To assuage some of the paranoia about coroners' powers it should be remembered that the coroner has no powers save those necessary in the investigation of circumstances of a particular death. In particular:

(a) He can make no effective ruling as to the steps any doctor should take in relation to any patient before death—even where that death, when it occurs, will fall within the coroner's jurisdiction;

(b) He may indicate—as anyone else may—the type of deaths which he wishes to be reported to him—for example all deaths within 24 h of any operation, but there is no legal requirement upon anyone to comply with such a request;

(c) Even in circumstances where it is obvious that the coroner's jurisdiction to investigate the death arises (e.g. a road traffic accident), there may not be any legal requirement upon the doctor to report the death to the coroner [1]. There is, however, a requirement to complete a death certificate in every case [2] (although this is often not done where a death is referred to the coroner). The certificate of death should be endorsed, “Death referred to HM Coroner for the District of...”. The duty to inform the coroner falls upon Registrar of Deaths [3]. He will not register any death where it appears to the registrar “to have occurred during an operation or before recovery from the effect of an anaesthetic”.

Upon the coroner's jurisdiction arising, he has considerable powers of inquiry. Once the coroner has been informed that the body of a person is lying within his district, the coroner’s powers arise if there is reasonable cause to suspect that the deceased:

(a) has died a violent or an unnatural death;
(b) has died a sudden death of which the cause is unknown [4].

THE UNNATURAL DEATH

If the coroner is not interested in investigating the death, the first hurdle that an aggrieved relative [5] has to overcome is to persuade the coroner that there is reason to suspect that the death was “unnatural” [6]. Many attempts have been made to define unnatural, but the Oxford English Dictionary definition is probably sufficient: “... at variance with what is natural, usual or to be expected; unusual, strange”.

A death believed to be due to smallpox would be “unnatural” and, having fulfilled that level of suspicion, the coroner would be obliged to hold an inquest and to summon a jury [7]. Looked at the other way, one might say that any notifiable disease causing death is “unnatural”. The same might be said of a fit 25-yr-old who goes into hospital for a simple appendicectomy operation and dies. In the field of medical negligence, deaths are much more likely to occur as the consequence of failing to make correct diagnoses than by failures of medical management. Acts of omission are more frequent than acts of commission. Where there is reason to suspect that the death should not ordinarily have occurred, the coroner's jurisdiction to hold an inquest arises and, on occasions, relatives of the deceased will obtain an order of mandamus from the High Court requiring the coroner to hold an inquest.

THE INVESTIGATION

Usually through his officers, the coroner will carry out inquiries. The simplest of these is in relation to a sudden death of which the cause is unknown. In such a case the coroner would direct a postmortem examination to be carried out [8], the result of which alone may satisfy him that an inquest is unnecessary. Where he has reason to suspect that the death is a violent or an unnatural one the coroner has no power to dispense with the inquest even if the pathologist is of the view, following the postmortem examination, that the death was natural.

The first event in the investigation of the circumstances of death from the coroner's viewpoint is the postmortem examination which is often performed on the coroner's instructions soon after the death has occurred. The coroner's pathologist is not permitted to disclose a copy of his report to anyone other than the coroner without the coroner's permission [9], and the solicitor for the relatives may have required the coroner to instruct a pathologist not on the staff of, or associated with, the hospital where the deceased died [10]. If it is likely that an anaesthetist will be implicated in the cause of the death, the anaesthetist may (preferably under the guidance of his medical defence organization) be interested in the results of the post mortem.

KEY WORDS
THE CORONER'S INQUEST

There are three (official) ways in which the anaesthetist may obtain the results of a post mortem on the deceased:

1. He may simply ask the coroner to provide a copy of his pathologist's report [11]; or
2. He may request the coroner to be represented at the post mortem by a legally qualified medical practitioner [12]; or
3. He may give instructions for a separate post-mortem examination to be carried out [13].

It is, of course, not uncommon for the anaesthetist himself to ascertain where the post mortem is being done and simply turn up. A person attending a postmortem examination "shall not interfere" with the performance of the examination [14]. Often an interested party's pathologist will prepare his own report from a simultaneous examination of the deceased with the coroner's pathologist.

