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The Coronial System: A Short History

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Editorial

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Abbreviation: MCCD: Medical Certificate of Cause of Death.

Editorial

The system of death investigation in England and Wales is complex and its origins based in history and is commonly referred to as the 'coronial' system. The coronial system was established in England during the reign of Richard 1st [1]. The word 'Coroner' was derived from the original title of 'Crowner' and their purpose was primarily the collection of revenue to support King Richard's conquests in the Holy Land. This was done by establishing an inquisition into the death of a person and recovering any assets due, but also enquiring as to the cause of death with a view of identifying cases of murder and in particular suicides. Suicide was an offence against God, and therefore all assets of the deceased were taken by the state and became the property of the King [1].

The origins of the ancient office of 'coroner' appears to be lost in time, but the standard textbook about the law and practice of coroners known as 'Jervis on Coroners', stated at the beginning 'the office is of such great antiquity that it's commencement is not known' [2]. The first known reference to the office of coroner was formally established in England by Article 20 of the 'Articles of Eyre' in September of 1194 to 'keep the pleas of the Crown' which effectively meant to investigate a criminal offence against the crown which included murder and suicide [1]. A description of the coroners duties at the time Edward I became King in 1272 was as follows:

"The office and power of a Coroner are also like those of a Sheriff, either judicial or ministerial, but principally judicial… and consists, first, in inquiring, when a person is slain or dies suddenly, or in prison, concerning the manner of his death. And this must be upon sight of the body; for if the body be not found, the coroner cannot sit. He must also sit at the very place where death happened, and the inquiry must be made by a jury from 4, 5, or 6 of the neighbouring towns over which he is to preside. If any be found guilty by this inquest of murder or other homicide, the coroner is to commit them to prison for further trial and must certify the whole of his inquisition, together with the evidence thereon, to the Court of King's Bench, or the next assizes."

Due to the fact that the coroner could not try a person for a crime, the suspect would have to await the next time the 'assizes', or in other words, the judges and their court visited the coroner's jurisdiction. This was the periodic visit of the Kings Judges or what would now be referred to as 'Circuit Judges' to visit that part of the country which was often a wait of many years. The job of the coroner was to record the facts of each case, examine the body and report this to the Judges, a process known at the time of 'keeping of the pleas' [1]. The Latin for this term was custos placitorum coronas which is where the word 'crowner' and 'coroner' was derived. When a body was found, the person who was the 'first finder' was required by law to commence a 'Hue and Cry', which was the commencement of the search for the murderer. However, complex rules emerged, and the coroner fined those who had not obeyed them, thus securing another source of revenue for the King. This led in many cases to people hiding, burying, or even dragging bodies to another area in order that no fines were levied in the community where the body first lay [1]. There was a requirement that all males over the age of 12 years had to come to the coroner and assist with the decision as to what had happened to cause the death. This was later amended to include nominees of communities and was the basis of the jury system we have now [1].

Part of this process was to establish the ethnic origin of the deceased, or as was known as 'Presentment of Englishry'; or in Wales 'Presentment of Welshry'. This was to identify whether the victim was a Norman or Saxon. If the deceased was a Norman, the Saxon community had to pay a 'murdrum' fine. Clearly the word 'murder' is linguistically derived from this expression [1].

By the 1700's coroners were severely underpaid; they were not required to be medically or legally qualified and received no additional fee for conducting an inquest unless the case was a murder where a conviction was secured. Only on conviction was a coroner entitled to a proportion of the convicted persons goods and chattels. This system naturally encouraged corruption and neglect. Many murders were never investigated at all [3]. However, from 1738, a fee was payable to coroners for an inquest 'Duly Held' but an inquest was not considered duly held unless there were obvious signs of violence. The medieval system of death investigation invited the concealment of murder [4] but it was not until 1836 that coroners were permitted to pay for a medical opinion as to the cause of death [1]. However, the costs of autopsy and the inquest was from the coroner's own pocket for which he had to request reimbursement [4]. The reimbursement process required the coroner to provide evidence of his expense under oath. Justices were reluctant to award reimbursement in cases other than homicide and so there was a built-in motivation for cases to be disguised as murder.

Child homicide was commonplace due to the poverty of the time and burial clubs emerged which further encouraged the murder of children by parents with the favourite method of child killing at the time was laudanum and other opiate preparations. There was little risk of detection [3].

In 1860, the County Coroners Act placed coroners on a salary and the number of inquests and counts of murder at the behest of coroners increased significantly. In 1874, medical practitioners became legally obliged to fill out a death certificate if they attended a patient at their last illness. The call for coroners to be suitably qualified either in law or medicine was championed by Thomas Wakely, who was the first medically trained coroner for London in 1839 [3]. The responsibility of collecting revenue for the King ceased in the 12th century, but little changed in the role until the middle of the 19th century when it became almost exclusively concerned with the investigation of the cause of death.

