Faculty of Forensic & Legal Medicine

A Day in the Life of a Coroner

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The office of coroner is the oldest judicial office in English law, dating back to the reign of Richard 1 and the Articles of Eyre from 11th September 1194. The law under which the coroner operates is now the Coroners and Justice Act 2009 (The Act). I have held coronial office since 2004 and have had the privilege of being Senior Coroner for the County of the East Riding of Yorkshire and the City of Kingston Upon Hull since I was appointed to office in September 2012. Prior to this, I worked for the NHS as a consultant neurosurgeon for over 20 years. The range of work, challenges and rewards associated with the coronial jurisdiction is huge; no day is ever the same, nor can it be predicted what "comes across the desk".

I was the last medically qualified coroner to be appointed to a full time jurisdiction and some readers may be interested in reading some of my background in the 'BMJ confidential' series which I was asked to contribute to in 2016 (BMJ 2016;355:i5824 dli: 10.1136/bmj.i5824).

I have decided that to confine this article to a day would not adequately reflect my work and so I have taken the liberty of setting out a random week in the life of a coroner. Whilst the cases described are true, they are presented in such a way to ensure anonymity.

Background

I am always up and about at 6 am. The drive from my village in North Yorkshire to my office and courts, on a good day, is never less than seventy-five minutes, but can take up to two hours. Court starts at 10:00 hours, but prior to this, the cases that have been referred overnight need to be assessed and decisions made about the need for post-mortem examinations or whether the coroner's duty under section 1 of the Act to investigate, is engaged or not.

Apart from hearing inquests, other matters such as reviewing cases and preparing them for inquest is part of the daily routine. On occasions, when not presiding over inquests, I may choose to work at home. Whilst court in general, runs from 10:00 hours to 16:30 hours, I rarely leave the court before 18:00 hours and then drive home. When I first started in Hull, I was acutely aware of the minimum travelling time of three hours to and from work and how this was "dead time". I resolved to utilise the time productively and do this in several different ways. I might listen to music, listen to a podcast or reflect upon and consider a difficult problem that has presented during the course of the day's work.

Monday

My phone rings at 07:30am and I am informed of a suspicious death that occurred in the small hours of the morning. It involves a known heroin user who has allegedly been assaulted by a third party and the police are requesting permission for a Home Office post-mortem examination. Having listened to the circumstances, I authorise the forensic post-mortem examination. After my journey, I arrive at work at 09:15 and review the file for the pre-inquest review hearing upon which I am sitting at 11:00am.

The case involves a young man detained under section 2 of the Mental Health Act 1983, who despite being on ten-minute observations, takes his own life by hanging in the secure facility. As this tragic death occurred in state

detention, amongst other things I will need to sit with a jury. The pre-inquest review hearing goes well, and decisions are made about the scope of the inquest, whether Article 2 of the European Convention of Human Rights is engaged, and submissions are received about the need to instruct expert witnesses. A decision is made that the case will occupy five court days. In the afternoon, I am doing a treasure inquest, which represents one of the less well understood duties of the coroner, and the law under which I operate is the Treasure Act of 1996. The find concerns two Roman rings which are found on cultivated land in the East Riding of Yorkshire. The local representative of the British Museum has prepared an extremely scholarly and erudite report describing the dimensions and precious metal content of these artefacts, which are photographed and show exquisite filigree detail around the bands of the rings. In terms of precious metal content and age, I rule that these artefacts qualify as treasure within the meaning of the Act. Following the inquest, I read the files of the two cases upon which I am presiding the following day.
As I am leaving, I receive a telephone call about a motor cyclist who has suffered a catastrophic head injury and is about to be declared brain dead in the local neurosurgical intensive care unit. I am asked whether I have any objections to tissue and organ donation. Having heard the circumstance of this tragic death, I indicate that I have no objection to transplantation. I drive home, have my dinner and relax with a glass of red wine, before retiring to bed at midnight (I rarely go to sleep before midnight).

Tuesday

I arrive at the court review the files once again and hear the first inquest, which concerns the death of an elderly gentleman from hypothermia. The afternoon inquest relates to a gentleman in his fifties who is found hanging from a rafter in his garage and who had no previous psychiatric history but had recently run into financial difficulties. Coroners will always extend their condolences to the family of the deceased at the time of the opening of the inquest and when the conclusion, formerly known as the verdict, has been delivered.

