

The office of the coroner: past, present and future

The coroner cannot pretend to be a member of the oldest profession – doctors, lawyers and prostitutes might lay prior claim – but he/she is a member of one of the oldest legal institutions in England and Wales. There were coroners in Saxon times but it was not until 1194 that the office was revived, to remain as an institution through to the present time.

THE PAST

In 1194 the coroner's duties were many and far ranging, and death was perhaps only an incidental aspect of the jurisdiction of the coroner. Instead the coroner's *raison d'être* was fiscal. In an age with less formal taxation, the King's Treasury still had to be filled. This was the case with Richard I (1189–1199) who fought during most of his reign, being captured on his return from the Third Crusade. A huge ransom was the price of his release in 1194.

The newly established coroners were keepers of the pleas of the Crown (*custos placitorum coronas*, hence 'coroner'). The freeholders of each county were required to elect three knights as coroners and a clerk.

Mediaeval law was complicated and an infringement usually involved payment in one form or another. The consequences of convicted criminality were likely to be twofold. First there was punishment, often in the form of the death penalty, and second there was the financial penalty. This might involve not only the forfeiture of the convicted felon's goods but also the punishment of the community as a whole, as it was the responsibility of the community to preserve law and order.

Sudden, unexpected or violent death was also an opportunity for financial return to the Crown. In such an event it was the responsibility of the community to summon the coroner, who would view the body, and the community would be fined if they did not do so. If the

deceased happened to be Norman (or more correctly if it proved impossible to establish that he/she was English or Welsh) the community would be fined.

The coroner was required to hold an inquest or inquiry into the death. The inquest was always held with a jury and always in the presence of the deceased (which might account for the greater speed often achieved in holding the mediaeval inquest as opposed to now). The jury held something of a dual function as both judge and witness.

In the early days the coroner's jury was assembled from male representatives of four or more communities neighbouring upon where the deceased was found. The function of the inquest was to determine who the deceased was and how, when and where he/she died. The medical cause of death was not a requirement although the manner in which the deceased died might be apparent from examination of the body or determination of the circumstances in which the deceased was found. The final function of the jury was to establish the article responsible for the death, be it a knife, a horse or whatever. Originally the actual object but soon its value was forfeit to the Crown.

At first only an aspect of the coroner's duties, investigation into violent, unnatural, sudden and unexpected death ultimately has become the core of the coroner's duties. Gone is his/her jurisdiction over fires, forfeiture, banishment from the realm, sanctuary and catches of royal fish (Brodrick, 1971).

THE PRESENT

In the Local Government Act 1888, the responsibility for appointing coroners passed from the freeholders of the county by-election to the county and borough councils. There the responsibility lies today. Unique within the legal system, the coroner is appointed by the county or borough where he or she serves. The county or borough retains a statutory duty to reimburse

the coroner's expenses and to pay the coroner's salary but has no power to control or influence the coroner.

The coroner is either a lawyer or doctor of not less than 5 years standing. The Coroners' Service is administered in England and Wales by the Home Office, which again has no powers of control. The coroner is, however, under the disciplinary control of the Lord Chancellor who can dismiss the coroner in the event of wrongdoing or mental incapacity.

Apart from duties in relation to items defined as Treasure, the coroner is a judicial officer dealing almost exclusively with sudden death. As such, the coroner becomes duty bound to act when informed of a body lying within his/her jurisdiction when there is reasonable cause to believe that the person died an unnatural death, a sudden death (the cause of which is not known) or has died in prison or police custody or during the course of arrest.

The majority of deaths reported to the coroner will not be overtly unnatural. Typically, it will be a case of a doctor reporting the death because the cause of death is not known or because the statutory rules relating to the issuing of a death certificate cannot be made out. In the former event the coroner may order a post-mortem examination in the expectation that that will reveal a natural cause of death, which can then be registered. In the latter event, which may arise for instance because the doctor who has treated the deceased in his or her last illness has not seen the patient within the previous 14 days or after death, the coroner, if satisfied that the death is natural and the cause known, may permit the doctor nevertheless to issue a certificate.