The primary role of a coroner in modern times therefore, is to enquire into the death of a human being within their jurisdiction. Their role was directed by several statutes and rules but has now been consolidated into current legislation under the Coroners and Justice Act 2009. Section 1 of the Act defines the primary role of the coroner to investigate a death where the body lies within their jurisdiction if:

- The deceased died a violent or unnatural death,
- The cause of death is unknown, or
- The deceased died while in custody or otherwise in state detention.

In practical terms, this is any death where a medical practitioner cannot issue a Medical Certificate of Cause of Death (MCCD).

The purpose of the coronial investigation is to establish who the deceased was, how, when and where the deceased came by his or her death, and the particulars (if any) required to register the death [5]. The detailed guidance as to the role of the coroner is set out in the 'Guide to Coroners Services' [6].

Coroners are independent judicial appointees and are paid and funded by local authorities. Their governmental oversight lays with the Ministry of Justice and since July 2013, all newly appointed coroners must be legally qualified. This new requirement may be counterproductive as it may lead to unnecessary autopsies being ordered by legally qualified coroners, nervous about calling the cause of death because they are not knowledgeable about medical issues [7]. Carpenter and Tait [7] claimed that there is perhaps an over reliance on the medical reports from the pathologist rather than the scene report outlining the circumstances of the death, resulting is more focus on the science rather than the investigation. This is due to the perceived superiority of the 'scientific' medical evidence verses what is seen as less scientific circumstantial and physical evidence from the police investigation at the scene [7].

This over reliance on autopsy demonstrates a risk averse approach which is driven partly by a fear of missing homicides. If the coroner makes the call without the PM, and it is wrong, it is the coroners fault. If a post mortem is conducted and the outcome is wrong, it is the pathologists fault [7]. The existence of this risk averse attitude of coroners is supported by Luce [8] and Smith [9]. Over reliance on the medical cause of deaths can lead to less consideration as to why the death occurred, which the medical evidence cannot reveal [7].

The 2009 Coroners and Justice Act created the post of 'Chief Coroner' whose main responsibility is to provide support, leadership, and guidance for coroners in England and Wales. The 2009 Act also introduced the concept of Medical Examiners. This was due to recommendations of Dame Janet Smith in the 2003 public enquiry which took place following the conviction of Dr Harrold Shipman for murdering what is estimated to be at least 215 of his patients

dating back to the 1970's [10]. The necessity for Medical Examiners was reinforced by the Francis Inquiry into Mid Staffordshire Foundation Trust [11] and the Kirkup Inquiry into the Morecambe Bay disaster [12]. It was recognized that the quality of the MCCD reports completed by doctors was flawed [13-17]. The Medical Examiners system, unlike the system of the same name in other jurisdictions, will not replace coroners, but acts as an oversight second opinion for all deaths except those which are deemed to be suspicious from the outset. It is still unclear how Medical Examiners when appointed will interact with coroners but speculation was made by the interim National Medical Examiner, Professor Peter Furness for which the title of his lecture to the Medico-legal Society in 2012 summeds up the possibilities; 'Mutualism, Commensalism or Parasitism?' [18]. The system of Medical Examiners has been piloted in various parts of the country and a review of these pilot studies found that the quality of death certification by doctors improved, there was more consistency of reporting to coroners where a doctor could not issue a certificate, and a better liaison with next of kin. In one pilot area, the medical examiner altered the MCCD in 83% of cases and in another site 33% required 'major changes' [19]. Figure 1 appears complex but in fact the medical examiners system will improve the quality of death investigation and assist to reduce the potential for missed homicides and will take place prior to registration of the a death.

