence, misconduct or malpractice arises; but the death is nonetheless reportable to the coroner.[21] In most of these cases, the coroner will advise the doctor reporting the death that a death certificate may be issued. The operation may have been an attempt to improve the quality of life of a seriously ill, or even terminally ill, patient, or it may have been an attempt to save life in circumstances where death would have been inevitable without the operation. At the time of death, however, it may be difficult to know whether the death was due to the medical procedure, the effect of an anaesthetic or some unforeseen medical complication. The coroner must make an assessment each time such a death is reported[22] and this calls for complete candour on the part of the clinicians concerned. All the circumstances should be discussed and, if necessary, the coroner could seek independent advice from the State Pathologist's Department.

3-11 In deciding whether to allow a death certificate to be issued the coroner will normally take into account any complaint made by the patient's family about the patient's treatment. Usually complaints of this nature are made in the first instance to the hospital concerned, though sometimes they are made directly to the coroner by the family or by a solicitor acting on their behalf. Where this happens it is prudent for the coroner to make a detailed note of the report and of the nature of the complaint or the allegations made, as these will require subsequent investigation either by the coroner personally or by a police officer acting on his behalf. The latter may take a formal statement from the complainant. Almost inevitably, the consequence in such cases is that the coroner will decide that the issuing of a death certificate is not appropriate and that a post-mortem examination should be carried out. Knowledge of the complaints or allegations will also assist the pathologist in

[21] *Cf* in England and Wales the Registrar of Deaths must report to the coroner (i) deaths which occur during an operation or anaesthesia, (ii) deaths which occur within 24 hours of the operation or anaesthesia, and (iii) deaths believed to have been caused by an operation or anaesthesia: Registration of Births and Deaths Regulations 1987, reg 41(1). The "24 hour" rule for anaesthesia does not actually appear in the text of the regulations, but is a commonly used measure of full recovery from an anaesthetic - see *Jervis* (4th supp, 1996), para 5-27. *Jervis* also advises that "where a death will be reported by the Registrar to the coroner, it is desirable for the doctor himself to report such death".

[22] *Jervis*, para 5-32 helpfully suggests five questions which may assist the coroner in this assessment.

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deciding how to approach the post-mortem examination and it is desirable that his subsequent report addresses these matters. In practice there will be close liaison between the coroner, the pathologist and the police in all cases of this kind.

The duty of the police to report a death (section 8)

3-12 Section 8 of the 1959 Act provides:

> "Whenever a dead body is found, or an unexpected or unexplained death, or a death attended by suspicious circumstances, occurs, the superintendent or chief superintendent[23] within whose district the body is found, or the death occurs, shall give or cause to be given immediate notice in writing thereof to the coroner within whose district the body is found or the death occurs, together with such information also in writing as he is able to obtain concerning the finding of the body or concerning the death."[24]

This section deals with the duty imposed on the police to report the finding of a body to the coroner and also to report any unexpected, unexplained or suspicious death. It covers a wide range of deaths, from the finding of a murder victim, or the recovery of a body from the sea, to the discovery of the body of an elderly person who lived alone and where the circumstances do not indicate anything other than a natural death. It may be noted that section 10(1) of the 1959 Act, which makes it a criminal offence not to report a death under section 7, does not apply to a failure to report under section 8; but presumably a failure by the police to make an "immediate" report in accordance with section 8 will be dealt with by means of disciplinary proceedings.

DEATHS IN POLICE CUSTODY

3-13 The Brodrick Committee recommended that there should be, as a matter of principle, a statutory obligation on the part of the officer in charge of a police station to report all deaths in police custody to the coroner.[25] Neither section 8 nor any other statutory provision in Northern Ireland (or England and Wales) expressly requires this to be done, although many such deaths will, of course, come within the terms of section 8 (or section 7) for one reason or another. In any case, as a matter of practice in Northern Ireland, as in England and Wales, the death of a person in police custody is always reported to the coroner.[26]

[23] Substituted for "district inspector" by the Royal Ulster Constabulary (Ranks) Regulations 1970, reg 6(*b*). In practice, this function is normally performed by the Sub-Divisional Commander, a post which has the rank of "superintendent".

[24] *Cf* Coroners Act 1962 [Ir], s 18(3) provides that an officer of the Garda Síochána is under a duty to notify the coroner if he becomes aware of the death of any person "in whose case a medical certificate of the cause of death is not procurable ...". This will include any death reported to him under s 18(5) of the Act - see above note 2.

[25] *Brodrick Report*, para 12.07.

[26] It was for this reason that the Brodrick Committee acknowledged (*ibid*) that the absence of a statutory obligation "is not very important".

