THE CORONER*

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H.M. Coroner for Greater London (Western District)

Every County has to appoint Coroners from among doctors or lawyers of at least five years' standing to investigate all violent, unnatural or sudden deaths where the cause is not known. The cost of the service is met from the rates, but the Coroner works for the Crown and is only answerable to the Lord Chancellor. The Coroner is independent of both local and central government, but he is obliged to act within the confines of the law and is subject to orders or judgments of the High Court. He is required to be available at all times or to arrange for a suitably qualified deputy to be available. The Coroner is assisted by a staff of officers, whose number will depend upon the size and population of the district.

Reporting cases to the Coroner

Any doctor may give a certificate of death where he has treated the patient in the last illness and knows the cause of death(1). However, the Registrar of Deaths may not register a death unless the death is due to natural causes and the doctor treating the patient has seen him within fourteen days. If this is not so the case is referred to the Coroner(2), which occasions delay and difficulty for the relatives. All doubtful cases should therefore be referred to the Coroner for advice. All deaths in prison must be referred to the Coroner(3).

Action by the Coroner

If the death is natural but the doctor attending is away and his partner certified the death; or in similar circumstances, the Coroner can give a certificate to the Registrar to allow the death to be registered on the doctor's certificate. In the majority of cases the Coroner will order a post-mortem examination. If this shows the death to be due to natural causes there will normally be no inquest. The Coroner gives a certificate of cause of death to the Registrar, and also gives a cremation certificate if one is required. All other cases will require an inquest.

Hospital post-mortem examination

If there is a prospect that the death may be referred to the Coroner, the hospital should not ask the relatives for permission to carry out an autopsy. If permission is refused and the doctor cannot give a certificate of death that will be registered, the Coroner would be obliged to order the examination against the expressed wishes of the family.

Need for an inquest

When the death occurs in prison or is not due to a natural cause, the Coroner is obliged to hold an inquest. He has no discretion at present, even in those cases where the facts are not disputed. The length of time between an incident and death is not material—it can be years.

Hospital deaths

Death attributed to any accident, industrial disease, poisoning, abortion, neglect, or occurring under an operation or before recovery from an anaesthetic must be reported. Poisoning includes the side effects of drugs and alcohol(1). Deaths of mental patients and foster children are reported in the same way as all others. If allegations concerning the treatment are made, it is wise to inform the Coroner, who is in a position to investigate the cause of death if necessary. Patients in receipt of a disability pension are usually referred to the Coroner; it may affect the outcome of the widow's claim for compensation.

Doctors' reports

Ideally, the doctor treating the patient attends the autopsy and brings the patient's notes. A short preliminary report or statement to the Coroner's Officer is essential before the autopsy, to ensure that the correct investigations are carried out. A full written report may be requested by the Coroner. A rather inadequate fee is paid for this, but it may make it unnecessary to trouble the doctor with attendance at the inquest. The Coroner needs reports in cases of 'hospital deaths' in order to know whom to ask for information. It would be impracticable to have the police interview every person in the hospital.

Attendance at the inquest

Witnesses are normally informed orally. A summons may be issued, and there is a penalty for disregarding this(4). Most Coroners try to arrange a suitable time for the doctor and release the doctor quickly. There is a payment for attendance at court.

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Sometimes the evidence of the doctor is to give continuity to the evidence; to show that the death is related to earlier injury. Pulmonary embolus is a typical case.

Inquests with a jury

All road traffic deaths, industrial injuries, railway deaths, aircraft accidents and prison deaths must be heard with a jury. It is difficult to adjourn an inquest with a jury, as the same jury would have to be recalled. For this reason all witnesses are needed, and the doctor may feel that his evidence was of little value. In non-jury cases it may be possible to hold the inquest without the doctor and adjourn to allow the doctor to be called if necessary. This can be unfortunate if allegations are made about the hospital, as they are reported by the press and the explanation is delayed for some days.

Representation at the inquest

All interested parties at an inquest are entitled to be represented by a lawyer and to ask questions(5). The inquest is an inquiry, not a trial, and there are no closing speeches. It is usually known in advance if there is a need for a doctor or a hospital to be represented. Prescription of a month's supply of barbiturate to a patient in the habit of taking it in one go, or use of a drug with known adverse side effects without any warning to the relatives may require to be justified. The medical defence organizations will give expert advice and arrange representation if it is advisable. The doctor is in a difficult position with difficult relatives. The suggestion that the mother was the cause of a child's suicide and not an incompetent doctor will not get a sympathetic newspaper report, however correct the statement.

Criminal jurisdiction

A Coroner's jury still has the power to send a person for trial if it decides that the death was due to murder, manslaughter or infanticide(6). There have been cases where the conduct of a doctor was thought to be sufficiently grave to amount to criminal negligence, as required for a charge of manslaughter. It is most unusual for any criminal verdict to come from the Coroner's court. Where a person is charged with causing the death, the inquest is adjourned until the conclusion of the trial(7).