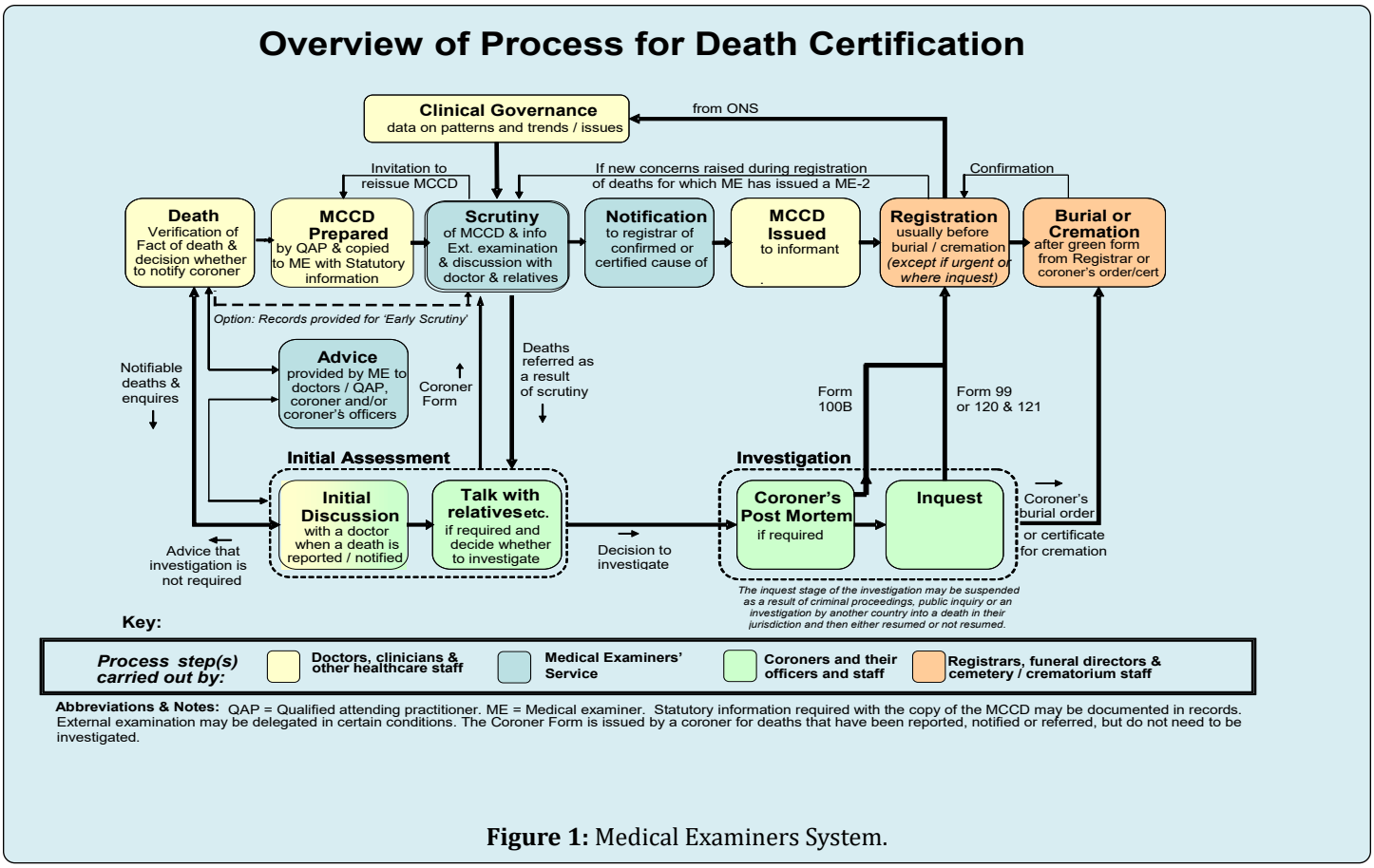

Figure 1: Medical Examiners System.

The reason that the coroner is an important figure in the potential for homicides to be missed, is because of their gate keeping and decision-making role in death investigations which are not certified by an attending doctor. Because only the coroner can authorise a post mortem examination under Section 14.1 of the Coroners and Justice Act (2009), any erroneous decision leading to a missed homicide may be shared between the police and the coroner. However, the coroner does rely on the police report and opinion in making directions as part of their investigation. If the police investigation at the scene is inadequate, the decision making thereafter may be flawed [7]. There are political influences which can shape the decisions of professional death investigators, especially when suicide is suspected where there is great pressure to reclassify for the sake of grieving relatives [20]. Another area of external influence relates to terminally ill people where the euthanasia debate is often encountered. It can therefore be seen that there are

outside influences on decision making other than the actual evidence from the scene and at autopsy. There are also social issues which can affect an investigation into a death such as a reluctance of some police officers to examine a dead body or do not know what to look for [20]. There may be objections to the invasive post mortem process on ethical or religious grounds [21].

There have been several academic studies in relation to shortcomings in the current coronial system, none of which have been 'fixed' by the 2009 Coroners and Justice Act, which introduced largely cosmetic changes and has been viewed by many within the system as a missed opportunity [22]. The deaths caused by Dr Harold Shipman, the Marchioness disaster and the Alder Hay tissue scandal all highlighted that the system is not watertight [23]. Although there have been several reviews dating back to 1920, there has been no significant change in a system which is embedded in history [24].

Whatever the shortfalls of the coroner system, the main reason for the coronial investigation is to identify suspicious deaths where third party involvement is suspected, in other words 'homicide'. If the coroner's inquest cannot identify a cause of death, the jury will normally return what is termed an 'open verdict' – this means that the cause of death cannot be established and doubt remains as to how the deceased came to their death. There were over 1700 open verdicts in England and Wales [25] and although the majority tends to be possible but unproven suicides, this is the arena where unidentified homicides are most likely to be found.

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