3-14 Indeed, although there is likewise no statutory requirement either in England and Wales (or in Northern Ireland) that an inquest must be held in such a case,[27] the Home Office has recommended that:

> "... it is desirable for an inquest to be held in every case of a person dying while in legal custody so as to ensure that any possible allegation of ill-treatment or neglect may be investigated. We therefore hope that coroners will exercise their discretion in this matter and decide to hold an inquest whenever the death of a person in legal custody is reported to them ...."[28]

Although it is clearly desirable that practice in Northern Ireland follows that in England and Wales, a coroner cannot hold an inquest unless he has jurisdiction and it does not appear to be the case that a coroner has a discretion to hold an inquest simply because the deceased died in police custody.[29] But the coroner always has the option of directing that a post-mortem examination be carried out[30] and of holding an inquest even if the post-mortem examination establishes that death was from natural causes - provided, of course that the requirements of section 13 of the 1959 Act are otherwise satisfied.[31] Where, in particular, the death occurred in police custody, this may be the only way of allaying any concerns of the family or of the wider public.

DEATHS IN PRISON

3-15 A clear statutory obligation to report the death of any prisoner to the coroner is laid down by section 39 of the Prison Act (Northern Ireland) 1953 and rule 29 of the Prisons and Young Offenders Centre Rules (Northern Ireland) 1995. Section 39(1) of the 1953 Act provides that "in the event of the death of a prisoner"[32] the governor of a prison-

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[27] Coroners Act 1988, s 8(3)(*b*) provides only that if an inquest is held in such a case, the coroner must sit with a jury. According to *Jervis*, para 5-59: "it is not a strictly logical necessity, from the fact that any inquest held must be a jury inquest, that an inquest be held at all".

[28] Home Office Circular 35/1969. The Brodrick Committee also recommended that an inquest should be held in the case of every death in police custody: *Brodrick Report*, para 14.10.

[29] 1959 Act, s 13 confers jurisdiction to hold an inquest only where a dead body is "found" or the death is unexpected or unexplained or occurred in suspicious circumstances or in any of the circumstances mentioned in s 7. In England and Wales, the 1988 Act, s 8 only gives the coroner jurisdiction to inquire into a violent or unnatural death or a sudden death of which the cause is unknown. Home Office circulars are made available to coroners in Northern Ireland even though responsibility for coronial matters within the province lies with the Lord Chancellor; but a Home Office circular does not *per se* confer jurisdiction either in Northern Ireland or in England and Wales.

[30] 1959 Act, s 28(1), discussed below Chapter 6, paras 6-04 to 6-07.

[31] *Cf* the wording of the 1988 Act, s 8 means that in England and Wales there is no power to hold an inquest into a death from known natural causes.

[32] "Prisoner" is defined in the Prison Act (NI) 1953, s 47(1) as including "any person lawfully committed to any prison" and by the Prisons and Young Offenders Centre Rules (NI) 1995, r 4 as "any person required to be detained in a prison".

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> " ... shall give immediate notice thereof to the coroner within whose area the prison is situated, and to the board of visitors or the visiting committee, as the case may be, and, where practicable, to the nearest relative of the prisoner."[33]

As in England and Wales,[34] the coroner is by section 39(2) of the 1953 Act under an express statutory obligation to hold an inquest "into the cause of death of any prisoner in a prison within his area", and section 18(1)(*b*) of the 1959 Act further requires that in any case where there is "reason to suspect that ... the death occurred in prison" the coroner must hold an inquest with a jury.[35] In other words, the death of a prisoner must be reported to the coroner and an inquest held with a jury even when the death is clearly due to natural causes and there is no suggestion of anything untoward (such as ill-treatment) having taken place.

3-16 "Prison" is not defined in the 1959 Act, but section 47(1) of the Prison Act (Northern Ireland) 1953, as amended by article 9 of the Treatment of Offenders (Northern Ireland) Order 1989, provides:

> "For the purposes of this Act 'prison' includes any prison or other institution for the treatment of offenders not being -
>
> (a) a young offenders centre;
> (b) a remand centre;
> (c) a remand home; or
> (d) a training school,
>
> but this Act, except sections 10, 23 and 46, shall have effect in relation to young offenders centres and remand centres and to persons detained therein as it has effect in relation to prisons and prisoners."

By section 47(2) of the 1953 Act (as amended[36]):

> "A reference in this Act to any prison for the treatment of offenders shall be construed as including a reference to all land and buildings used for the purposes of or in connection with that prison."

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[33] The 1995 Rules, r 29 further provides that where a prisoner dies "the governor shall immediately notify ... the Secretary of State".