Other offences and claims for damages

All lesser charges have to follow the inquest(8). These include offences under the Road Traffic Acts, the Factories Act, etc. The purpose of an inquest is to find out what caused the death. A trial is intended to find if a certain person is guilty or liable. No person may be asked an incriminating question in the Coroner's court, but a question cannot be rejected on the ground that it might affect payment of damages(9). The Coroner may not appear to have made any finding of civil liability—that is a finding of negligence or breach of a duty—in his verdict. There can be no doubt, however, that the inquest is of great assistance to the family of a person who has died. There may be no other means of finding out the true facts concerning the death. It can also help other people who may work in a similar industry to avoid a similar death.

Evidence at the inquest

The purpose of the inquest is to determine who the deceased person was, and how, when and where he came by his death(10). The Coroner decides which witnesses are necessary, but any person with information to give is entitled to attend the inquest and give evidence. Any person whose conduct is likely to be called into question should be called to the inquest or given notice of the time and place(11). If the conduct of a person is called into question on substantial grounds and he has not been given such notice, the Coroner must adjourn the inquest to allow his attendance(12). The procedure is governed by the Coroners' Rules 1953, and the Coroner may disallow any question that is not proper or relevant(13).

Reporting of inquests

All inquests are held in public and may be reported in the press. The Coroner tries to use words that are not sensational and will not cause distress, but the inquest must be accurate and deal with all the necessary facts. Justice must be done to all the parties. It is unfortunate that the personal interest angle is the one most welcomed by the press. The mother who shouts out that her son was murdered will receive more column inches than the rest of the inquest which showed that he was not. A doctor witness should have all his facts available and an explanation for his acts and decisions. He must also be prepared to be treated unfairly, for the problem family will still create problems and, being bereaved, will have the sympathy of the media.

The verdict

There is really no difference between 'Accidental Death' and 'Misadventure'. The latter is used in hospital cases where the act was performed deliberately but was attended by misfortune. In the case of self-inflicted deaths, the position is rather strained. The High Court insists that suicide must be

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roved by evidence and not presumed because it eems the most likely explanation. The demands of ie evidence required seem to be constantly extended. n 1975 the Lord Chief Justice, setting aside a icide verdict, took the view that 'no reasonable oroner properly understanding the obligation to rove suicide could have found suicide in this ase(14)'. No Coroner relishes such a stinging rebuke, nd there is thus an apparent fall in the incidence f suicide. The alternative is an open verdict. erdicts of 'Addiction to Drugs' and 'Chronic lcoholism' are possible, but again are misleading. Many alcoholics die of intercurrent infections, and rug addicts seem prone to misadventures.

attered babies

'Non-accidental Injury' of children as a cause f death has been the subject of some recent ensationalism. The figure quoted at meetings is hat 750 children are killed by their parents every ear. This figure was a consequence of doubling he previous one, but it is not clear how that figure llowed the actual number of 30 to 40. The iscrepancy between the history and the finding f healing injuries causes suspicion. Where previous attering is suspected, the Coroner should be warned, nd the body may be X-rayed if necessary.

ot deaths

The Sudden Death in Infancy Syndrome is ccepted as a cause of death. The age group is sually around three months. The pathological indings cover a wide spectrum from severe, nrecognized natural disease to minimal changes n the air passages. Normally there is no inquest, ut attempts are made to contact the family doctor o enable him to counsel the parents and to assist im where he had actually seen the child shortly efore death and found nothing to warrant admission o hospital. In some areas there is a study of these eaths involving the paediatric pathologist and the ommunity health workers. They are concerned with oth the aetiology of the disease and the rehabilitation f the family.

rgan transplants

The Human Tissue Act 1961 covers the law in his field, and its restrictions must be accepted. If case is to be referred to the Coroner, then the onsent of the Coroner must be obtained before ny tissue or organ is removed. This requirement in addition to the need for consent from the eceased or his relatives. The hallowed tradition of emoving organs at autopsy for inclusion in the athology museum or of taking tissues for a graft or some brain tissue for prothrombin time is not legal. The need to ask relatives for specific consent at a most harrowing time is unfortunate. The brain-damaged patient on the respirator allows time for diplomacy, but these cases are not of sufficient number. The Coroner normally gives consent before the death; there is so little time afterwards. He may advise the procedure for removing the organs if it might interfere with evidence, and may refuse consent if a homicide charge is anticipated. It is hoped that organ and tissue removal will one day become accepted by the public in the same manner that they accept the need to lay out the body and to embalm it for the funeral. All transgressions of the Human Tissue Act delay the desired public unconcern and allow sensational reporting of the events.

A circular from the Department of Health and Social Security is expected in the near future to assist those responsible for dealing with these cases.

