

The role of the coroner: what you need to know for the foundation years

Introduction

Very many doctors are likely to qualify with very little knowledge of the coroner or indeed forensic medicine. After all, it is highly likely that in London medical schools at any rate, there are no lectures on forensic medicine since there are no university departments of forensic medicine. In times past, a lecture or two on the coroner was part of the undergraduate programme.

Coroners are independent judicial officers tasked to be responsible for investigating violent or unnatural deaths, or sudden deaths where the cause of death is unknown. There are 130 coroners in England and Wales (there are no coroners in Scotland, a country with a separate legal system). Whereas a coroner may be a doctor or lawyer, 95% of coroners are lawyers, a handful are both (including the author). About 80% of coroners are solicitors, probably working from their solicitors' offices, reflecting the fact that they are part time. Indeed only 30% of coroners have their own coroners' court.

How the system works

The government has recently had an inquiry into how the coroners' system operates. This inquiry observed that there was a paradox, in that whereas most of the work of a coroner involves medical matters, 95% are lawyers. Against that, a lawyer's training is clearly appropriate for court work and particularly hearing cases of deaths in prison or involving the police. The inquiry therefore advocated a new position, a 'medical examiner', perhaps assigned to each new coroner district, who would not be a pathologist (for he/she would continue to do autopsies), but who would make decisions concerning issues such as accuracy of death certification, trends, and requesting autopsies. Moreover there would be one Chief Coroner for

England and Wales, with a smaller number of coroners than at present, but they would be full time and also lawyers.

The Shipman Enquiry also looked into the subject of coroners. Dame Janet Smith came up with rather more fundamental changes, for example that all deaths ought to be reported to the coroner. The government has attempted to reconcile the differences and has indicated that legislative changes will occur. The details of such intended changes will be set out in a White Paper to be published in the 'spring of 2005'. At the time of writing no details had been announced (January 2006).

Which cases should be reported?

Meanwhile what occurs? Well, things continue as they have done. Doctors still have an obligation to report certain cases to the coroner. Although not enshrined in statute the generally accepted criteria are:

- The cause of death is unknown
- The death cannot readily be certified as being the result of natural causes
- The deceased was not attended by the doctor during his/her last illness or was not seen within 14 days or viewed after death
- There are any suspicious circumstances or history of violence
- The death may be linked to an accident (whenever it occurred)
- There is a question of self-neglect or neglect by others
- The death has occurred or the illness arisen during or shortly after detention in a police or prison custody (including voluntary attendance at a police station)
- The deceased was detained under the Mental Health Act
- The death is linked with an abortion
- The death might have been contributed to by the action of the deceased (such as a history of drug or solvent abuse, self injury or overdose)
- The death could be a result of industrial disease or related in any way to the deceased's employment

- The death occurred during an operation, on or before full recovery from the effects of anaesthetics or was in any way related to the anaesthetic (in any event a death within 24 hours of the operation should normally be referred)
- The death may be related to medical procedure or treatment whether invasive or not
- The death may be the result of lack of medical care
- There are any other unusual or disturbing features to the case
- The death occurs within 24 hours of admission to hospital (unless the admission was purely for terminal care)
- It may be wise to report any death where there is an allegation of medical mismanagement.

Once a doctor reports the case to the coroner, or more likely the coroner's officer, the options are:

1. The coroner may decide to take no action (issue a Pink Form A)
2. The coroner may decide to hold an inquest. This will involve delay of some weeks or months while the coroner's officer assimilates evidence. It is likely, however, that the body will be released for funeral straight away. If the death is an 'unnatural' death then an inquest must be held. Deciding on whether a death is natural or unnatural, particularly in respect of a death after some hospital treatment, is not without difficulty.
3. The coroner may order an autopsy in the expectation it will show the cause of death and if this is a pure natural death he/she will take matters no further (issue a Pink Form B). He/she may, however, hold an inquest if it appears the death was not natural.