GIVING A STATEMENT TO THE CORONER

While an anaesthetist is under no obligation to provide the coroner or his officers with a statement as to the circumstances of a death being investigated by the coroner, it is sensible to do so. It is only perhaps if the anaesthetist has particular cause for concern as to the proper discharge of his duties that this course may, from his point of view, not be desirable. Usually he would be able to obtain professional legal help from his defence union and statements made for the coroner may be vetted by a lawyer.

The coroner can compel the attendance of a witness but he has no power to require the production of the medical notes or anaesthetic record [15]. Should the anaesthetist come to court without the records, he might well find himself embarrassed by their absence and in difficulties when giving his evidence. While it is said that a coroner's court is not the ideal forum for close examination of medical notes, nevertheless there are an increasing number of occasions when interested parties, such as the relatives of the deceased, will not only have access to copies of the medical notes, but they, their legal representative, or both will have had the opportunity also to obtain expert assistance in their interpretation. The coroner may choose to disclose copies of the medical notes he has obtained from the doctors or from the hospital [16]. More likely, relatives will seek copies of the medical notes from the hospital before the full inquest pursuant to the Access to Health Records Act 1990. Alternatively, as a preliminary step to civil litigation for damages, the personal representatives of the deceased, or his dependants, are able to obtain copies of the medical notes as part of "pre-action discovery" and the copies so obtained can be used at a coroner's inquest [17]. From the anaesthetist's point of view, if there is even a hint of an allegation against him of negligence or misconduct he or his legal advisers would be well advised at least to ask the coroner to provide copies of statements obtained from other persons to be called to give evidence at the inquest. The coroner is not obliged to give discovery of them:

"... I see no way in which anyone other than the police authorities can obtain any sort of legal title to these documents, and therefore, prima facie they are not available to be handed over to the applicant. Prima facie the present custodian of the documents, the coroner, could not without breach of confidence or trust show them to the applicant..."

Per Lord Widgery CJ R v. HM Coroner for Hammersmith, ex parte Peach (Div C), [1980] 2 WLR 496 at 503

The coroner is usually prepared to provide a list of the names of the witnesses he proposes to call. This then provides an opportunity to address him upon the propriety of calling other witnesses not on his list. He will be aware that if he does not cast his net wide enough, there is a risk that he may have to adjourn the inquest part heard. An adjournment part way through an inquest is unsatisfactory from everyone's point of view. If the anaesthetist is not solely responsible, it would be wise to advise the coroner of others who might help in his inquiry.

"Any person whose conduct is likely in the opinion of the coroner to be called in question at an inquest shall, if not duly summoned to give evidence at the inquest, be given reasonable notice of the date, hour and place at which the inquest will be held."

[Coroners' Rules 1984, Rule 24]

and

"If the conduct of any person is called in question at an inquest on grounds which the coroner thinks substantial and which relate to any matter referred to in Rule 36 [who, how, when and where, etc] and if that person is not present at the inquest and has not been duly summoned to attend or otherwise given notice of the holding of the inquest, the inquest shall be adjourned to enable him to be present, if he so desires."

[Coroners' Rules 1984, Rule 25]

There is no dishonour in an anaesthetist identifying to the coroner anyone else whose evidence might be material to the inquiry. On the contrary, it is a matter of protecting one's own professional integrity and helping to ensure that the coroner's inquiry is not deprived of the benefit of the evidence of relevant witnesses.

GIVING EVIDENCE IN A CORONER'S COURT

It is essential that the anaesthetist summoned to give evidence before the coroner be prepared to answer questions in detail and to justify exactly what was done. In virtually every case I have come across it is the deficit of explanation which is the trigger for the relatives to seek the help of a lawyer. The movement towards open accountability is slow. Lawyers have a professional duty to inform clients when they make mistakes and judges are keen to see a legal duty imposed upon doctors [18]. It the anaesthetist is not open and honest at the inquest he is likely to exacerbate a sensitive situation [19]. The reader will know of stories of such good doctor/patient relationships even frank negligence was forgiven without retribution being sought. The genuinely felt and freely and frankly expressed apology is capable of healing many wounds, a fortiori when it is made at the inquest.

The single most important piece of advice which I believe should be given to any doctor summoned to give evidence is to be prepared. I am astonished how frequently medical witnesses are poorly prepared.
Few seem to appreciate that there is a risk they may be in for an exacting examination by the coroner and informed lawyers instructed by the interested parties. Of course, the inquest may prove to be a low key affair. Everyone at the inquiry may miss the point. There is even a chance that seriously poor anaesthetic performance can be covered up—dressed up in such a way as to look as though the death was both unexpected and unavoidable. Do you remember the sop to the medical laity of "status lymphaticus"? Anaesthetists who feel they may get away without careful preparation deserve what is coming to them.