[34] 1988 Act, s 8(1)(*c*): "Where a coroner is informed that the body of a person is lying within his district and there is reasonable cause to suspect that the deceased ... has died in prison ... the coroner shall ... hold an inquest into the death ...". It would appear that this requirement has existed since the institution of the office of coroner. *Jervis on Coroners* (7th ed, 1927), p 10, referring to *De Officio Coronatoris* 1276 (see above, Chapter 1, para 1-04), states: "Although it makes mention only of persons slain, or drowned, or suddenly dead, yet the coroner was also required to investigate other matters such as deaths in prison, in order that the public might be satisfied that such persons came to their death by the course of nature and not by duress of imprisonment or by default of the gaoler. To the present day it is the duty of the latter to send for the coroner in all cases of the death of prisoners under his care before the body is interred."

[35] The Prisons (NI) Act 1953, s 39(2) further stipulates that "where practicable, sufficient time between the death and the holding of the inquest shall intervene to allow the attendance of the next of kin of the prisoner".

[36] By Treatment of Offenders (NI) Order 1989, Sch 1, para 10.

Rule 5 of the Prison and Young Offenders Centres Rules (Northern Ireland) 1995 further provides:

> "(1) The Secretary of State may, in pursuance of section 1 of the [Prison] Act:
>
> (*a*) declare that any premises, building, enclosure or place shall be a prison;
>
> (*b*) alter the boundaries of any prison;
>
> (*c*) amend or revoke any such declaration.
>
> (2) The prisons specified in the Schedule to these Rules are hereby declared to be prisons for the purposes of the Act and of these Rules."[37]

3-17 No problem of jurisdiction arises where a prisoner dies in what is indisputably a prison or concerning which the Secretary of State has made the declaration referred to in rule 5(1)(*a*). Similarly, if death results from any of the circumstances listed in section 7 or 8 of the 1959 Act, the coroner will have jurisdiction regardless of where the death occurred. But it is not entirely clear from any of these provisions whether a coroner has jurisdiction when a prisoner dies from natural causes in a hospital, or some other building, outside the prison precincts.[38] Much may depend on whether "in prison" is interpreted literally or in the broader sense of "in prison custody". According to the Prison (Northern Ireland) Act 1953:

> "A prisoner shall be deemed to be in lawful custody while he is confined in, or is being taken to or from, any prison and while he is working, or is for any other reason, outside the prison in the custody or under the control of an officer of the prison or while he is temporarily detained, pending trial or sentence, in any lock-up and while he is being taken to any place to which he is required or authorised ... to be taken ..."[39]

In addition, the Home Office has expressed the view that it is desirable for an inquest to be held, with a jury, "in all cases of deaths occurring in any form of legal custody, even though the death may have occurred in hospital or elsewhere and even though it may have been due to natural causes".[40] Both these provisions were referred to in *R* v *Inner London North District Coroner, ex parte Linnane*,[41] where the deceased had been serving a short prison sentence in a cell in a police station. When he became seriously ill, he was taken to a

[37] The Schedule currently refers to the prisons at Maghaberry, Magilligan and Maze.

[38] It must be extremely doubtful that a "rule 5(1)" declaration would be made to cover a prisoner receiving treatment in an outside hospital.

[39] Section 18(2), as amended by the Treatment of Offenders Act (NI) 1968, s 35(1) and Sch 3, Pt III, replicating the Prison Act 1952, s 13(2) in England and Wales.

[40] Circular 109/1982. Similar guidance had earlier been given in Home Office Circular 35/1969 (cited above, para 3-14), in which the hope was expressed that "coroners will ... decide to hold an inquest whenever the death of a person in legal custody is reported to them, regardless of whether the person has been confined in a prison as such or in any other kind of Prison Department establishment and even though the death may have occurred in a hospital or some other place outside the confines of a Prison Department establishment."

[41] [1989] 2 All ER 254.

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[42] *Ibid*, p 258, *per* Taylor LJ.

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hospital, where he later died. The coroner held an inquest, but took the view that the death had not occurred "in police custody" and that he was not therefore obliged by section 8(3)(*b*) of the 1988 Act to sit with a jury. The divisional court, "looking at this matter ... with common sense", held the deceased *had* died in police custody:

> "He was not in the physical custody [of the police] in the sense of being physically held by, or arranged to be physically held by, any specific officer, but he was in the legal custody of the police or at any rate (and this is sufficient) there must have been, to anyone properly directing themselves on the circumstances then existing, reason to suspect that he was in police custody."[42]

Had the deceased been taken to hospital from a regular prison, it seems clear that the court would equally have decided that he had died in prison custody. It is submitted, however, that modern authorities make it unlikely that a coroner would step so far beyond the statutory parameters as to base a claim to jurisdiction on the premise "that every place where any person is restrained of his liberty is a prison".[43]

Capital punishment

3-18 It may be now of academic interest only, but there still exists a requirement that the coroner holds an inquest on the body of an offender upon whom *judgment of death* has been carried out. Section 5 of the Capital Punishment Amendment Act 1868 (as amended[44]) provides:

> "The coroner of the jurisdiction to which the prison belongs wherein judgment of death is executed on any offender shall within twenty-four hours after the execution hold an inquest on the body of the offender; and the jury at the inquest shall inquire into and ascertain the identity of the body, and whether judgment of death was duly executed on the offender; and the inquisition shall be in duplicate and one of the originals shall be delivered to the governor [of such prison]."

