Show Me the Money: the New Death Investigation System

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A meeting of the Medico-Legal Society was held at the Royal Society of Medicine, 1 Wimpole Street, London W1, on Thursday, 14 June 2007. The President, Mr Bertie Leigh, was in the Chair.

The President: The main purpose of this evening’s meeting, having dealt with such minor matters as the AGM, is to hear from Paul Matthews who is going to talk to us about coronial matters as they are at the moment. Paul is an extremely distinguished speaker, he is – as I suspect many of you know – a distinguished academic on the subject of coronial matters. He is also the editor of Jervis, he is a coroner for the City of London and an extremely distinguished authority on these matters. As I suspect you all also know the coronial function is hotly under debate, more people have had a go at reforming it in the last five years than you could shake a stick at – most of them, I am glad to say, without any conspicuous success. Can I call up Paul Matthews, please?

Professor Matthews: Thank you very much, Mr President. This is, I am afraid, the second talk I have given today. The first one was at the Gare du Nord end of the railway line, so if I start breaking into French part way through you’ll know that the transition back to Blighty has not quite had effect.

When I was asked to speak about what was going to be the new system grandly proposed for Coroner’s Inquests and other investigations in this country we all thought there was a good chance there would be legislation in final form and, even if it was not in force, we could discuss it. I am afraid that the reality, as many feared, is rather more messy than that and there isn’t anything like the certainty that we might have expected. So what I am going to do is set out quite briefly the current system and then the various proposals that have been made in outline – if I tried to do it in detail we would be here all night – and bring us up to date with where we probably are as of today.

Let me begin with some statistics just so we are clear what it is that coroners and the system are dealing with at present. In 2006 there were 502,000-odd deaths registered in England and Wales. That is not the same as deaths reported but unfortunately we don’t have any reliable statistics for deaths reported. Deaths registered, of course, may be in any given year – a number which bears no relation whatever to the number of deaths reported in that year because deaths can be reported and registered some time later, e.g. when the inquest has come to an end, but it is approximately right. Of that sort of order of magnitude about 230,000 (i.e. if we took the 502,000 as representing the deaths in the year, about 46% of all deaths in the year in England and Wales) were reported to coroners – that is a very high proportion it seems to me. Out of that approximately 110,000 autopsies were directed to be held by coroners – that is about 22% of all deaths, and 48% of all deaths reported to coroners. Around 27,500 inquests were actually held by coroners – i.e. about 5.5% of all deaths, and about 12% of deaths reported to coroners. So coroners tend to hold something like one inquest out of every eight deaths reported to them.

Who are the coroners today? There are about 111 (the number keeps changing from day to day but it was right last time I looked) of whom I think 12 were women, that’s slightly misleading because there are lots more women at the Deputy level and Assistant Deputy level, but it is actually about six times more women than when I first started, which is a terrific increase in my opinion. There are about 117 different jurisdictions up and down England and Wales, which means some of the 111 have more than one job. The qualification is either a legal or a medical one, having been held for five years, but nearly 90% of those coroners are, in fact, legally qualified rather than medically qualified – only about 11% have a
medical qualification. 23% of all coroners are full-time and 77% are part-time. There are lots of good reasons for this including the fact there are some very big Coroner’s Districts and there isn’t enough death perhaps in their area to justify a full-time coroner. Most of the part-time coroners are the lawyers and quite a lot of the full-time coroners are the medics. Incidentally, I should say I am the only coroner in London who is not full-time. There are eight coroners of whom seven are full-time, and I am the eighth.

The curious feature about coroners at present is that they are both appointed and resourced by local authorities, it is a locally paid for service; however, they are not capable of being removed from office by the local authorities that appoint them, or pay them, they can only be removed by the Lord Chancellor and, since the Constitutional Reform Act 2005, the Lord Chief Justice acting together. The government department which has any responsibility in the matter is the Ministry of Justice (formerly the Department of Constitutional Affairs and before that the Lord Chancellor’s Department) but until 2005 it was actually a quite different department altogether, namely the Home Office, that had responsibility for coroners.

The current legislation: there is an Act of 1988 which you might think is terrifically recent, except that it is simply a consolidating Act and it brings together parts of Acts going back to 1844. There is an Act in 1996 – one of the crappiest pieces of legislation on the Statute book – there is some other primary legislation, bits and bobs here and there, births’ and deaths’ registration legislation and so on. Then there were some statutory instruments – the primary one is the Coroners’ Rules 1984, which deals with quite a lot of the practice and procedure, and then there is some other secondary legislation that is relevant to coroners, RIDDOR, which is dealing with the reporting of dangerous occurrences, various infectious diseases – all sorts of nasty things.

What jurisdiction do coroners have to inquire under the current law? They have no jurisdiction unless and until there is a report to the coroner of the presence of a body – dead obviously – in the coroner’s own district and the death is suspected to be one of three kinds: (i) a violent or unnatural death, (ii) a sudden death of unknown cause; or (iii) a death in prison. If it is a death from any of those causes and the coroner is never told about it he has no jurisdiction to inquire. If he is told about the death but in fact there is no basis for suspecting that it falls into any of those categories, again he has no jurisdiction to inquire. If he inquires and has still no reason to believe that it is any of these, he has no jurisdiction and lets the body go, only to find out a week later that he does have reason to believe, but it is too late. The two things must happen simultaneously; there must be a coincidence between the presence of the body and the basis for suspecting that one of these three types of death has occurred. There is a very limited form of extra-territorial jurisdiction where the coroner does not have the body either by agreed transfer between coroners, or where the Secretary of State tells the coroner that he has jolly well got to hold this inquest into this body that he hasn’t got.

Just so that it is clear, because this is something that crops up from time to time: what happens where there is a death abroad? Well if you just think back to what I have just said it is blindingly obvious that unless and until the body pitches up there is not going to be any basis for jurisdiction in normal circumstances. So first of all, bear in mind there is no particular reason for the coroner to be concerned about death registration issues because there is no death registration of someone who dies outside the United Kingdom, at any rate unless you voluntarily go to the nearest Consulate and try to register it there. You can, as I say, register voluntarily in some cases. If the body stays abroad that means that no coroner will inquire because it is not in his district. If the body comes into England and Wales or Northern Ireland, the coroner will apply the usual test which I have just mentioned for his jurisdiction to inquire, and where the coroner has jurisdiction. For example, suppose you just happened to be driving under the Pont de l’Alma in Paris and you hit a wall and unfortunately die and the body is brought back to this country (probably on an aircraft of the Queen’s Flight) then there will have to be an inquest because the body is within the coroner’s jurisdiction – even though the coroner has no (or very little) evidence in many cases with which to make decisions because, of course, the witnesses and all the other real evidence is somewhere else. Try persuading the authorities in Pago Pago, or São Tome, or somewhere that you really do need something from them this side of the century. It is, frankly, in many cases a waste of time. In
other cases, rare cases, it is sometimes worth it. There are also problems in the case of death abroad with death disposal certificates but we won’t go into those now.

