'Reforming the Coroner and death certification service - a position paper' Cm 6159 March 2004

Following the Luce and Shipman reports, the Government published their response in the form of a position paper.

They have made the following proposals;

- to meet the needs of the bereaved and the public at large
- to identify more effectively cases requiring investigation and target resources accordingly
- to have a national professional service under a Chief Coroner and around 40 - 60 Coroners, with dedicated trained medical support
- to have an advisory Coronial Council
- to have direct links to the public health service
- to incorporate a greater degree of medical expertise in scrutinising deaths, training and accountability
- new legislative framework for death investigation

The new system envisaged by the Government covers the verification of the fact of death by doctors or other suitably qualified professionals, which starts the case record and provides a convenient point for the collection of medical and circumstantial documentation for all deaths.

The first certifier of the medical cause of death (a doctor either from a hospital or general practice) must provide supporting evidence with this certificate, in the form of medical notes, results of investigations or X-rays etc. Al deaths are then referred to the medical examiner, based at the Coroner's office. This person will scrutinise these reports and gather additional medical information as well as information regarding the death from family members.

Where deaths can not be certified, they will be reported to the medical examiner in the first instance, so that there is consistency in the death investigation process.

The medical examiner will have the authority to authorise burial or cremation, or refer the case to the Coroner for an inquest etc.

The role of the Coroner will remain to ascertain who has died, when, where and how they died.

In fulfilling this role, the Coroner receives advice from the medical examiner regarding the medical cause of death, and whether the death

can be certified on the information available, or whether further tests are required. The need for a post mortem examination (full or partial) is also determined at this stage. The Coroner will also have the power to carry out targeted investigations, e.g. into a specific nursing home etc.

Coroner's officers will have an enhanced investigative role, such as obtaining witness statements etc, and will therefore undertake some of the current police roles in relation to sudden deaths.

The Government hope that this system will also make better use of post mortem examinations, and improve national consistency. They also recognise the need for clarification of the Coroner's Rules in relation to the retention and use of tissues removed post mortem.

One interesting development is the proposed linkage of the death investigation system to the public health system. By improving the flow of information between the two areas, it is hoped that there will be a more robust approach to death prevention and a more effective use of data. Medical examiners will be required to maintain a database of deaths in their are for statistical purposes, and it is envisaged that an annual report will be produced in each Coroner's district.

Proposed deaths to be reported to the Coroner;

- violent, traumatic deaths including traffic deaths, workplace deaths, deaths apparently from self-harm, injury, poisoning, fire or drowning or other unnatural cause in the home or in any other place, or as a result of the operations of the law and order services
- any death of a person detained in a prison or in military detention, in police custody, in a special hospital or under statutory mental health powers, or of a person resident in a bail or asylum hostel
- any death in which occupational disease may have played a part
- any death in which lack of care, defective treatment, or adverse reaction to prescribed medicine may have played a part, or unexpected deaths during or after medical or surgical treatment
- any other death which a doctor may not certify as being from natural disease
- any death which is the subject of significant unresolved concern or suspicion as to its cause or circumstances on the part of any family member, or any member of the public, any health care, funeral services or any other professional with knowledge of the death
- any death in respect of which the Registrar has significant continuing uncertainties

For a good overview article covering the review of death certification etc and the Government response, read **'Reforming the Coroner and death certification service'**, Hasleton P. (2004) Current Diagnostic Pathology 10:453-462 (available via www.sciencedirect.com provided by Elsevier publishers - this is a free service, but a registration password is required to access the full content).