Occasional Article

Reform of the coroner system: a potential public health failure

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ABSTRACT

The Coroners and Justice Act (2009) represents the latest in a long series of legislative and policy measures aimed at reforming the coroner system. Unfortunately, the Act represents a continued failure to recognize that the legal orientation of the coroner system threatens its capability to contribute to adequate cause-specific disease surveillance and, in doing so, to fulfill its proper role in a public health system.

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The Coroners and Justice Act—which received royal assent on 12 November 2009—represents the latest in a long series of legislative and policy measures aimed at reforming the coroner system.¹–⁵ The Act comprises nine sections with the first section relating exclusively to the reform of the coroner system in England and Wales. Reforms in the Act are intended to address the shortcomings of the current death investigation and certification systems, as identified by the Luce Review and the Third Report of the Shipman Inquiry.³,⁴ Unfortunately, the Act represents a continued failure to recognize that the legal orientation of the coroner system threatens its capability to contribute to adequate cause-specific disease surveillance and, in doing so, to fulfill its proper role in a public health system.

Determination of cause of death matters for public health

An accurate representation of the cause and circumstances of death is integral to exploring societal risks, and helps in developing preventive measures and promoting the public’s health and safety. This representation, in aggregate, can be used to: understand the distribution and determinants of mortality in the population; identify at-risk populations; understand the natural history of disease; inform service quality improvement; and identify disease outbreaks.⁶ Accurate and timely disease surveillance can detect: outbreaks of infectious diseases, increasing incidence of chronic disease, environmental hazards and, potentially, bioterrorist attacks.⁷–⁹

The coroner as a key contributor to cause of death statistics

Nearly half of all deaths in England and Wales fall under the purview of the coroner.¹⁰ The coroner is involved in the determination of cause of death when the death is suspected to have been the result of unnatural or unknown causes, and/or when a doctor is unwilling or unable to certify the cause of death.¹¹ Emerging infectious diseases can appear suddenly and unexpectedly, affecting the elderly, the sick and the less socially mobile; producing a disproportionate number of deaths outside hospital; and thus increasing the likelihood of coronial investigation.
**Reasons for reform**

Dame Janet Smith began the Shipman Inquiry by stating:
It is said that [the coroner system] does not satisfy the public interest in the discovery of the true causes of death in the population. It does not contribute, to the extent that it should, to the improvement of public health and safety. (Ref. 4, p. v)

The shortcomings of the system in terms of its lack of attention to public health were elaborated upon further in the Luce Review:

There is no formal linkage to or communication with other public health services and systems locally and nationally, such as those concerned with looking at drug abuse, public health trends, the safety and effectiveness of medical practice, adverse reactions to medicines etc. (Ref. 3, p. 17)

Most coroners in England and Wales are legally, not medically, qualified, hence, most may not understand fully the medical circumstances of death. Moreover, the coroners’ officers undertaking much of the initial death investigation are also not required to be medically trained. Data collected at scenes of death by the police or coroners’ officers may not, therefore, include data on known biological, social, cultural and/or behavioural disease risk factors. A lack of understanding of the clinical symptoms and epidemiology of infectious diseases will undoubtedly result in death investigations that may not document and detect ‘signal events’ caused by an infectious agent. It has been well-documented that the quality and thoroughness of an autopsy is compromised when the pathologist is either misinformed or uninformed as to the relevant circumstances of death before the autopsy.11,12

In her *Proposals for Change*, Dame Janet envisioned a new coroner system administered by three senior coroners who together would be able to provide medical, investigative and legal expertise ‘within’ the system. She proposed that the following duties might appropriately define the role of the Chief Medical Coroner:

He or she would establish links at a high level with those concerned with public health and public safety. The position would call for a doctor with administrative ability and some knowledge of or experience in the fields of public health and forensic medicine. (Ref. 4, p. 494)

**The Coroners and Justice Act**

Under the new legislation, the system is to be restructured, in part, by the appointment of a chief, deputy chief, senior, area and assistant coroners as well as medical examiners (MEs). The chief coroner will be responsible for: setting national standards, arranging for the training of coroners, hearing appeals against the decisions of coroners and overseeing the system in general. To qualify for the position, the chief coroner must be a Circuit or High Court Judge. The positions of deputy chief coroners are likewise to be filled by Circuit or High Court Judges, or by persons who have experience as a senior coroner, or as a coroner for treasure. The duties of the deputy chief coroners are expected to mirror those of the chief coroner.