The current personnel involved in the coroner’s system are: the coroner, the deputy coroner (there must be a deputy for every coroner), and an assistant deputy if the coroner wants to appoint one – some coroners love them so much they appoint several; there is no proper statutory basis for this but they like doing it. That means you have three people in every district who are able to deal with Coronial matters. Coroners could not function, however, without Officers, i.e. people who are the case workers, who answer the phone, interview the relatives, deal with the forms and the paper work, and do some of the leg work.

Where do we get the case workers from? Where do we get our Officers from? In many parts of the country a lot of them are serving police officers who may be specially seconded to the coroner – or they may not be. In some districts they are just the person who found the body and you say: “Right, you're Coroner’s Officer for this case.” Sometimes they are employed by the police but actually as civilians rather than as police officers, which means that the numbers of serving police officers are not hit by putting them into this kind of work. In many cases they are retired police officers or retired police staff of some kind. Sometimes they come from other professions, e.g. fireman, nurses or undertakers in a previous life. In addition to the case workers and the officers in busy coroners’ districts there may be other staff – some coronors have a PA or a secretary, some have a bookkeeper, there may be other people too. Then the coroner will buy in other services on a case by case basis, particularly the professional services of pathologists, scientists and other experts. Some coroners will always go to the same pathologists, others might have a list of pathologists and they may vary their choice, depending on the specialisation required in a particular case.

What are the current procedures involved in investigation? A death being reported to the coroner’s office means that the coroner’s officer will actually make some initial inquiries, almost certainly by telephone and as a result of getting that information one of several things might happen. First, no further action may be taken, and that happened in 2006 in just over 51% of cases. Or the coroner might say: “We’ll have an autopsy” and then on the result of the autopsy say: “That is perfectly natural, we don’t need to take this any further”; and that happened in 36% of cases in 2006. In about 12% of cases you get an autopsy and then there is an inquest – the autopsy does not show the death to be from a completely natural cause and therefore there is an inquest which follows. Lastly, in a very small number of cases (less than 1%) there is an inquest even though there has been no autopsy; often that is in cases where there is no body to start with, or for some reason the body is not available, or perhaps the body is available but nobody wants to touch it, or because it is blindingly obvious why the person died and there is no need to carry out an autopsy.

What about other investigations? The coroner is doing these things which are mainly form filling but also involve medical investigations – the medical cause of death – what about other circumstances? The police may obviously carry out investigations, particularly in the case of road traffic accidents – they may collect witness statements and so on and present them all to the coroner. When there is a death in prison there is a report made by the Prisons and Probation Ombudsman (PPO). If the police are involved in killing somebody – whether it is because they have shot them thinking they are about to blow everybody up, or because a police car has run a little old lady over on the pedestrian crossing – then the Independent Police Complaints Commission (IPCC) will carry out an investigation and the results of that investigation will (as with the PPO’s report) be made available to the coroner. Then in cases of death at work, or where health and safety rules are involved, there will often be a health and safety inspector investigating the matter and passing on some, at least, of the fruits of that inquiry to the coroner. So the coroner actually has some assistance in a number of cases which might otherwise raise formidable problems of resourcing. However, it is worth bearing in mind that in all these cases two consequences will follow: (i) it will take an awful long time and slow down the whole procedure because you have to wait until they have done this; and (ii) the purposes for which these investigations are being carried out are not the same as the coroner’s purpose.
The coroner has to be careful about what he does with this report, and very often there are issues raised in the report which are not properly admissible in the coroner’s own inquiry. You may say: “Why bother if it takes a long time? Why not ignore it?” The trouble is that if anything comes out in that report which is not something that the coroner dealt with then there will almost certainly be an application to the High Court to quash the decision of the coroner and say: “There is new evidence and it will have to be done again.” So it is really not worth taking the trouble to do it quickly when you are waiting for one of these reports, and you have no control over how long they take. I have been preparing a prison death inquest, which was a death that occurred as long ago as 2005 – more than two years ago – and it took the PPO almost 20 months to produce a report, and that is not unusual.

The current system is creaking at the edges for all sorts of reasons. One of the things that is wrong with it is that it was designed for the 19th century and here we are in the 21st century and we still have pretty much the same laws. A few tasters of things that are silly about it: there is no time limitation on jurisdiction so you dig up one of the Princes in the Tower and you would have to hold an inquest, because there is nothing saying: “As long as it is over more than X years ago” – in practice coroners just ignore old bodies but they shouldn’t; technically they should hold an inquest.

Bodies coming from abroad need to be inquested; you fear sometimes that people are thinking: “Well, they’re not going to investigate here in Bosnia and Herzegovina, let’s import the body into the UK and the coroner will have to do something about it and then we’ll find out what’s happening.” So we have the idea that the British coroner is the “world’s policeman” or the “world’s investigator” who must investigate anybody who lands on his doorstep. If you want to carry out some specialist investigation, e.g. medical or scientific investigation, even if we just want to have an MRI scan rather than an invasive or conventional autopsy, there is a primary legislation rule that says that the coroner cannot send the body out of his district except to an immediately adjoining district. Therefore, if the nearest MRI scanner happens to be two districts away it is actually unlawful to send the body away. Coroners usually break the law! Of course, when it comes to holding the inquest you have to hold the inquest in your own coronial area – you cannot hold it outside your own coronial area – which is the reason, of course, why Lord Justice Scott-Baker is proposing to hold the inquest in relation to Princess Diana and Dodi Fayed at the Royal Courts of Justice; he had to be appointed as the Assistant Deputy Coroner to Westminster in order to do this. It is all back to front – having decided that is where he was going to do it he has been appointed the Assistant Deputy Coroner for Westminster because that is where the Royal Courts of Justice happen to be.

What about autopsies – what is the present position there? You need an autopsy obviously where the medical cause of death is obscure or unknown, or perhaps you need to exclude other possibilities. Even if you have a good idea of what it was you may think: “Let’s make sure that it was really a heart attack rather than a stroke”, etc. The problem for coroners is that relying on the clinician is fraught with danger because such studies as there are, published in reputable journals, give an error rate for clinicians compared to the results of an autopsy of anything between 25 and 50%, and I guess most people would say that wasn’t an acceptable error rate, which is a reason why many coroners direct autopsies. So the coroner will either direct or request the pathologist (and there is a difference, though I am not going to go into it now) – in some circumstances he can tell the pathologist to do it, but very rarely. In most cases he requests. This is something which will override the relatives’ (or even the deceased’s) wishes which causes some problems when you have, let us say, very religious families, whether Jewish or Muslim, or even Catholic – there was one Polish family which got into the law reports a couple of years ago because they didn’t want grandma to be autopsied. The law is that if the coroner requires it then that is what is going to happen, but of course those decisions are capable of being challenged (as indeed is every other decision of the coroner) as irrational and so on under Judicial Review.