The relationship between hospital doctors and the coroner

Hospital doctors sometimes come into conflict with coroners because the reasons for their actions do not stand up so well to detailed scrutiny. Thus they may say they do not know the cause of death, because

they wish to have an autopsy purely out of clinical interest or perhaps for their research project. On the other hand, out of sympathy for the family (whether by reason of a common religious solidarity, or otherwise) a hospital doctor will 'sign up' a death certificate, when in reality it ought to be reported to the coroner with all the delay and perceived 'fuss' that may follow. Both are to be deprecated and might end up the worse for the doctor concerned.

There is a paradox about a coroner's post mortem examination. On the one hand it is highly likely that the pathologist will be on the staff of the hospital or an adjoining hospital. Yet on the other hand, he/she is performing it at the request of the coroner and the fee (currently £87.70 or with histology an additional £28.00 per block) is paid by the coroner. The report belongs to the coroner, although depending on local circumstances it is very likely to be made available to clinicians. It is not a hospital procedure. Whereas the pathologist may be a clinical colleague, he/she should see him-/herself as independent. Indeed, strictly speaking, Rule 6 of the Coroners Rules 1984 provides:

'If the deceased died in a hospital, the coroner should not direct or request a pathologist on the staff of, or associated with, the hospital to make a post mortem examination if ... (ii) the conduct of any member of the hospital staff is likely to be called into question or (iii) any relative of the deceased asks the coroner that the examination be not made by such a pathologist...'

But there is a catch provision because the section continues:

'...Unless the obtaining of another qualification and experience would cause the examination to be unduly delayed.'

Inquests

If an inquest is being held into a death, it is likely that the coroner's officer may request a report. The attendance of the doctor at the inquest may also be necessary. Failure to produce a report, or a report within the timeframe requested, is likely to be followed by a witness summons to attend the inquest. Coroners have sometimes, in the very presence of the doctor called, enquired in open court from the relatives what it has been like to have been kept waiting by the tardy doctor. It will not have escaped the observation of the coroner, nor the family, nor the doctor, that the local press may be in court and report the matter in the local newspaper or television news.

If a doctor is asked to produce a report he/she must bear in mind there is a chance it may be seen by others. But worse than that, it may be seen by the very person referred to in a report in (bad) terms. Thus to refer to 'angry and unreasonable relatives' or to 'well documented allegations of sex abuse of the deceased by her father' may be unwise. The experience of attending an inquest may be variable. It may prove an interesting exercise with a benign coroner and very grateful relatives who wish publicly to thank the doctor for all his or her efforts. Alternatively, the doctor may be subjected to nit-picking cross-examination by lawyers whose inflexion of voice may be none too deferential. A legal point-scoring exercise may be interspersed by a cacophony of jibes from relatives. A doctor will have to be prepared for either eventuality.

Matters are probably not helped by attendance at court in what might be described as scruffy attire. For good or ill, a lot of the witnesses, relatives and/or friends, will be of mature years. They belong to a generation when a doctor was perceived as a person of authority and a person of authority looked and dressed like a person in authority. An aide to gravitas is a suit and tie, or its female equivalent. Whereas it is perfectly true that casual or scruffy dress and hairstyle do not affect the quality of a doctor's abilities, it does send a message about his/her lack of appreciation of social niceties, as he/she stands there in a solemn court. It is good manners and good sense to be well groomed and well dressed.

Conclusions

Doctors in the foundation year must be aware of the coroner and of what sort of deaths he/she must be informed. If a patient dies a natural death there will be no problem, but again a doctor must be aware of how to fill out a death certificate. The instructions are to be found in the introductory pages in the books of Certificates of Medical Cause of Death. They can easily be photocopied. As I used to tell the medical students 'Photocopy the pages and take them home. Set aside three quarters of an hour, one evening, this once in your medical career. Pour yourself a stiff gin – and read and understand the instructions!' **BJHM**

Conflict of interest: none, but note that the author is a coroner.

KEY POINTS

- Coroners are people who foundation doctors should be aware of.
- Foundation doctors are unlikely to have had much teaching about the coroners' system.
- Changes in the coroners' system will be evident in a few years.

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