The new Act also calls for the creation of independent MEs to provide scrutiny to the certification process (thereby increasing the accuracy of mortality data) and to be available for consultation should the coroner have any questions relating to the medical aspects of death. According to the Department of Health, the newly proposed MEs will submit a list of deaths and their associated causes to the Office for National Statistics (ONS) monthly.13

**Current reforms are inadequate to protect public health**

In England and Wales, the risk of dying from disease vastly eclipses that of dying from homicide or negligence. According to the National Risk Register, pandemic flu is deemed to be more likely to occur and have a greater impact than terrorism, climate change or attacks on critical national infrastructure.14 It is, therefore, perplexing that the Act focuses predominantly on matters of criminal justice: needs of victims and witnesses, pornographic images, sentencing of terrorists, rights of bereaved families and data protection. Although these are important and understandable inclusions, given the Act’s source in the Ministry of Justice, it is striking that public health is given short shrift.

Despite the conclusions of both the Luce Review and the Shipman Inquiry—that the capacity to support public health must be incorporated into any reformed system—there is no mention of disease surveillance in either the Act or its accompanying schedules. No statutory requirement has been made requiring a public health official in the system. No provisions, beyond the independent scrutiny of death certificates offered by the newly proposed MEs, are proposed to protect public health and safety. As the local Primary Care Trust will appoint the ME, it seems unlikely that he/she would have the appropriate population perspective to notice mortality trends because the MEs will only be responsible for reviewing deaths in their appointed region. It is unclear whether MEs, or the newly proposed National Medical Examiner, will be able to offer adequate guidance for the
purpose of re-orienting the entire system towards the pursuit of public health.

Furthermore, it is unclear whether coroners will consult with the MEs. The information provided to the ME, should he/she be consulted at all, will presumably include only the information that the coroner deems important or relevant to the determination of cause of death. If the ME chooses to enquire further about the circumstances of death, it is entirely possible that evidence that might have been of epidemiological importance may no longer be easy, or even possible, to obtain.

The focus on coroner system reform has very much become about preventing another Shipman—about protecting the public from the exceedingly improbable circumstance wherein a doctor wantonly kills his/her patients—whereas official death investigation system whose ethos and expertise neglects the role of disease surveillance, risk reduction and health service quality improvement in society.

Moving forward: a public health focus in the coroner system

One of the aspects of the coroner system that was uniformly deemed deficient by all those consulted on its reform was the lack of central guidance. Senior officials in the new system should oversee the system, introduce national standards and set training requirements from a public health perspective. They should guide the system in terms of its mandate as an organization devoted to public health—one responsible to current government priorities in terms of mitigating the risks deemed to pose imminent threat to life, health and safety. A public health official in the system would contribute to the training of coroners’ officers and would ensure that all scene investigators are familiar with disease risk factors and the information that can be collected at a scene to better inform the coroner/ME/GP and/or pathologist about the context for the cause of death.

The inclusion of such an officer should be statutory, making his/her presence mandatory under the law. It seems entirely consistent with the purpose of the reformed coroner system—and the requirements of any effective and efficient mortality surveillance system—to have, at the very least, one senior-level public health professional in the coroner system, most appropriately as the newly proposed Medical Advisor to the Chief Coroner or a Deputy Chief Coroner.

If the new coroner system is to be guided by the principles of public health, then certainly someone operating in the system needs to be responsible for exercising various duties such as liaising with the Department of Health and the Health Protection Agency to ensure that all current and important public health issues are understood by all in the coroner system. As we have seen with the recent spread of H1N1, outbreaks of emerging infectious diseases are unlikely to be confined to specific geographic locations. Cases of an infectious disease, for example, may be spread over more than one coroner/ME region, making it difficult for a single ME to notice a trend. Although the ME would be required to submit regular, once-monthly reports to the ONS so that unusual trends in mortality can be detected, this arrangement can hardly be considered an effective component of sentinel surveillance, as an outbreak of, for example, pandemic influenza needs to be detected early for effective containment.

It is just this type of concern that has inspired several death investigation systems to implement coroners’ databases for the ‘real-time’ documentation of death for the purpose of ‘providing a valuable hazard identification and death prevention tool for coroners and research agencies’. Should this type of programme be considered in England and Wales, a public health official inside the coroner system would be best suited to spearhead such an initiative.

Changes in the manner and the extent to which data are collected or created need to be well documented, as even minor changes in procedure may have a significant impact on surveillance data. For instance, a public health official would be able to monitor and feed back to the ONS and other public health officials any notable changes in data collection. Additionally, the coroner system should be responsible for facilitating health research, liaising with health researchers, and ensuring that research ethics are observed. None of these latter considerations is anywhere close to being adequately reflected in the new Coroner and Justice Act.

There are two key messages. First, the legal orientation of the coroner system threatens its capability to contribute to adequate cause-specific disease surveillance. Second, the omissions from the Act concerning the structuring and staffing requisite for coroners to fulfil their proper role in a public health system present clear implications for health and safety of population of the UK—particularly when it comes to effectively addressing emerging infectious diseases.

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