How do you dispose of a body? There are three main ways:

(i) you can bury it here,
(ii) you can cremate it here; or
(iii) you can remove it from England and Wales.

An awful lot of bodies are in fact removed; 75% of those disposed of inside this country are actually cremated (England and Wales). If you look at the figures for the whole country – that is to say, including Scotland and Northern Ireland – the numbers go down but that is because in Scotland and Northern Ireland they don’t fancy cremation very much. The figures date from 2001, which is the most recent figure that the Cremation Society has, but I don’t suppose it has changed very much in the last few years.

If there is to be a cremation then two doctors’ certificates are needed – “I’ve got a Dr Shipman here, would you like to sign the cremation certificate?” (Laughter) – plus registration at the local Registrar of Deaths, or the coroner’s certificate saying that it is all all right and you can have a cremation, so you do not need the doctors’ certificates and the registration in that case. But in either case, whether it is two doctors’ certificates plus registration or it is the coroner’s certificate, you will need the medical referee at the crematorium to say everything is all right.

If you want to bury someone it is a lot easier, you just need to register the death and you will get the order for burial from the Registrar, or the coroner can give you a certificate to say that you can have the burial. If you want to remove someone from England and Wales the coroner will need to give you a certificate or four days without anything happening would have to elapse. I am told reliably, incidentally, that airline staff never, ever look at certificates!

When do you need to have an inquest with a jury? Before 1926 all inquests had juries, but after 1926 it is a much smaller number and only when:

(i) There is a death in prison – question: what counts as a prison for this purpose? A good question but we will not deal with it now.

(ii) There is a death which is notifiable under other legislation to a government inspector or to the HSE. That can lead to all kinds of anomalies because the legislation requiring a government inspector or the HSE to be notified of death has nothing to do with whether it is a good idea to have an inquest with a jury or not, it is simply that somebody thought: “How do we know if a case is important? I know, it’ll be because it has to be reported to the government, so let’s make that a criterion for having a jury inquest.” That means, for example, that if you blow yourself up with a refillable gas canister, that has to be reported to the HSE and there will have to be an inquest with a jury into your death. If, however, you blow yourself up with a disposable gas cylinder – exactly the same gas, exactly the same explosion, that’s not reportable to the HSE and the inquest does not have to be held with a jury.

(iii) There is a death in police custody or a death which is suspected to have been caused by the police.

(iv) There are public health or safety issues – the actual legislation says: “A death in circumstances the continuance or recurrence of which is or may be prejudicial to the health or safety of the public or of any section of the public.”

Taken literally, that’s barking, because everybody ex hypothesi dies in circumstances which, if they were repeated, would mean that somebody else would die. If you stopped breathing well those are circumstances which show that it’s happened again! (Laughter.) It clearly does not mean that, and the courts have had fun trying to restrict it to circumstances where there is some kind of systemic problem – something has gone wrong with the system – and it’s not just because you’re a British Princess and you’ve been foully and brutally driven into a brick wall in the tunnel underneath the Pont de l’Alma in Paris. Unfortunately it was said in that case that that was exceptional and that it had to have a jury. So now coroners are faced with lots of lots of requests to hold inquests with juries because “it was a road accident just like that Princess Diana”.

If it is not one of those compulsory cases then it is just a discretionary situation and you do not have to have one. Any coroner who has half a brain cell always refuses to hold an inquest
with a jury unless he is absolutely compelled to, because they are much, much longer, much slower, much more difficult, much more stressful.

What is the current scope of the inquest? It is fact finding and not fault finding, which means that you answer these questions: Who was it? When was it? Where was it? How did it happen? There are two ways of looking at “How did it happen?” Usually in most cases it is: “By what means did it happen?” But in some cases, where Article 2 of the European Convention on Human Rights is engaged, it will be: “In what broad circumstances did it happen?” which is a much broader form of inquiry. Rule 36 of the Coroners’ Rules prohibits the inquest from dealing with other matters, and Rule 42 prohibits the inquest from even purporting to find fault. It does it in a more roundabout way but that is the effect of it, so it is not about attributing blame to anyone, it is about trying to find out what happened. The last point to make is that the coroner, under Rule 43 of the Coroner’s Rules, has the power to report the circumstances to an authority whom he believes may have the power to take steps to prevent a recurrence of the fatality in question. Now, there used to be a rule that the coroner (or the coroner’s jury) could make recommendations for the prevention of the recurrence of the fatality. That power was actually taken away by ministerial fiat in 1980 – no primary legislation, no debate about it, “We just do not want that any more, thank you very much” which throws into stark relief some of the things I am going to be saying later on about “Oh, we do want something”. What they did not want, of course, was coroners making recommendations which would cost money. All they wanted was something that said: “Well you can tell somebody about it.”

The verdict of the inquest is actually all the information recorded in the inquisition form. The bit that the media call the “verdict” is what the form itself calls the “conclusion” as to the death. The conclusion as to the death is the shorthand summary e.g. “misadventure”, “suicide”, “unlawful killing” – a couple of words which summarise the kind of case it is, but there is a lot more information than that answering the questions: “Who?”, “When?”, “Where?” and “How?” Before 1977 it was quite different because until 1977 it was possible for a coroner’s inquest, if it considered that somebody was actually responsible for the death in a way which might amount to murder or manslaughter, to actually name that person in the inquisition form, and the inquisition would then amount in legal terms to an indictment on which that person would stand trial at what was originally the Assizes and subsequently the Crown Court. The last person in this country to benefit from this enlightened procedure was a certain Lord Lucan – hands up anyone who has seen him recently? You may remember he was named by the jury at the inquest into his children’s nanny’s death – Sandra Rivett was her name, but nobody remembers that these days – she was found dead at the bottom of the staircase in the family home. That was thought to be a very bad thing; it was so bad it had been recommended that that power be abolished in 1911, then it was recommended it be abolished in 1935, and it was recommended it be abolished in the Broderick Report in 1970. Did the government do anything after any of those three reports? No, it did not – it took an aristocrat to get the law changed. No sooner had Lord Lucan been named than wheels started turning and the law changed. The moral of the story is if you want to get the law changed, murder somebody then make it aristocratic.

The standard of proof for a verdict or conclusion as to the death in the inquisition form is, generally speaking, the civil standard, i.e. on the balance of probabilities, and completely inexplicably and unhistorically it is the criminal standard when you are dealing with the conclusion of unlawful killing and suicide, but I am not going to go into why that is so.

All these other cases – natural causes, accident, misadventure, dependence on drugs, drug abuse, industrial disease, disaster, stillbirth – are dealt with on the balance of probabilities. If none of those apply and you can’t find one that satisfies the appropriate standard then the appropriate conclusion is an “open verdict”. That is not a “cop out”; it is just saying “the evidence doesn’t go far enough”, that is what we’ve got and it’s not enough.