At the inquest questions directed at the issue of reckless professional behaviour may be addressed to the anaesthetist called to give evidence at a coroner's court. As with other courts, provided that the doctor is properly summoned, he is under a duty to attend [20], and once sworn he is obliged to answer questions put to him [21]. Where it appears to the coroner that a witness has been asked such a question, the coroner is obliged to inform him that he may refuse to answer [22]. Provided the questions are proper and relevant, they must be answered truthfully even though the answer may incriminate a professional colleague.

In my opinion the best witnesses are those who have the teacher's ability to educate the jury without being patronizing. A witness who is arrogant or who prefers to baffle his audience with science is doomed. Unfortunately those anaesthetists who underperform professionally are usually the ones who also perform poorly in explaining physiological and pharmacological matters in terms which the average layman can understand. Unless an anaesthetist can do this with ease, he may find it difficult to persuade the coroner or a jury to accept his explanation for the death.

**QUESTIONS AT THE HEARING**

Interested parties [23] have a right to examine witnesses at an inquest either in person or by counsel or solicitor [24]. The coroner is obliged to disallow any question which in his opinion is not relevant or is otherwise not a proper question [25]. There is some judicial guidance on the scope of examination of witnesses at an inquest but there is little a lawyer instructed on behalf of an anaesthetist can do to stop questions. The judicial dicta are more helpful to those trying to uncover the truth than to those who would prefer to cover it up:

"But to my mind in these rules the expression 'examine any witness' merely means 'question a witness', and what is contemplated is that the party in question should be able to put to the witness his allegations, put the points which he wants to raise and the time which he is prepared to give it;"

Per Lord Widgery CJ 7 v. HM Coroner for Hammersmith, ex parte Peach (Div. C), [1980] 2 WLR 496 at 504.

Those called to give evidence as expert witnesses are in no better position:

"A subsidiary complaint is made of this inquest, which was that the coroner was unduly restrictive of the questions which he permitted Mr Ashton to ask of Dr Wayte and indeed Professor Johnson. The coroner indicated on a number of occasions that he would not permit Dr Wayte to be impugned. What he meant by impugning Dr Wayte I do not know. If he meant that Dr Wayte's opinions, already given and explained in evidence, were not to be challenged or contradicted by other evidence the coroner was wrong. Having permitted Dr Wayte to express them he should have permitted Mr Ashton to test them, to put it to Dr Wayte that they had no sufficient foundation and, if he thought it right to put it to Dr Wayte in plain terms that his view was wrong." Per McCullough J. In the Matter of an Inquest into the Death of Adam Bithell Deceased, J. P. Rep. (1986) 282

**DOCUMENTS AS EVIDENCE AT THE INQUEST**

Oral evidence has to be given on oath. Whilst the rule against hearsay is not strictly enforced in a coroner's court, as far as possible the usual rules should apply. It is in the interest of justice that the best evidence is given wherever possible and the admission of documentary evidence should be strictly controlled [26]. No documents should be admitted in evidence save under the provisions of the Coroners' Rules. This protects any party whose conduct may be the subject of criticism to the extent that if evidence is given against him, the anaesthetist himself or through his lawyer has the opportunity to cross examine the witness giving that evidence. No backdoor method, such as the coroner asking one of his officers to read the document into evidence, should be permitted [27].

**THE EXTENT OF THE INQUIRY**

How extensive an inquest depends on a number of factors which rarely have anything to do with issues of law, for example:

(a) the interest of the coroner in the subject matter and the time which he is prepared to give it;
(b) the interest of the relatives in seeing a full inquiry;
(c) the interest of the media;
(d) the experience of lawyers instructed on behalf of the deceased's family. Occasionally, some other "interested party" will be the motivating factor in the size of the inquiry—for example where some drug product or piece of equipment is blamed as being responsible for the death.