Copies of Coroners' notes and reports

Any properly interested person is entitled to ask for a copy of the Notes of Evidence or a post mortem report on payment of the proper fee(15). The fee is statutory and related to the length of the document unless photocopies are used. Information that was not given publicly is not available. Suicide notes are normally not read out or supplied. A report from a psychiatric hospital concerning the deceased and his family would not be divulged unless the evidence had been given publicly.

Properly interested persons are normally those affected by the inquiry. Coroners try to provide material for research, but this can be very disruptive to the work of the court, and a personal approach is advised.

Complaints procedures

There seems to be a tendency now to appoint another tribunal to hear the complaints of dissatisfied patients and relatives, rather than to appoint another doctor or nurse to deal with the original problem. The Coroner is an impartial officer who must deal with the genuine concern of the bereaved where it affects the death. Collateral complaints that have no relationship to the cause of death must be made to the appropriate National Health tribunal. The Coroner will try to prevent the use of his court and the immunity from any action for defamation in any attempt to get publicity for matters that should be heard elsewhere, but he cannot always succeed.

The Coroner is human

The Coroner is concerned with an inquiry from the moment that the death is reported. He is not

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entirely dissociated from the reality, as the Judge at a trial will be. He may be well aware of the effects on a family of the death or of the difficulties of living for years with a mental patient who refuses to stay in hospital—they will have told him or his officer. He may also be aware that a problem is a recurring problem. There is little purpose in pointing out an individual's inadequacies. Few people make mistakes intentionally. There may be a need to alter a system of working to prevent similar fatalities. There is not always a simple answer to every problem, but it is grossly unfair to place the responsibility for the deaths of patients upon a staff working under difficulties and pressure. However, the Coroner cannot do anything without evidence, and it does not help to have all the witnesses deny that there is a staff shortage or lack of facilities when that is the real problem.

References

1. Births and Deaths Registration Act 1953 s. 22(1).
2. Registration (Births, Stillbirths, etc.) Regulation 1968. Regulation 51.
3. Coroners' Act 1887 s. 3(1).
4. Coroners' Act 1887 s. 19.
5. Coroners' Rules 1953. Rule 16.
6. Coroners' Act 1887 s. 4.
7. Coroners' (Amendment) Act 1926, s. 20.
8. R. *v.* Beresford. 1952. 116 JP 194.
9. Coroners' Rules 1953 Rule 18.
10. Coroners' Rules 1953 Rule 26.
11. Coroners' Rules 1953 Rule 19.
12. Coroners' Rules 1953 Rule 20.
13. Coroners' Rules 1953 Rule 16.
14. R. *v.* City of London Coroner. 1975. 1WLR 1310.
15. Coroners' Records (Fees for Copies) Rules.

REPORTS AND PAMPHLETS

A Survey of the Need for Secure Psychiatric Facilities in the Oxford Region. Report of Oxford Regional Health Authority.

This interesting study by Dr Gath and Dr Orley for the Oxford Regional Health Authority gives the results of an attempt to define, in a more practical and realistic way than has hitherto been possible, the number and varieties of people who required or were suitable for a Regional security unit in one Health Authority.

The long debate, since the Working Party on Special Hospitals in 1961, on whether some varieties of violent and dangerous patients should be accommodated in a few beds in each NHS hospital, or in a certain number of hospitals, or in specialized units has given rise finally to the decision recommended in the Glancy Report and the Butler Report to set up regional security units as a matter of urgency. Both of these Reports admitted that it was in some respects easier to define who were unsuitable for such units than to describe the range of suitable cases in any detail, and in consequence it proved very difficult to estimate the number of beds which would be necessary. The Glancy Report made an estimate that the number of subjects in *NHS psychiatric hospitals* in 1970 requiring secure treatment was about 1,000. The Butler Committee judged that the number was about 2,000, if one added about 900 places to supply the hidden demand from overcrowded prisons and Special Hospitals.

A Working Party of the Oxford Regional Hospital Board (1971) thought that it was almost impossible to measure the size of the problem because of the wide variety of agencies concerned, but estimated that the total number in the Region did not exceed 100. The research team sought this information systematically from senior medical and nursing staff of all NHS psychiatric hospitals in the Region, the social service departments, the probation service, medical officers of the local prisons and some other long-stay prisons, and Special Hospitals in relation to relevant cases, inviting them to be over—rather than under—inclusive in their lists. Although in the end the authors made their own judgment, it was always done after personal discussion with a notifying agent, and the results are set out in the report with a modesty and simplicity which conceals the careful thought which lies behind it.

They concluded that there were 193 subjects in the Region, consisting of 166 adults, and 27 adolescents (12–17 years) who are discussed separately. They make an interesting initial division between (for adults) 125 subjects 'in need', who were judged to require some kind of additional facility not currently available to them, and 41 in a 'no need' group, who seemed suitably placed at notification or were so placed soon after. The sources of notification (in 13 of them by more than one agency) were mental illness hospitals (38), mental handicap hospitals (30) Special Hospitals (35), social services (14), probation services (35), prisons (31).

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