What are the weaknesses of the present system? “Who Killed Roger Ackroyd?” is a good start. I don’t know how many of you have read Agatha Christie’s famous detective story – in fact, there is no detective in it but that’s another story. It caused a scandal at the time that it was published because the narrator was the deceased’s GP, and you’ll never guess who did it!
So what is the problem with the present system? The present system deals with the fact ultimately that you trust the doctor if the doctor says that it is a natural cause of death. The coroner is not even engaged – the system never even gets going if there is a doctor who is prepared to sign a certificate that says: “This person died from completely natural causes.” The Registrar accepts it, the death is registered and the coroner doesn’t know about it.

The second weakness is that there is a serious under funding of the system; it runs on a shoestring and because it is financed locally it is a postcode lottery. It depends on whether the inquest you are concerned with takes place in a district where they have money to spend, or in a district where they have no money to spend and they would rather spend it on something else, so it is completely unbalanced. It would be one thing if it was under resourced in the same way throughout the country, everyone would be on the same level – like the child who came home from school and mum said: “What’s your new teacher like?” and the child said “Oh, she’s mean but fair.” “What do you mean, ‘she’s mean but fair’?” “Well she’s mean to everybody.” So if the system was the same everywhere we might at least not have that complaint, but in any event the system is seriously under funded.

The third weakness is that it is not clear what the objectives are. It is something that has hung over from previous systems, previous generations. Are we just looking at the facts, are we trying to find out what happened? That is what the rules say we are supposed to do, but it is not what the families say. The families say they want to blame somebody and what’s more their lawyers, I am afraid to say – being one myself – very often put them up to it and then, of course, when they do not get what they think they are entitled to they blame the coroner – obviously. They want the hand of God to come crashing through the ceiling of the Coroner’s Court and point a big, big quivering finger at the non-defendants in the non-dock saying: “You bastard, you killed this person” – that’s what they want, but they don’t get it. Is it to concentrate on public health or public safety issues? We have very archaic legislation, legislation that goes back to the yeardot. Some of the things in the Coroners Act can be traced back to the 13th century, it has not changed.

Coroners do not just deal with death, they also deal with treasure. There is an historical reason why this is so. Historically, the coroner was there as the person appointed by the King to look after the King’s financial interests in all sorts of litigation. The King had a financial interest in people dying because of the “murdrum fine” which was levied on people who went whopping Normans in the middle of the night, and if they couldn’t prove that they were Saxons they were presumably Normans and everyone would get fined a huge amount of money – the “murdrum fine” which the King’s men took. Also the King would take treasure and that has continued even to this day in that coroners still deal with treasure inquests – a complete waste of time for all sorts of reasons: first, because the test is such that you cannot know actually whether or not it is satisfied; and secondly, even if the coroner comes to the conclusion something is treasure it has no binding effect on anybody, and anybody who is concerned by that conclusion can go and sue in the ordinary courts and just carry on as if nothing had happened – it is a complete farce.

In these circumstances in the late 20th century, the government – the Home Office – appointed Tom Luce, a former high level civil servant at the Department of Health, to look at the possibility of reforming the whole system – coroners and death certification together. He produced a report in June 2003 saying that what we need is a national coroners’ system, i.e. run from the centre, financed from the centre, equality of resources, etc. We need a chief coroner at the top and then, say, 60 or so full-time coroners around the country and they will all be lawyers, not doctors. There will also be some part-time coroners for the days off and learning curve stuff and so on, and there will have to be some judges drafted in for the difficult inquests. However, there will be a need for coroners to have access to medical advice and therefore there will have to be a medical assessor in every coroner’s office, and all deaths – whether it is a cremation, burial or anything else – whether reported to the coroner’s office or not will all have to be looked at by two doctors. All certification will be copied to the coroner and in the coroner’s office they will do the odd audit to see that GPs are not bumping off their patients and that sort of thing. We will not have all the inquests in public, we will only have those in public where there is a genuine public interest – some will not be in public,
they will be done privately, but that is still the same with the people involved, but not with the public admitted, so cutting down on the publicity aspect.

Simultaneously with the Luce Inquiry going on there was an inquiry set up into the activities of Dr Shipman, and this reported on many things, including death certification and the coronial system, which is a bit odd really because the coroner’s system never really played any part in the Shipman case for the reason that I have already mentioned, namely, that Dr Shipman signed them all up as natural deaths. However, ultimately the Shipman Inquiry did look at death certification and coroners and it reported about a month after the Luce Report. It said: “We need a national coroner system but, differently from Luce, we are going to have two sorts of coroner – judicial coroners, and medical coroners.” The judicial coroners are going to do the judging and the medical coroners (rather like the medical examiners in the United States) are going to be the ones in charge of finding out the medical cause of death. So you have these two quite separate power bases. There will be trained investigators – every office will have a bloodhound. There will have to be, of course, a chief coroner, but since there are two sorts of coroners we will have a chief judicial coroner and a chief medical coroner. All deaths will be reported to coroners, and there will be random and targeted investigations. So any GPs thinking of “knocking off” their patients will start quaking in their boots. There will be an audit system and new appeals systems to appeal the decisions of the coroners if they won’t do what people want.

The Home Office was now in the happy position of having not one but two fully argued reports on how the coroner’s system should be changed, and the death certification system. So it thought about this for a bit (in the way that Home Offices do) and thought: “How do we resolve the fact that there are differences? We will get somebody to write us a Paper on what was different between the two positions.” They did that and then thought: “What do we do now? We had better produce a position Paper.” This position Paper was published in March 2004 (about eight months later). It was taking a rather cautious approach and in expressing itself in rather undecided terms – in fact, for a position Paper it did not take much of a position except the fence. (Laughter.) What it did say were things that do not cost anything – e.g. “We shall retain the coroner system, but we shall reform it.” “There will be a national system” – well that was safe, wasn’t it, because both of the other reports had said that. “There will be between 40 and 60 full-time coroners” – this number keeps coming up again and again. You may wish to note there are about 55 Police Authority areas in the country, but the Metropolitan Police Area is much bigger and one might expect there to be a few more coroners in that particular area.

“Yes, there should be a chief coroner and there will have to be a Coronial Council so that we can get all the touchy-feely stuff in there – everyone who might have a stake to hold will be on the Coronial Council and will be able to give advice on what the system ought to be delivering. We are going to completely overhaul death certification – memo to the Home Secretary: ‘We’re not actually responsible for death certification, that’s the responsibility of the Office for National Statistics, which comes under the Treasury’. So we can say that, it’s cheap, because it’s not going to cost us anything. We’re going to put medical advisers in coroners’ offices, and the Shipman Inquiry said: ‘Medical coroners who will face off with the judicial coroners.’ However, we’re not going to provide any more money for any of this. What we will have to do is to spend the existing money better, more wisely.” There is a slight difficulty about this and I will come on to the money question in a moment. “We are going to have to capture the existing funding” – easier said than done – a bit like Mrs Beeton’s cookbook: “First catch your turkey.” (Laughter.) “There will be a White Paper and a Bill within one year” – note the date at the top of the slide, March 2004. Did we have a White Paper and a Bill within one year? We did not.