In the more significant inquests the coroner may sit with a jury and he is obliged to do so where he has reason to believe "that the death occurred in circumstances the continuance or possible recurrence of which is prejudicial to the health or safety of the public or any section of the public" [28]. In almost all cases of medical negligence in hospital which lead to death there is some system or procedure which has failed, for example:

(a) a failure of a proper system of referral and preoperative consultation with other specialists;
(b) a failure to ensure that proper procedures are established for checking drugs, instruments, etc;
(c) a failure to establish a proper system for the recording of investigations and their follow-up;
(d) a failure of supervision of inexperienced anaesthetists, ODAs and recovery nursing staff;
(e) confusion over the chain of command with patients on an intensive care unit [29].

It is not difficult for experienced lawyers for relatives who are intent upon a public exposé to find an area
of public concern that, in the absence of a change in the procedures, might lead to other deaths in patients treated at that hospital. I believe that the majority of "medical negligence deaths" fall within S.8 (3)(d) Coroners' Act 1988 (cited above): the coroner has to sit with a jury. In general, juries start with a presumption in favour of the deceased's family. It is there that their sympathies lie and they soon recognize that they have the power to imply (if not express) censure of the establishment. There are some dicta which support juries being used in medical cases in R v. HM Coroner at Hammersmith ex parte Peach (CA), [1980] 2 WLR 508:

"For instance in hospitals where the method of prescribing drugs or keeping them might be such that the continuance of such methods might be dangerous to the public...it is when the circumstances are such that similar fatalities may possibly recur in the future, and it is reasonable to expect that some action should be taken to prevent their recurrence..."

Per Lord Denning MR at 508

and

"To take an example which was canvassed in the course of argument, suppose a patient in a hospital dies from a mistaken injection of a drug in a fatal quantity, and suppose that there is reason to suspect that that happened because the system operated in the hospital for the control, issue and handling of dangerous drugs is defective. This, in my judgment, although not a physical circumstance, would quite clearly be a circumstance of the kind contemplated in paragraph (d) ...the continuance or possible recurrence of which is prejudicial to the health or safety of...any section of the public', namely those members of the public resorting as patients to that hospital."

Per Bridge LJ at 509

and

"I therefore come to the conclusion that if before the coroner there are circumstances, the continuance or possible recurrence of which are prejudicial to the health or safety of the public, and those are circumstances in which the death occurred in the sense of being circumstances present where there has been a death, then causation is not essential. In those circumstances, in the public interest, the sub-paragraph requires that a jury should be called."

Per Taylor LJ R v. HM Coroner for Inner London North District ex parte Gregory Linnane (Div C), January 20, 1989

It is a fair generalization to say that coroners do not look kindly upon the interventions of lawyers. Their involvement, even if it does not spell trouble, means that there is going to be considerably more work involved for the coroner. The coroner usually feels he is more than capable of dealing with the matter expeditiously and efficiently. When the coroner sits with a jury, it is the jury which will make all the decisions on the facts and reach a verdict, and so it is the jury and not the coroner which the advocates and the witnesses have to impress.

The legal representative of the family may become the means by which the jury can see the important issues explored with the Health Authority witnesses. He or she will almost always have the sympathy of the jury (if not of the coroner) as the key witnesses are probed in cross-examination.

THE ASSESSOR

In matters of some complexity the coroner may choose to sit with an assessor who may ask questions, or give evidence. It is often helpful to the coroner for him to be provided with the names of experts recognized by the Royal Colleges as being suitable. Obviously it would not be right for the coroner to select some expert who was partisan, but if he is going to do so then let the expert be one nominated by the anaesthetist. The role of the assessor is not defined. He should not be called to give evidence if he is also advising the coroner. The coroner may, however, invite the assessor to ask questions of the witnesses. These may prove to be even more searching than those from well instructed counsel.

THE VERDICT

A coroner or a coroner's jury has the power to return any "verdict"—which is merely a recording in "concise and ordinary language" [30] as to "how" the deceased met his death. Nevertheless there is a tendency for customary certain verdicts to be returned. Some would still argue that there is a difference between "accident" and "misadventure" [31] and there are still coroners who will return "misadventure" verdicts in medical mishap cases. The verdicts which anaesthetists fear most are "lack of care" and "unlawful killing". A verdict of "lack of care" is perhaps the most frequently sought-after verdict by bereaved families where medical negligence results in death. The standard of proof is on the balance of probabilities [32], but it is only appropriate where lack of care (in the physical sense of lack of the physical needs of the body being met) is the cause or a contributory cause of death:

"... The prime meaning is that of physical attention, preventing death from starvation, exposure, or bad nursing or medical care... If the verdict is proper when the deceased is not given enough nourishment by those caring for him it is also proper if the deceased is not given enough medicine. There is no difference. It may be a 'free-standing' verdict, on its own."