About 10% of deaths reported to the coroner will appear to be unnatural. This will either be apparent at the outset or become apparent following post-mortem examination. In these cases the coroner is required to hold an

inquest. Here the coroner takes the role somewhat of an examining magistrate. The coroner is responsible for collecting all relevant evidence, which he/she will do with the assistance of coroner's officers and usually the police. The coroner will then set a date for the inquest and call all relevant witnesses. Rules of evidence are not as strict in the coroner's court and the coroner can admit written statements into evidence unless there is objection.

The coroner takes a more active part in the proceedings than a judge in a criminal or civil trial. Having called the witnesses, it is the coroner who will in the first instance examine them under oath and, except in those cases where the coroner is required to empanel a jury, the coroner will pronounce a verdict at the conclusion of the inquest. The coroner is charged with determining the identity of the deceased, the medical cause of death and how, when and where the deceased met his or her death. That is as far as the coroner may go. The coroner may not as part of the verdict make a finding of criminal responsibility on behalf of a named person and the coroner may not make a finding of civil responsibility. The coroner's inquest is said to be a neutral fact-finding exercise far removed from the adversarial proceedings of the criminal and civil courts.

Although most deaths reportable to the coroner will be reported by doctors, the only person with a statutory duty to report such deaths is the Registrar of Births, Deaths and Marriages. This may render the coroner impotent, in that if a death has not been reported to him/her, the coroner, through ignorance, is not able to intervene. Further the current system of registration depends largely on the honesty of doctors. One of the reasons why Dr Shipman was able to evade detection for so long was that for the most part he was the doctor in attendance during his victims' last illness, had seen his patients in the 14 days before death and falsely certified a natural cause of death. Thus the coroner was not involved.

For the most part, the law relating to coroners is from the 19th century and earlier, although the Coroners

(Amendment) Act 1926 did make some changes. The law has been in serious need for reform for some considerable time. However, it was not until the public disquiet that followed the trial of Dr Shipman, together with the scandals in Bristol and Liverpool, that the government announced a fundamental review of the Coroners' Service. It is anticipated that the findings of the review will be published next year and will be tied into the findings of the Shipman inquiry.

THE FUTURE

And so, what does the future hold so far as the office of coroner is concerned? It is a matter for speculation as to what the review may recommend and whether thereafter the law may be changed. In the last 100 years there have been a number of reviews but few amendments to the law.

The author and John Pollard, Her Majesty's Coroner for Stockport, have produced a paper setting out their vision for the future (unpublished observations, 2002). A unified and strengthened procedure for investigating and registering death is favoured, with the formation of a new service in each district headed by a coroner and encompassing both the coronial and registration systems. Reporting to the coroner would be two branches of the service. The one branch would be headed by a Senior Registrar of Births, Deaths and Marriages and the other by a medical referee. The service would operate a single computer system so that the system could be interrogated to spot unusual patterns emerging, for instance one doctor or nursing home accounting for more deaths than would be statistically expected.

The medical referee, a qualified doctor of at least 5 years standing, would receive details of all deaths. The ref-

eree would have power to examine the deceased and call for all medical records. The referee would either confirm for registration a cause of death or order a post-mortem, with an appeal to the coroner, who would have an overriding discretion in this regard. At present the writer believes that too many post-mortems are performed. By having facilities for a full inquiry the referee would be able to avoid many unnecessary post-mortems. The coroner would continue to hold inquests into unnatural deaths and deaths in custody but would exchange his or her medical function for a more administrative and supervisory role.

At present there is no right of appeal from a coroner's decision. Under this proposed new system an appeal process would be instituted whereby an aggrieved party could challenge a decision, for example to hold a post-mortem, or the findings of a coroner at inquest.

The coroner would be imbued with powers sufficient to adequately discharge the coroner's duties. A power of entry and search and seizure of documents including medical records would be provided.

Finally, a greater emphasis would be placed on training, extending this to aspiring coroners, instead of limiting such training to serving coroners and their deputies. In this way it is to be hoped that greater consistency in approach can be engendered as well as encouraging a wider pool of applicants for the post of coroner. **HM**

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Brodrick N (1971) *Report of the Committee on Death Certification and Coroners*. (The Brodrick Report.) Cmnd 4810. Her Majesty's Stationery Office, London

KEY POINTS

- The office of coroner has survived for more than 800 years.
- It has been adapted and developed over the centuries, but it is now more a product of the Victorian era.
- The law is not entirely sufficient for modern times.
- A change in the law is needed.