Now, what about the money? Tom Luce and his Inquiry carried out as best they could some sort of inquiry into the costs of the current system. They tried to make the figures reasonably robust but there was a fair amount of guessing going on. They said that the costs for the entire coroners’ system in England and Wales (and I think the year for which this counts is about 2001/02 – the beginning of this century) was £71 million – most coroners think this is a horrible underestimate, it is actually more expensive than that. He said: “We
think it will cost an extra 10% for my new system” – that is a few million more. Remember, the Home Office just said: “By the way, no extra money”. Luce said: “My system will cost more than the current system but I hope not too much more.”

The problem with the resources that coroners enjoy is that a lot of them actually come out of their own pockets, e.g. if you are a solicitor coroner and in the country you probably have your office receptionist handle coroner’s work calls, and your secretary will deal with correspondence which makes a lot of sense, so you are actually subsidising the coroners’ system. Similarly, with some GPs who are coroners they may use some of the resources of their practice as the friendly front of their coronial office. Again, look at the police, the police up and down the country have, for years and years, financed coroners’ officers. Coroners’ officers in most of the country are actually not employed and paid for by the local authority, although that is the fall back position, they are actually financed and paid for by the police because most of them are either police officers (or retired police officers) or civilian staff employed by the police. All the coroner’s officers in Greater London (except in the City of London) are actually employed by the Metropolitan Police – they are all civilian staff employed by the police – so it all comes out of the police budget.

This money is in a sense not being provided by the local authorities, it is being provided by other people within the system, so that is going to have to be captured and brought back if you are going to say “No new money, you’ve got to do it on the money you have”, because otherwise you have a big hole in your available resources. Can you imagine going to the Police and saying: “By the way, we’re going to actually dock you next year this amount of money because we need it for the new coroners’ system.” What would their response be? Fortunately we know what their response would be because they have said it already, they said: “We were never given the money to deal with coroners in the first place, so you’re not having it.” Imagine going to the local authorities and saying: “Up until now you’ve paid for the coroners’ system, next year we’re going to stop you this much money.” They’re not going to like it either, but at the end of the day the government is the government and can pass the law; it can actually do what it wants, and at the wrong part of the cycle of the parliamentary session and that may not be something they want to have.

Can they claw back the money? Well, maybe. I was a member of a resources subgroup operating at the Home Office in 2004 and we spent many meetings debating how much this amounted to and whether or not it could actually be got back. I have to say the coroner members thought it couldn’t, and the Home Office people thought it probably could.

What happened after that? Remember we are looking for the White Paper and the Bill within one year of March 2004. Well the White Paper and the Bill were repeatedly put off – we were told: “In the Autumn 2004”, “Definitely before Christmas 2004”, “Sorry, Christmas holiday, just after Christmas 2004”, “Definitely before Easter 2005” and unfortunately there was a General Election in May 2005 with the result that it didn’t happen then either. Immediately after the election the Coroner’s Unit transferred from the Home Office to the Department for Constitutional Affairs (as the Lord Chancellor’s Department had then become). The Department for Constitutional Affairs was immediately nicknamed: “Decaff”.

The next thing that happened was the bombings in July 2005, and that was an awful tragedy for the people involved but it highlighted the need to think about what the coroners’ system could deliver or should deliver, and the resources that it might need. That series of bombings probably cost several million pounds in resources (and that is more than any coroner has) and that was ultimately paid – I am reasonably confident – by Central Government. So the resources available to coroners in the year 2005 were many millions more than they normally were – whatever the normal figure actually is. Still no White Paper, no Bill, and that persisted for the rest of 2005.

In 2006 the House of Commons Constitutional Affairs’ Committee – one of those wonderful Select Committees with a few bolshie MPs on and which gets uppity from time to time – had a good idea and said: “Let’s inquire into the reform of the coroners’ system which the DCA keeps saying it’s going to do; they keep saying they are going to produce a Bill and so let’s investigate it.” So they announced an inquiry into this subject, which came as a
bombshell to the DCA; they had not anticipated this at all and the next thing there was a Ministerial announcement saying: “It is all nearly ready and it’s about to come, so here is my announcement”, and the announcement came. What did the announcement say: “There is going to be a greater focus on bereaved families.” “There is going to be a national framework for coroners” – oh dear! We seem to have lost the word “system” and replaced it with “framework”. “There is going to be a chief coroner and a Coronial Council, but coroners are going to be appointed and financed locally” – oh dear! “There will be 60–65 districts, but of course coroners will be local and accessible”. Now, wait a minute, 60–65, population of England and Wales about 53–54 million, something like that, so a bit over one million population for each district. Take 1 million at the top end of England, and that is about six counties, you are driving 400 miles in any direction to get from one side of the district to the other – that is not a runner. So there is obviously going to be a problem there. These coroners are not going to be capable of being full-time coroners in a big enough catchment area to produce the sort of work that a full-time coroner ought to have; they have not really thought this through. “Not every death will have to be reported to the coroner” – you see that would cost too much money.

That was the announcement. The House of Commons Select Committee got on with the job. It started in January 2006 and held some public hearings. The first public hearing was with Dame Janet Smith, the burden of whose evidence was to judge from what the Department of Constitutional Affairs had said was going to be in the Bill – the Bill still had not come out then – about local coroners financed locally etc, but nothing about death certification, nothing about re-organising the way in which you deal with certifications around a death. “This will not stop another Shipman” – a nice headline in the paper the next day. There were other people who gave evidence: Tom Luce, who of course had conducted the other inquiry, Michael Burgess, the former Secretary to the Coroners’ Society and then quite high profile as the Coroner for the Royal Household, Victor Round, the then Secretary to the Coroners’ Society and many others as well. The DCA eventually managed to publish its Bill in June 2006 for consultation, so it was a pre-legislative draft, because it was not published as part of a programme before Parliament, it was simply published for consultation.