Croom-Johnson LJ put it in R v. The Southwark Coroner, ex parte Hicks (QBD) January 26, 1987

The conclusion of an inquest has no direct bearing upon civil litigation for damages but the way in which the hearing goes will have a considerable influence on the advice an anaesthetist may be given by his lawyer about the advisability of defending any civil action.

On occasion a jury will return a verdict of unlawful killing. They may not identify the person they consider to be responsible [33], and the returning of such a verdict would lead to the coroner referring the papers to the Director of Public Prosecutions. The coroner is under a duty to adjourn the inquest if during the course of the hearing evidence is given from which it appears to him that the death of the deceased is likely to be due to an offence within Rule 26(3) [...manslaughter... of the deceased] and that a person might be charged with such an offence. In these circumstances particulars of that evidence are sent to the Director of Public Prosecutions. If a verdict of "unlawful killing" is to be returned the criminal standard of proof must be applied—that is, being sure, beyond any reasonable doubt [34]. A test [35] which may be applied is as follows:

"What the jury should be told was that when considering manslaughter by neglect, they would have to be satisfied upon the evidence of these four ingredients of the offence:
16. If he does so without seeking the permission of all involved he

will run the risk of acting in breach of the rules of confidentiality.


LR 284.

18. In respect of the duty of a doctor to account see: Lee v. South

West Thames RHA, [1985] 2 All ER 385 and Naylor v.

Preston Area Health Authority, [1987] 2 All ER 353 at 360.


Criminal Court): Anaesthetist convicted of manslaughter—
criminal negligence in leaving anaesthetized patient in
theatre—patient became hypoxic and died—conviction up-
held by Court of Appeal: R v. Holloway & Others, [1993] 4

ML Rep 303.

20. Should he fail to do so he would be liable to a fine not

exceeding £1000—S.10 Coroners’ Act 1988 as amended.

21. For fine see previous reference. He may only refuse to answer

a question with "lawful excuse". In practice he may only

refuse where to answer a question might incriminate him—
Coroners’ Rule 1984 r 22; R v. Boyes (1861) 1 B & S 311; Rio
Tinto Zinc Corp v. Westinghouse Electric Corp, [1978] AC
547; Rank Film Distributors Ltd v. Video Information Centre,


27. I draw attention to the wording of subrule 37(1): "Subject to

the provisions of paragraphs (2) to (4), the coroner may admit
at an inquest documentary evidence relevant to the purposes
of the inquest from any living person which in his opinion is
unlikely to be disputed, unless a person who in the opinion of
the coroner is within Rule 20(2) objects to the documentary
evidence being admitted". There is an exception to this rule
set out in subrule 37(2): "documentary evidence so objected
to may be admitted if in the opinion of the coroner the maker
of the document is unable to give oral evidence within a
reasonable period." This does not give the coroner an open-
ended discretion to admit any document he chooses. He may
only admit a document under (2) if he has first jumped the
hurdles in (1). In particular, it must be his opinion that the
document is "unlikely to be disputed". Where he is clearly
told that the document is disputed it is difficult to see how he
could form a contrary opinion. There is therefore no means of
admitting any document which is in fact disputed by an
interested party.


29. There are too many cases where there are power struggles for

the clinical control of patients on intensive care units. Yet
when the death of a patient on an ICU gives rise to public
concern no-one is prepared to take responsibility for the
management.

30. Simon Brown J. in R v. Southwark Coroner’s Court ex parte


31. I sought to do this in the 3rd edition of Thurston’s Coronership
but was overruled by the Mann J. in Divisional Court in R v.
HM Coroner for Portsmouth Ex Parte Anderson (July 31,
1987) when his lordship said any distinction should be given
its quietus.

32. See R v. HM Coroner’s Court Hammersmith ex parte Gray and
others, QBD December 19, 1986.

33. Coroners’ Rules 1984 r. 42(a).

34. See R v. HM Coroner’s Court Hammersmith ex parte Gray and
others, QBD December 19, 1986.

35. Per Watkins LJ. R v. HM Coroner’s Court Hammersmith ex