Section 39(3) of the 1959 Act accordingly provides:

> "This Act shall, in its application to inquests on the body of any offender on whom judgment of death is executed, have effect subject to section five of the Capital Punishment Amendment Act, 1868."

As sentence of death will have been carried out within the precincts of a prison, the prison governor is accordingly required to notify the coroner under the

[42] *Ibid*, p 258, *per* Taylor LJ.

[43] *Hobert and Stroud's Case* (1630) Cro Car 209. *Cf R* v *Moss and Harte* (1986) 150 JP 26, where Cantley J took the view that a prisoner in a prison is in a different category to "any man who is in a state of imprisonment or legal custody". See also *Nicoll* v *Catron* (1985) 149 JP 424, where it was held that a prisoner had not escaped from a "prison" when he escaped from a police station yard.

[44] By the Under-Sheriffs (Abolition of Office and Transfer of Functions) Order (NI) 1982, Sch 1.

provisions of section 39 of the Prison Act (Northern Ireland) 1953 and the coroner must hold the inquest sitting with a jury.[45]

THE DEATH OF A CHILD IN CARE

3-19 Under the provisions of the Children (Northern Ireland) Order 1995[46] there is now no longer any specific statutory requirement to notify the coroner of the death of a child in care. But such a death is, of course, subject to the general reporting requirements of sections 7 and 8 of the 1959 Act.

THE REMOVAL OF A BODY OUT OF NORTHERN IRELAND

3-20 The coroner is concerned with the removal of a body out of Northern Ireland if it is within his territorial jurisdiction[47] and the intention to remove has been brought to his notice. Section 25 of the 1959 Act provides:

> "Where it is brought to the notice of a coroner that it is intended to remove out of Northern Ireland the body of a deceased person which is within his jurisdiction he may certify, in such manner as may be prescribed, that he has been satisfied as to the cause of death and that no circumstances exist necessitating the retention of the body, or any part thereof, in Northern Ireland."[48]

The coroner may have been so notified, irrespective of whether a death certificate was issued by a medical practitioner, in circumstances where there is no requirement to notify the coroner of the death, or it may be a case where the coroner must be notified of the death. In the latter instance a post-mortem examination may or may not have been carried out. The purpose of the section is to provide some means of controlling the movement of dead bodies out of Northern Ireland by making it a requirement that a coroner who receives such notification must satisfy himself that no further investigation into the

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[45] 1959 Act, s 18(1)(*b*).

[46] Schedule 10 to the Order repeals ss 5(3) and 6 of the Children and Young Persons Act (NI) 1968, which required the coroner to be notified in such cases; this brings the statutory position in Northern Ireland into line with that in England and Wales.

[47] Such jurisdiction exists if the body was lying within the coroner's district; this includes bodies already interred but which are to be exhumed.

[48] Originally this provision had been drafted to require the coroner's consent in every case. But the wording was amended during its passage through Parliament in order to facilitate funerals to graveyards along the border where death was from natural causes: see Sen Debs (NI), vol 43, cols 679-682 (3 November 1959). However, it appears that the intention was that the coroner's consent would always be required where the death had been reported to the coroner pursuant to ss 7 and 8, although the wording of s 25 as enacted does not make this clear. So far as the removal of bodies to the Republic of Ireland is concerned, s 25 appears in practice to be honoured more in the breach than in the observance. The removal of bodies from the Republic to Northern Ireland is governed by the 1962 Act, s 48, a provision which is identical to s 25 of the 1959 Act. The removal of a body from Northern Ireland to other parts of the United Kingdom or abroad is more strictly regulated. In England and Wales it is mandatory to give notice "to the coroner within whose jurisdiction the body is lying" in *all* cases where a body is being removed out of the country: Removal of Bodies Regulations 1954 and see *Jervis*, paras 7-26 to 7-33.

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circumstances of the death is necessary. If so satisfied, the coroner will issue a "Coroner's Certificate for Removal of a Body out of Northern Ireland".[49] Where the death has not previously been referred to the coroner, he will require to see the original death certificate or a certified copy thereof to ensure that one was properly issued by a medical practitioner and that the cause of death stated thereon is a natural one. If the coroner is not satisfied, it is incumbent upon him to make further inquiries before issuing the certificate. Ultimately, of course, the coroner may refuse to issue the certificate and refer the death to the police for investigation or order a post-mortem examination.

[49] This is a prescribed form under the Coroners Rules 1963, Sch 3, Form 18.