The House of Commons Constitutional Affairs Committee considered this, considered evidence on it, actually had evidence from Harriett Harman (Minister of State for Constitutional Affairs) and it published its report on this Bill and on the investigation it carried out in August 2006. What did the Coroners’ Bill actually say? Well, it had a pretty cover! (Laughter.) It said absolutely nothing whatsoever about death certification – no change there. It did solve – a plus point – several technical legal issues which, frankly, could have been solved by a one clause Bill 20 years before, and I know that because I drafted one. (Laughter.) It does deal with a Chief Coroner, who is funded centrally (hurrah!) and a secretariat. There will be fewer coroners than there are today but they will be full-time; on the other hand they will be funded locally according to the Bill, and the bereaved will be much more involved in what happens. Even better for the bereaved, there will be a faster, easier appeals’ system, so that if you do not like the decision that the coroner has made, you can appeal it quickly. Well from one point of view that is an achievement, that is an improvement; the trouble is that means there will be more decisions that are overturned, there will be more decisions that have to be taken which again has a resource implication; you don’t get something for nothing. You might get better results in the sense that you get the right result more often, but you have to pay more for it. Is the government willing to pay any more for it? Oh dear – no new resources. I say “nearly no new resources”, because they have to pay centrally for the chief coroner but that’s something else entirely; no new resources for actually being a coroner and investigating deaths. That means that when the coroners are tied up in the newer, faster, easier appeals system, and dealing with that and taking all the decisions again that have been overturned, they are doing that on the same resources that they had to deal with the original workload – obviously they will do it much quicker, won’t they?

The Constitutional Affairs Committee reported in August 2006: “The government is in danger of wasting a golden opportunity for substantial reform of the systems of death certification and investigation in England and Wales. Much of the improvement which might
come about as a result of the proposals in the draft Bill will be threatened by the paucity of resources which are likely to be devoted to this important area. We believe that this draft Bill falls well short of what is required to reform the system.” If I was the Minister I think I might have gone and topped myself (Laughter.) but our Minister is made of sterner stuff!

The next thing was the Queen’s Speech. You certainly will know that the Queen’s Speech is the announcement by the government of what Bills it is going to bring forward during the course of the next legislative session as government Bills with a view to enacting them. The Department for Constitutional Affairs told the coroners and, indeed, anyone else that would listen that they were putting this in, this was definitely in the box and it was only up to the legislation managers for the government to decide which Bills they were going to put forward into the programme. So we were all on tenterhooks to know and, indeed, on the day I logged on to the 10 Downing Street website to see what was in the Queen’s Speech – I couldn’t actually get to a radio to hear it – “Is there any other point to which you would wish to draw my attention?” “To the curious incident of the dog in the night time.” (Laughter.). “The dog did nothing in the night time”; “That was the curious incident,” remarked Sherlock Holmes. (Laughter.) The Bill did not figure and I couldn’t understand it. Looking at the website there was a helpful note there which said: “Do you want to send a question to Tony Blair?” I thought: “Yes, I do!” (Laughter.) So I sent this:

“According to the 10 Downing Street website today after the Queen’s Speech had been given: ‘The Bills announced in the Speech are designed to reflect the priorities of the British people’ and tackle the ‘big issues that will affect future generations.’ So, for example, to quote from the speech: ‘Legislation will provide for free off peak local bus travel for pensioners’ (Laughter) ‘and disabled people’. And ‘Legislation will provide for improved arrangements for the regulation of estate agents.’ However, the DCA’s draft Coroners’ Bill, drawn up after considerable consultation following recommendations by not one but indeed two important inquiry reports, Luce and Shipman, and published in the summer is not mentioned. But is not reform of the coroner system a priority of the British people and a big issue that will affect future generations? Everyone who comes into contact with it, including Coroners thinks it is, why don’t you? Paul Matthews. H.M. Coroner for the City of London.”


Dear Mr Matthews,

Thanks for the question you sent to the web chat. As you know I didn’t get around to answering it during the interview but I wanted to assure you we have not forgotten this report. I totally agree with you on the importance of improving the way the Coroner system works; you play a vital role at a time when families are at their most vulnerable. The government, like you, wants Coroners to provide a best possible service for bereaved people, and we are sure you and your colleagues have the powers” – it doesn’t say “resources” – “to carry out effective investigations and inquests.

This, as you know, was the goal of the draft Bill we published in the summer. But it is exactly because we agree on the importance of these wide-ranging reforms that we are determined to make sure we get them absolutely right. We want time for extra consultation with Coroners, your staff, the voluntary sector, and other stakeholders so we can improve the Bill further. We are exploring other changes that can be made to improve the system to pave the way for (and in advance of) legislation, so I am sorry that you are disappointed that the Bill was not one of those announced last week but I can promise you that this was because we take improving the current system very seriously rather than because we do not think they matter to the public.

Yours ever,

Tony Blair.”

“Dear Prime Minister,

Thank you for your enlightening letter of 21 November 2006. Let me see if I now have understood this correctly. Everyone, including you, wants to reform the Coroner system in this country. The DCA produced a Bill for this purpose, which they told Coroners they were submitting to the government’s legislation managers for inclusion in the Queen’s Speech, but the House of Commons’ Select Committee and, indeed, many other organisations which
considered it, criticised it as too limited in scope and too weak in effect. You have now told me that the Bill was not included in the Queen’s Speech not because there were other things that were more important, but precisely because you wanted to improve it before introducing it into Parliament. In other words the government’s legislation managers pulled the Bill because they saw the defects which the DCA did not. If this is the case I congratulate your legislation managers on their perspicacity in an arcane and neglected area of law. I hope it leads to a better Bill which does at least some of things that the House of Commons Select Committee said that it should.

Yours sincerely,
Paul Matthews.

P.S. I also congratulate you on your uncanny ability to write in exactly the style of Jeff Bradshaw of the Coroners’ Unit at DCA.” (Laughter.)

Unsurprisingly there was no reply. But the government has had second thoughts – hurrah for second thoughts! First, it said, “We are going to have a bereaved people’s panel”, which they duly held in November 2006. They were assembling a panel of people with recent experience and contact with the coroners’ system to look at the draft Bill and say: “What do you think?” The DCA itself responded formally and in a written form to the consultation in February 2007. Three government departments, the DCA, the Department of Health and the ONS produced a further report called: “Learning from tragedy, keeping patients safe”, which has the great merit of not telling you what it’s about. Just recently – last month in fact – the Minister of State for Constitutional Affairs and the Minister of State at the Department of Health gave further evidence to the House of Commons Constitutional Affairs Committee – the so called follow up evidence. So there is a number of occasions when the government has had to think about what it’s going to do in light of all the criticism that has been pointed at the Bill.

First, the Bereaved People’s Panel. This is a rather novel aspect to law making. You say: here is a draft Bill which we have prepared, we would like to submit it to the views of a number of people who have a particular viewpoint – only that viewpoint of course. Now, you can’t just pick people off the street, you’re going to have to prepare them for it and it’s going to be pretty trying for them in one sense because they are bereaved after all. But nonetheless you bring them in and you make them a cup of coffee, sit them down and tell them lots of stuff and then say: “Go away into little break out groups and decide what you think about these particular provisions.”

It was rather a concentration on people’s negative experiences, and that is not terribly surprising given the circumstances. What was quite surprising was in fact that something like 75% of the people involved actually said that they thought that coroners and the system were doing reasonably well. But nonetheless, there was concentration on the negative experiences. The thing that people criticised in particular was how long it all took, the fact that they weren’t at the centre of the system, they were only part of it. There were such variations in the quality of the service from one district to another. The scope of the inquest was too narrow – they wanted it to be much wider and that there was an uneven playing field very often because the families might not be represented whereas the authorities would be. So that was the bad side of things.