After the hearing, I complete a *memorial* to the Attorney General to have an inquest conclusion quashed pursuant to section 13 of the Coroners Act 1988, which remains in force. The case concerns an inquest on a missing person presided on by one of my assistants 8 years previously. No body was found, but last year, a dog walker came across skeletal remains which were subsequently identified by DNA as belonging to the missing gentleman. On the basis that new evidence has come to light, I initiated the procedure of having the conclusion quashed, which is a two-stage process which firstly involves obtaining the authority of the Attorney General, which if given, then involves application to the Hight Court. This is an unusual occurrence, which unlike judicial review of a coroner's decision, is not time limited.

Wednesday

Today, I am hearing an inquest touching upon the death of a serving prisoner who has died from natural causes. There are three prisons in my jurisdiction, one of which is a high security category A prison (HMP Full Sutton). Prisoners who are serving life sentences and who will not be released, die in prison from all the usual range of natural disease processes such as dementia, cardiovascular disease and malignancy. As they are in state detention, an inquest touching upon their death must be heard, but since the inception of the Coroners and Justice Act 2009, if the death is attributable to natural causes, there is no longer any requirement to sit with a jury. If, however, the death is not due to natural causes, it is mandatory to sit with a jury, which comprises between 7 and 11 jurors. The gentleman concerned sadly died from carcinoma of the head of the pancreas and I return a short form conclusion of *natural causes*. It is essential in the analysis of the case to ensure that the prisoner received care, whilst incarcerated, that was equal to that which he would have received in the community.

Thursday

I get up earlier than usual, as last night I received the final chapter of a book for which I am co-editor entitled: *The Autopsy – A Guide for The Legal Profession*. I check the manuscript and having corrected a number of typographical errors, I cut and paste it into the latest iteration of the book's manuscript. I leave for work and on my way in, I am informed that one of the witnesses for the two-day hearing over which I will be presiding, has been taken ill. I am asked whether the case should be removed from the list or whether his evidence can be adduced under the authority of Rule 23 of the coroner's inquest rules. Court time is very precious, and I am reluctant to remove the case from the listing and tell my coroner's officer that I will address the interested persons on this issue at the start of the inquest. The case concerns a lady who was run over by her own motor vehicle and following an extensive police investigation, lasting eighteen months which ruled out criminality, the case was returned to my office for hearing. At the opening of the inquest, no submissions were received to remove the inquest from the list, and I ruled therefore that the witness's evidence could be heard under Rule 23 of the Coroner's Inquest Rules.

Following the conclusion of the first day of that inquest, I had organised a teaching session for my coroner's officers on medical topics. It has been my practice to hold regular sessions for my staff and for legally qualified assistants to deal with common medical disorders which they will encounter daily as part of their work.

Friday

I receive a telephone call before coming into work about serious issues relating to a funeral director and his premises, for which the police are requesting an urgent meeting with me. On arrival at work, I am briefed by the senior investigating officer and make a number of decisions relating to the need for identification of the bodies stored in those premises. I am unable to elaborate on this further, as the matter is till sub judice, but suffice it to say, it has proved to be an extremely challenging matter. The conclusion of the motor vehicle inquest occurs sooner than anticipated and I hand down my findings of fact and conclusion by early afternoon. This is fortunate, as I have received a response from a Regulation 28 report (prevention of future deaths) that I had issued 56 days earlier. The organisation that I approached has indicate what remedial action they intend to take to decrease the probability of similar tragedies occurring in the future. Regulation 28 reports are an important public health measure, and all can be viewed, as they are within the public domain. Before leaving, one of my assistants asks me for advice about a case on which she is sitting the following week, which is a prison jury inquest. When I first started doing coronial work, it was pointed out to me, that being a coroner it is a lonely position and, in my area, we have regular meetings with the assistants to discuss cases and share ideas.

The Weekend

I am always on call. Out of hours I may receive calls relating to organ transplantation or requests for Home Office post-mortem examinations. On this particular weekend, the phone did not ring.

Conclusion

No day is ever the same and the variety of work is considerable. It can range from expected deaths from malignant disease in the community, to self-poisoning with cyanide obtained from laboratory furnishers in the United States, through to deaths in custody and police shootings. Do I miss the challenges of clinical practice and surgery? The short and unequivocal answer is no; the intellectual challenges and rewards of being a coroner are very considerable. Most of all, I find helping bereaved families, who must be at the heart of the inquest process and who are suffering the loss of a loved one, is one of the most rewarding and fulfilling duties in public office.

I would finally like to share the words of Dr Thomas Wakley with you; he was a 19th Century coroner:

The coroner was the people's judge, the only judge the people had the power to appoint. The office has been specifically instituted for the protection of the people.

References

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