What they liked – they liked the new charter for bereaved people. They liked the new faster, easier appeal provisions. They liked the possibility that fewer things would be reported about coroners’ inquests; there would be greater reporting restrictions, less publicity. But they were concerned if any of these things should cost them money; that was one of their concerns.

The Minister’s view of this: “This is democracy in action.” I have to say that I respectfully disagree with that; it seems to me to be the complete antithesis. Democracy is when everybody has an equal vote. This seems to me to be giving weight to a particular class of person who has a particular experience and thereby skewing the result – I do not think that is very democratic at all, but perhaps I’m just an old fuddy-duddy!

What about the DCA’s written response to the criticisms that were made in the consultation exercise on their Bill? They said they had had 150 responses. I am not sure I regard that as democracy in action either. They said they would change some things. They will change the
appeal system, they will change the rules on deaths from abroad because they were going to restrict those and there were lots of criticisms of that. They were going to change their decisions about juries, they were going to restrict juries and cut down the numbers and change the way in which they learned lessons from investigations for the future – the health and safety aspect of it. This was actually touted in a Ministerial statement towards the end of January (this came out in February 2007) and it made quite a big splash in some newspapers such as The Guardian and The Times as though this was going to be some great advance and change. It turned out to be that the Bill would be strengthened in the sense that first the coroner would be able to make a report to the appropriate authority and it would be obligatory for the person who received the report to say what he was doing about it, but not that he should actually do anything. So he would come back and say: “We do not have the money, I am not doing anything, thank you very much” and that would be it. That is the sum total of his form. Then these reports would be submitted also to the chief coroner who would keep tabs on them and he would report on to the government, but pretty much a feeble improvement if you ask me.

There would be some new provisions dealing in particular with reports of deaths by medical practitioners, and also dealing with the role of coroners’ officers, which would be a first because so far they have not been mentioned in any legislation. They were going to discuss some things a bit further before coming to a final view. They would discuss the question of reporting restrictions, sharing information between agencies, how and how far to disclose information to the bereaved, how to give people improved support; they were going to think further about the rules on autopsies, and also on how the coroners might receive medical support, i.e. expert advice on medical matters – they are all going to be lawyers, of course, in the future. So they have not actually reached a conclusion on any of those, they are just saying: “We are going to think further about those.” Then, as I say, there were the three government Ministries which produced this document, which was largely a response to the Shipman Report; it was largely dealing with the problem of the fact that Shipman had been able to get away with what he did so easily because the system did not involve the coroner in that kind of case.

The government first of all says in this document that it does not accept that Shipman was unique and could not be guarded against. Well, fair enough, I think perhaps most people would accept that, but they do accept that the medical certification for the cause of death arrangements as they are at present are confusing and inadequate. I think again everybody would agree that that is so. Therefore, they propose first of all that there should be an independent medical examiner in every Hospital Trust with full access to all the medical records who could refer cases to the coroner in case of doubt. Yes, but this is going to be an employee of the Trust after all.

The second proposal is that there should be individual and team clinical audits. So obviously the medical examiner is going to be a really popular person around the hospital. The third proposal is the evidence which the two Ministers of State from Health and Constitutional Affairs gave to the Constitutional Affairs Committee of the House of Commons. They stressed again the importance of learning lessons from the inquest. They said there is going to be a duty on people who receive these reports from coroners to respond to them, but that is not telling us anything new, that is exactly what was already said in the response to the consultation in February.

The Minister of State for Constitutional Affairs, Harriet Harman, said they were going to go further and appoint a Shadow Chief Coroner already, even in advance of the legislation – even before there is a job called “Chief Coroner” – “We are going to appoint somebody as the Shadow Chief Coroner, and this person is going to be able to give leadership in the existing system; it is going to be a wonderful non-statutory improvement.” Yes, right! They were criticised heavily by the Committee because there is this problem of the splitting of responsibilities between the Department for Constitutional Affairs (now the Ministry of Justice) and the Department of Health, because doctors and hospitals and all that sort of thing come under one Ministry and coroners come under another, and there is a danger of things falling down between them. The response of both Ministers was: “Oh but it’s wonderful to
have diversity, bring different views to bear on the whole problem.” That is a much better way of doing it, isn’t it? Several times – well, at least two when I counted them – they said: “It is not the Department of Health’s fault that this happened, you know.” “Medical examiners should definitely work for the Hospital Trusts and not for coroners themselves” – “why?” “Well … because … well, because.” Well I think it would probably be cheaper, don’t you? (Laughter.)

Then a marvellous quote, and I promise you she said this: “There are a number of issues which still have to be sorted out.” Yes, we think so too.

Ladies and gentlemen, we know where the money is and we know where it’s staying. It’s not coming for us. Thank you very much for your attention. (Applause.)

Discussion

The President: Thank you very much for a splendid talk. Has anybody got any questions for Professor Matthews?

Miss Linda Lee: I am a solicitor at AvMA, and I hope you are going to shed light on my darkness. Discussions are starting to take place with the draft Coroners’ Bill team, but there is no information as to what their discussions are going to be about, and I suspect they are mostly going to be about increased reporting restrictions which I think arose entirely out of the Bereaved Panel. I wondered first of all whether you had any other evidence to support the increased reporting restrictions; and secondly, if you could give me your views on that aspect?

Professor Matthews: Yes, I am sorry, I didn’t catch where you were from?

Miss Linda Lee: AvMA, a medical negligence charity.

Professor Matthews: I see, yes. I don’t know that there is any other evidence than that is what the bereaved want. One of the things that I find quite peculiar about this whole business is the undue deference paid to the wishes of the bereaved. I do think that there is a lack of judgment here about the importance of the bereaved – they certainly are important but they have just lost control of where that importance goes. I don’t think there is any other basis for increased reporting restrictions. I don’t know that coroners have specifically asked for increased reporting restrictions, unless perhaps it is in cases where there is no particular public interest. The difficulty is to know in advance that there isn’t going to be any public interest in a particular case, even in a suicide case you may say: “This is a clear suicide” and it may not be; there may be arguments about whether or not it really was a suicide and so on.

As to what my own view is, at the end of the day I think I start from the position that if you take the view that the death of somebody in possibly unnatural circumstances is such a significant event that it ought to be investigated on behalf of the public at some level then there ought to be some public access to that information. Now, I can see that in some cases there are some exceptional cases of national security for example, where there would be greater danger done to society by releasing that information, but I think we must make those cases so exceptional. I do not think there is any case for just generally withholding information, I think specific exceptions have to be justified.

It is the same business in a way as in the ordinary courts. Generally speaking the courts sit in public and there has to be a very good reason why this is not so in a particular case, and at the moment I haven’t seen it. I hope that gives you some answer.

Dr Martin Mansell: I am a nephrologist and an expert witness, and I seem to be writing an increasing number of reports to guide counsel who are representing next of kin in the Coroner’s Court, presumably fishing expeditions for a clinical negligence claim. Have the lawyers always done this? Are they doing it more and, perhaps more interestingly, do you think that is a proper function of the Coroner’s Court?

Professor Matthews: To answer your last question first: I think not, and there are a number of occasions on which the senior judges of the Court of Appeal (and other courts) have said that it is not the function of the Coroner’s Court to provide evidence for personal injury or other clinical actions before the courts, so I don’t think it is the function of the Coroner’s Court to do that. Nevertheless, it is a very difficult thing to police and, as I say, if
you allow the information to come out at inquests then people will want to use it. But here it is going further because people are going into the courtroom with a view to particular information being obtained if possible. I don’t think it is a particularly new phenomenon; that sort of thing has always gone on at some level. It may be that in some cases it is being done – most cases perhaps – with a view to bringing an action for negligence against somebody in due course, but there may be other reasons why it is being done. There are some cases where there is a genuine public interest in the capability of a particular doctor, or some new technique being used, or some drug that is being used. There may be very good reasons why, at a different level, this sort of question is being asked.

I certainly think there is more of it on an anecdotal basis, simply because I think people are much more aware of the possibility of using the coroner’s inquest for this purpose, and as evidence of that there are a greater number of lawyers around who do know about coroners’ courts and the way they work because there are a number of specialists – 20 years ago I don’t think there were this number of specialists. So there are those who are interested in perhaps bringing actions against the police, those who are interested in bringing clinical negligence actions against doctors in hospitals; and those who are interested in attacking government policy in a general way, and they all have their own specialisation and they want the information to be able to do it. So long as the bereaved and other interested persons have the right to ask questions of the witnesses this sort of thing will happen. As I say, I don’t think you can actually stop it because it is very, very difficult to police. If a coroner can see that the questioning is going beyond the scope of the inquest that is a different matter, but this sort of questioning very rarely goes beyond the scope of the inquest.

The President: Forgive me, why do you think it is a bad idea?

Professor Matthews: To do what?

The President: For the bereaved to be able to find out if the deceased has been “done in” as a result of somebody doing something wrong?

Professor Matthews: No, I don’t think there is anything wrong with that. What I think is not desirable is to use the coroner’s inquest as the means of obtaining evidence which will enable you then to bring the action – that is quite different. I think that the purpose of the inquest is to find out what happened, that is to satisfy the public interest. If somebody has died in potentially unnatural circumstances there is a public interest in knowing why people die like that. We need to eradicate suspicion, we need to advance public health and all of these things – people need to be able to grieve, etc. But to say we are going to use this system for the purpose of obtaining particular information which will enable us to launch an action for negligence is, I think, quite different – it goes beyond the purpose for which the inquest originally existed, and I would say exactly the same if you said: “I want to ask these questions because then we might be able to launch a criminal prosecution against that witness”, or against some other person for breaches of this or that law. I would say exactly the same, it is using the information function, asking: “Why did this death occur?” for a completely different purpose, that is all.

Mr John Bearsted: I am a medic. I was recently involved in an inquest into a death in prison, and the coroner – to put it politely – was very derogatory about the PPO report and arranged for the coroner’s officers to do a whole lot more investigating, and I just wondered what the width of your investigative powers is prior to the actual inquest questioning itself?

Professor Matthews: It is a very good question. The true answer is that if we have the resources we could do everything that the PPO could do – we could go and ask all the questions, we could go and leave no stone unturned, but we don’t have the resources. It is difficult enough for the officers and the staff that we have to just deal with the paper work, to answer the telephone, to be able to tell people what is going on. The thought that they will actually have the time to go out and look at places where deaths have occurred, to interview witnesses who have been involved is just fanciful – I don’t think there is any coroner in the country who has that luxury. The best you can hope to do is to persuade the local police to go and interview some witnesses. So the PPO report is useful because you do get some idea of what witnesses may say when they come to the witness box, and it is on that basis, of course,
that you are going to select witnesses for the purpose of giving evidence live in the witness box.

So legally speaking we could do all of that and more. In practice we can’t because we don’t have the resources. At the end of the day this is all about resources.

It seems to me there are two ways you can approach this question. You can either say: “What results do we want?” “What do we want the system to achieve?” “At what depth do we want this to be done?” The second question: “What powers need to be conferred by law on the person that is doing the investigating to enable that to happen?” The third question is: “How much is that going to cost?”

Or you can do it the other way around, you can say: “We have only this much money to spare” – when you take out the priorities for this, that and the other in society – “what can we get in terms of legal powers and how many results will we get for that?” You have to do it one way or the other and, so far this government has resolutely refused to do either. What it is saying in practice is: “We will promise the families the earth, and we will not pay a penny for it.” That is what it comes down to.

Miss Selina Lynch: I am a deputy coroner. The Luce Review and the Shipman Inquiry both left juries alone, do you think there is a case for removing the jury so as to obtain more meaningful outcomes, and save an awful lot of money.

Professor Matthews: Another good question. I am convinced that if we did not have juries nobody in their right minds would think of putting them in. There is a very simple comparison to make – look at Scotland. In a Scottish fatal accident inquiry, conducted by a professional judge, he hears all the witnesses and in the same way as you do in an Inquest. He produces a lengthy report, sometimes 30 or 40 pages long, which details all the facts that he has found, the story of the whole business from beginning to end and provides some findings and says “these are my recommendations” where there are recommendations to be made. You cannot possibly expect the jury to do that, but you can expect a professional judge to do it. Now, what do you want? If you want to have something that people can take away saying: “I know now how my brother, sister, mother or father died. I know what actually happened. I know what the facts are, and I know that there are things that are good that are going to come out of this”, because recommendations have been made which is what the fatal accident inquiry does. I think that is a much better model than leaving it up to a jury who may not have any experience of this kind of work before. Nowadays, it is actually quite interesting because lawyers and judges and so on are now eligible to sit on juries which formerly they weren’t, but I think the chances of your getting a jury together which could produce a 30 page report, in the same way that the judge does in the Scottish fatal accident inquiry, is virtually zero, and if you did I think all the other people who did not get that would complain and say “They’ve got something that I haven’t.” I don’t think there is any case for having juries as a general rule in relation to inquests. There may be a case for saying that in certain limited cases a jury is a better tribunal; maybe when it comes down to, for example, a question of believing a witness or something, if everything turned on that then you might well say, just like a criminal case, a jury is a good instrument for doing that. But I think this notion of bringing together the jury as some kind of popular legislative assembly that is allowed to make up its mind on the facts of one case what the rules ought to be is quite wrong and, indeed, undemocratic, but that is my personal opinion.

The President: Thank you very much indeed for giving us a marvellous lecture and thank you very much, Paul, we are very grateful to you.

(Applause.)